The parallel report to Japan report to UPR

29 Mar.2017

Japan National Group of Mentally Disabled People (JNGMDP)

World Network of Users and Survivors of Psychiatry (WNUSP)

The Japan National Group of Mentally Disabled People (JNGMDP) is the nationwide network of individual mentally disabled people and groups of them, established in 1974. Our membership is only mentally disabled people and our mission is to advocate our own human rights by our own voices.
We are a member organisation of WNUSP and we participated to make the CRPD process with WNUSP international level and national level, we joined to cross disability organisation Japan Disability Forum (JDF) and also we are advocating to implement of CRPD with WNUSP and JDF

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The World Network of Users and Survivors of Psychiatry (WNUSP) is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide. The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD, which it played a leading role in drafting and negotiating.
WNUSP is a member organisation of IDA and has special consultative status with ECOSOC.

www.wnusp.net

Recommendation 147-86 by Armenia of the second cycle review of UPR was not implemented yet in Japan[1]

Introduction

1. Japan ratified The Convention on the Rights of Persons with Disabilities (hereinafter CRPD) in 2014 but there have been many new legislations and policies violating CRPD even after the ratification and especially persons with psychosocial disability, persons with dementia and persons with intellectual disability have been left behind the reform and the new legislations for ratification.

Many regulations and policies violate CRPD even after the ratification

2. Currently there is no national monitoring system of CRPD independent from the government and complies with Paris principle. The government explains that the Policy Commission in Basic Act for Persons with Disabilities (Act No. 84 of May 21, 1970, the last amendment No.65 of June 2013) is the national monitoring system in Art. 33 of CRPD but it is not independent from the government. It is under Cabinet office and it has not own secretory staffs or budget that it can control.

3. Furthermore, in the Act there is no article to give the mission of CRPD national monitoring to this commission because the Act was not amended after the ratification of CRPD. The main mission of the Policy Commission is to research and to review the Basic Programme for Persons with Disabilities, and to make the recommendation to the government. Also monitoring the status of implementation of the Basic Programme for Persons with Disabilities is its mission. So it is not a national monitoring system of CRPD.

4. The purpose of Promoting the Guardianship Act (Act No.29, 2016) is increasing the users of guardianship and the government recognized that guardianship is the only one tool to protect persons with psychosocial disability, persons with intellectual disability and persons with dementia. Some 190,000 persons are now under guardianship and the government claim that it is too small and to increase the number is necessary to protect their human rights.

5. CRPD Art. 12 requires that the state party to repeal guardianship and to recognize all persons with disability equal before the law. So guardianship itself and Promoting the Guardianship Act violate CRPD Art.12.

6. Japan is ranked no 1 for the highest number of psychiatric hospital beds

[1] 147.86. Continue the effective implementation of the CRPD (Armenia)

and the average length of stay in psychiatric hospitals of OECD countries. There are 300,000 inpatients in psychiatric hospitals and about 200,000 patients staying for over 1 year and over 36,000 inpatients staying over 20 years. And also the number of the new coercive hospitalisation has increased by 2-3 times in two decades, and about 40% of inpatients are subject to coercive hospitalisation. But the government recognises that coercive hospitalisation guarantees medical treatments and patients' health and wellbeing and there are no effective measures to reduce the numbers of beds in psychiatric hospitals and coercive hospitalisation and whole hospitalisation.

7. The bill of the amendment Act on Mental Health and Welfare for the Mentally Disabled (Act No. 123 of 1950, the last amendment in 2016 hereinafter MHA) is introduced to the Diet on 28 Feb. 2017 and the government explained that the purpose of the amendment was to prevent the crime such as the attack to Yamayuri-en[2], though arrested person was prosecuted as he had criminal responsibility on 24 Feb. 2017.

8. The amendment bill of MHA radically changed the purpose of mental health service from the patients' own interests of public safety, though the government always has explained that the purposes of the MHA and coercive hospitalisation are patients' own interests.

9. The bill includes the new system to make the "support plan" only for the patients who were subjected to the coercive hospitalisation by Art, 29[3] of MHA. It is the discrimination based on actual or perceived disability. There are many people without disability who are dangerous to others or to oneself, but they are not subject to such treatments and coercive hospitalisation itself. It is discrimination against persons with psychosocial disability.

10. Before the discharge from the psychiatric hospitals, the local governments which ordered the coercive hospitalisation have the obligation to establish the case management team and there is no obligation including a patient concerned.

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[2] On 26 July 2016, one ex-staff of the institution for persons with disability attacked the institution Yamayuri-en and killed 19 persons with disability and injured 26 persons with disability. He sent the letter to the chair of the Diet that he declared the plan of attack and said persons with disability should be killed in February 2016, and then he was coercively hospitalized by the Art. 29 of the MHA after the psychiatric exam that he was dangerous to others or oneself from 19 Feb. to 2 Mar. 2016.
The attack was the hate crime against the persons with disability. But the government established the team in Ministry of health, Labour and Welfare to review the coercive hospitalization system shortly after the attack on August 2016.

[3] Coercive hospitalisation reason for dangerous to others and to oneself

11. We are afraid that the process will take time and enlarge the term of coercive hospitalisation and if a patient refuse the plan, he/she will be detained until withdraw the refusal.

12. According to the bill of MHA, the local government has the obligation to establish "the committee to support persons with psychosocial disability in the community". However, the members of this committee are not really of support, instead, they are local health centre staff, a hospital staff, and other service providers and the police, etc.. Event more grave, between members of this committee, including the police, they share patients' sensitive private information without their consent. If the psychiatrist find illegal drug users or a patient who has the plan of the crime by "firm belief.

13. So mental health professionals should breach confidentiality. Furthermore, the private information of the persons should send to another local government even when they move homes and the term of sharing the information is indefinite.

14. The monitoring system in the bill makes the community as if it was the ward of a psychiatric hospital or of a prison. Whole daily life will be monitored and controlled by service providers and hospital staffs and the police.

15. If a person with psychosocial disability disagrees or is unhappy with the monitoring and control, they are subject to refusal of medical treatments or any service, including the disability pension and the social benefit and might become homeless or neglect to die.

16. Any support or support plan should be by their own will and preference and medical treatments also should be delivered with the free and informed consent by a person concerned.

17. And especially making the plan of the crime by "firm belief" is not yet the crime so the police should not and cannot make the intervention so the police sent the defendant in Yamayuri-en attack case to mental health system. And also mental health system should not make the coercive intervention. If the mental health system makes such intervention, psychiatric hospitals become the indefinite detention centres. Psychiatrists should not and cannot correct one's own belief. If they try to correct it, the whole mental health system becomes security measure and we are afraid that persons labelled with anti-social personality disorder will be subject to coercive hospitalisation and indefinite detention. To send the defendant to mental health system is the biggest fault and it is not the problem of mental health system.

18. CRPD requires that the state party should ban the detention of persons with disability based on disability against their will, and also any rehabilitation and medical treatments should be voluntary. CRPD requires also nondiscrimination against person with disability and respect the right of privacy and integrity. MHA itself violates CRPD and the bill of the amendment of MHA violates CRPD.

19. The government is now making the guideline of the plan for persons with disability welfare system from 2018 to 2020. But the government withdrew the agenda of deinstitutionalisation of long-term inpatients in psychiatric hospitals and even they declared 60% of inpatients hospitalized over one year were "very severely disabled and chronic patients" and they could not be discharged and live in the community so the numerical goal of service in the community should be only for 40 % of long-stay inpatients. Furthermore, the government explained that the guideline makes the number of long-stay inpatients over one year decrease, but 10 % of them would remain and the numerical goal of beds number of long-stay inpatients in 2025 would be 100,000 beds. CRPD Art.19 declares that no one forced to live in the institutions so the guideline violates CRPD.

Recommendations

20. Establish a national human rights institution or the national monitoring mechanism of CRPD compliant with Paris principles with including the members who are recommended by organisations of people with disability.

21. Repeal the guardianship system in Civil Code and abolish Promoting the Guardianship Act.

22. Repeal MHA and make the comprehensive deinstitutionalisation plan of psychiatric hospitals.

Annex 1

November 27, 2016

Request to Visit Japan in 2017

Dear United Nations Human Rights Council,

Committee for realizing the visit of the United Nations Working
Group on Arbitrary Detention to Japan in 2017
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1. Introduction

We are a Japanese organization of persons with psychosocial disabilities, their supporters, and their lawyers. We are writing to ask that you choose Japan as your country to visit in 2017.

Personal liberty is guaranteed for persons with psychosocial disabilities; thus, there is no justification for depriving liberty on the basis of psychosocial impairment (article 9.1 of the International Covenant on Civil and Political Rights [hereafter, ICCPR], articles 35.1 and 19 of the General Comment of United Nations Human Rights Committee, and article 14.1 of the United Nations Convention on the Rights of Persons with Disabilities [hereafter, CRPD]).

However, Japan's mental health system is mainly based on institutionalization, which means that liberty is usually deprived. In January 2016, there were 335,585 beds in Japanese psychiatric hospitals (section 2 below). To avoid having empty beds, psychiatric hospitals facing financial difficulty try to hospitalize a lot of persons with psychosocial disabilities. Moreover, it is difficult for people who support persons with psychosocial disabilities to promote discharge since; communities aren't prepared for inclusion and

participation in the community with persons with psychosocial disabilities (section 3). Persons with psychosocial disabilities face involuntary and illegal seclusion and restraint (sections 8 and 9), are forcibly detained and treated despite insufficient medical need (sections 4, 5, and 6), and their liberty is unjustly restricted (section 7). We are eager for you to become aware of the situation in Japan, which is incompatible with article 9.1 of the ICCPR and article 14.1 of the CRPD. Below, we will introduce cases that illustrate the state of Japan's mental health system.

2. Psychiatric hospital forcibly admitted persons with psychosocial disabilities, despite a lack of medical need

Hotoku-kai Utsunomiya Hospital in Tochigi Prefecture, which is over 100 kilometers far from Tokyo, is a psychiatric hospital where two patients died in 1983 as a result of staff violations.

By existing law, a person with psychosocial disabilities can be voluntarily admitted to a psychiatric hospital (voluntary admission), and when a patient asks to be discharged, the hospital must discharge him or her unless it was forced admission (section 22, clause 3, of The Mental Health and Welfare Act. However, Utsunomiya Hospital ignored inpatients' discharge requests and kept them hospitalized. In addition, many inpatients are treated in a locked ward eventually, between 2011 and 2015, lawyers were able to obtain discharge for more than 30 inpatients whose discharge requests had been denied.

About half of the inpatients at Utsunomiya Hospital received public assistance, and many had no relatives to depend on. The hospital was suspected of keeping long-term inpatients, despite a lack of medical need, to generate sustainable income, since the patients' medical expenses were covered by public assistance.

Case of G

G, who lived in the Taito district of Tokyo and received public assistance, began to suffer from insomnia. He consulted with a caseworker at a welfare center, and the caseworker told him to go a clinic.

G said to his psychiatrist at the clinic, "I would like to have a medical examination in a big hospital." The psychiatrist wrote a letter of introduction and told him to submit it to the ward office. Following the psychiatrist's instructions, he submitted the letter to the office.

In January 2011, the caseworker came by taxi and took him, who didn't know where he would be taken, to Utsunomiya Hospital.

Soon after arriving at the hospital, he was examined by a psychiatrist. The psychiatrist said, "I will cure you. I have cured hundreds of thousands of people and have given

lectures [this expression means the psychiatrist wants to convey that he is a famous psychiatrist]. You do not have a disease and will be cured soon." However, the psychiatrist didn't explain the diagnosis or cure plan.

Without explanation, he was taken to a locked word. It was dirty and smelled ward. Some inpatients were left in diapers. From the outset, he had no intention of being hospitalized. He forcefully demanded that he be discharged. Then, a nurse gave him an injection, rendering him half conscious. He couldn't remember what happened after that. For the next three months, G was put on medications that kept him only half conscious. He couldn't walk without help and sometimes wore diapers. When he resisted nurses' orders, they would increase his medication or inject him. He gradually learned to be well-behaved and inconspicuous. As a result, he was no longer injected.

Life on the ward was extremely monotonous. G would get up at 6:30 a.m.; have breakfast, lunch, and dinner; take a bath; watch TV; play shogi; and take a nap. When he took walks, the area was confined to the hospital premises, and he had to be accompanied by staff so he wouldn't run away.

In spring 2012, he asked the psychiatrist to discharge him. The psychiatrist said, "Another three years."

G thought that unless he took action, he would never be discharged. He planned, therefore, to gain favor with the psychiatrists and nurses so he could be moved to a group home on the hospital's premises and then run away during an unguarded moment.

One day, G learned that another patient on his ward intended to consult a lawyer to seek discharge. G and the other patient both met with lawyers and successfully persuaded the hospital to discharge them. At that point, G had been hospitalized for about two years.

3. Inpatient hospitalized for a long period with no support for discharge

Different from the preceding case, even if a psychiatric hospital doesn't intentionally block discharge, sometimes patients face long-term hospitalization because they don't receive the support they need to be discharged.

In the following case, B was hospitalized for more than 60 years without support for discharge from hospital staff or the government. In 2010, there were 36,584 inpatients who had been hospitalized more than 20 years. Indeed, it is not uncommon for inpatients to be hospitalized for several decades. Such neglect by hospitals or the government should be regarded as arbitrary detention.

Case of B

In the 1950s, following an incident, B was diagnosed as schizophrenic and

involuntarily admitted to a psychiatric hospital (compulsory admission). He has intellectual disabilities.
B's psychiatrist changed his admission form from compulsory to voluntary. Thus, B could be legally discharged any time he wanted. Yet, he has been hospitalized for more than 60 years, and there seems to be no active support for his discharge.
His condition is stable and there is no medical need for hospitalization. However, he is over 80 now and can't imagine life outside the hospital. He doesn't want to be discharged because he's had no relationship with the outside world for such a long time.
When his attendant talks about discharge, B becomes silent, and he gets angry when the attendant mention a discharge against his will. B seems to think the hospital is only where he belongs and discharge would drive him from his home.

4. Involuntary admission based on incompetency

Involuntary admission based on incompetency is a system in which a person with psychosocial disabilities is involuntarily admitted based on incompetency and examination by a qualified psychiatrist and with the consent of a close family member or a guardian (section 33, clause 1, of The Mental Health and Welfare Act). This system carries a high risk of abuse and since people can be forcibly hospitalized according to the will of their families, even if they resist the admission.
As a safeguard, a person with psychosocial disabilities can appeal for discharge to a prefectural governor. However, in 2014, only 104 of 2,455 requests for discharge or improved treatment were accepted. In other words, the safeguard is ineffective.
There is no justification for a system that deprives the liberty of persons with psychosocial disabilities, carries a risk of abuse, and has insufficient safeguards.

Case of U

When U sought public assistance at a welfare center in the Shinagawa district of Tokyo, a staff member took him to a mental clinic. A psychiatrist at the clinic asked, "Have you been admitted in psychiatric hospital?" and he said yes. The psychiatrist replied, "So, you should be admitted." After the examination, U was sedated by injection and taken to Utsunomiya Hospital by a caseworker from the welfare center.
U was then examined by a psychiatrist at Utsunomiya Hospital. The psychiatrist said, "You should be hospitalized for a year," but did not explain the diagnosis. U was then hospitalized as a voluntary admission.
One day, the psychiatrist suddenly announced, "You will be hospitalized as an involuntary admission based on incompetency." He didn't understand the need for admission and asked to be discharged. But the psychiatrist said, "Stay in the hospital

and do farming [in the hospital as a treatment]" and didn't consider the request.
U consulted with a lawyer and appealed for discharge to the Tochigi prefectural governor. However, Tochigi prefecture decided U should remain hospitalized as an involuntary admission based on incompetency because he was perceived to have a "minor anomaly of the cerebellum" and "insufficient intellectual ability." Both "symptoms" were never "cured," and U continued to be hospitalized as an involuntary admission based on incompetency.

5. Involuntary admission based on dangerousness

In the case of involuntary admission based on dangerousness, a person is involuntarily admitted to a designated psychiatric hospital, by the authority of the prefecture government, after more than two qualified psychiatrists examine the person and determine that he or she is psychosocial impaired and dangerous to self or others (section 29, clause 1, of The Mental Health and Welfare Act). According to existing domestic laws, people who aren't perceived as psychosocial impaired can't be involuntary hospitalized or treated, even if they are dangerous to self or others. In short, involuntary admission based on dangerousness to self or others is a discriminatory treatment that forces hospitalization based on actual or perceived psychosocial impairments.
As shown in the case below, involuntary admissions based on dangerousness occur that are neither valid nor necessary.

Case of Y

On March 10, 2015, Y was working in a bank as a temporary employee. However, she was troubled by her superior's abuse of authority and planned to resign by the end of the month. She consulted the public employment security office about the matter. They said, it would be better for her to get a medical certificate from a psychiatrist and apply for unemployment benefits, encouraging her to be examined in a psychiatric hospital. Y went to a mental clinic, told the psychiatrist about her insomnia, and was prescribed sleeping pills. At that time, she had no diagnosis.
Shortly afterward, on March 15, Y had words with her husband, while drinking alcohol in the second-floor living room of their house. She doesn't clearly remember why the dispute began, but it was something minor (e.g., her husband was being cold toward her). As they argued, he nearly struck her. She promptly grabbed the phone and called the police with intention to warn him. The police answered, but she hung up without saying anything. Angered by the call, the husband tore the wire from the telephone. Y and her husband pushed and shoved each other. Then, as Y tried to go to the porch to escape her husband,

he violently pulled her back into living room.
The police eventually arrived and rang the front-door buzzer. The husband said, “They have come, haven’t they,” and went down-stairs to open the door. As the husband and the police ascended the stairs, Y heard her husband say, “My wife may jump off porch,” to which the police replies, “She won’t die if she jumps from the second floor.” When her husband came to the living room and Y promptly went to the porch, the police found her, restrained her, and took her to the police station.
By the next day (March 16), Y had sobered up and was calm. However, the police had reported her to a public health center, and the Saitama Prefecture governor arranged for an involuntary admission based on dangerousness. Though a psychiatrist examined her, he asked very few questions.
Y was involuntarily hospitalized at Kawagoe-Dojin-kai Hospital for about a month. For the next a month, she was secluded and from March 16 to March 18, put in restraints.
This involuntary admission made her distrustful of mental health care. She feared that once she was labeled psychosocial impaired, no one would accept anything she said.
Though Y had irregularly visited psychiatric hospitals, she’d no prior history of being hospitalized. She had lived and worked normally just prior to her involuntary admission.

6. Involuntary admission and supervised outpatient treatment for insane or quasi-insane felony Act 2005

A person who commits serious crimes (murder, arson, robbery, rape, assault with injury), in a state of insanity, and is judged as having no responsibility or limited responsibility, can be involuntarily hospitalized and treated.
There are no limits on the term of admission. Therefore, persons with psychosocial disabilities can be isolated from their communities for a long time.

7. Spending control by a mental health agency

Welfare centers will sometimes recommend that a person receiving public assistance who can’t control his or her finance be examined at a day-or-night care center managed by a mental health clinic.
Enomoto Clinic has five clinics in Tokyo prefecture. It provides a service called psychiatric day/night care mainly involving a meal and recreation to persons with psychosocial disabilities, morning to night, Monday through Saturday. Most people who use the clinic receive public assistance. In some cases, the clinic controls its users’ money and gives them daily allowances for food or living expenses for example, 1,000
JPY (about 10 USD) per a day. In such cases, people with psychosocial disabilities have no choice but to continue going to the day/night center to get the money they need to live.

Such spending control is done without the consent of the users. In addition, it isn’t clear

whether there is any medical necessity or efficiency in these controls.

Case of "I"

"I" is a 65-year-old man living in Edogawa who receives public assistance. In June 2014, "I" started attending day/night care at Enomoto Clinic to treat alcohol addiction. After he started attending the clinic, a staff member ordered him to leave his residence and move into the Yoshioka building in Toyoshima. This was an office building with a room that had been divided into two rooms by a wooden wall that didn't reach all the way to the ceiling. Because of this gap, "I" could hear all the noise of daily life in the neighborhood, and there wasn't enough privacy. Some people shared a single toilet and there was no shower or bath. The clinic controlled his money, which meant he had no cash on hand. All of his daily needs, such as food, were rationed likewise. Since he couldn't pay to use a public bath, he washes using a towel at the sink. Others with psychosocial disabilities who attended the Enomoto Clinic lived in the Yoshioka building as well.

Day/night care is open Monday through Saturday, except for national holidays. Users go from 10 a.m. to 6:45 p.m. The recreation activities typically involve drawing, math quizzes, playing gate-ball, watching movies, reading, etc.

To buy food, "I" would go to a nearby convenience store or super-market with staff from the clinic, who would pay for the food. The staff only bought him enough for one day, so he would have to go to day/night care to get food for the next day.

"I" found the treatment inefficient and saw no purpose in attending day/night care. After consulting a lawyer, he was able to stop attending day/night care and regained control of his money.

8. Restraint by a private transfer agency

Families sometimes use a private transfer agency when they want a relative with psychosocial disabilities to be involuntarily hospitalized. Such agencies not only perform transfers but can also physically restrain people who are uncompliant, put them in a car, and transport them to the hospital.

Governments may introduce private transfer agencies to the families of persons with psychosocial disabilities. However, such agencies do not have legal authority to restrain people against their will. This is comparable to a crime in which a criminal needs to be arrested or detained.

Case of Z

Using a duplicate key, men opened the door of Z's flat and entered his room

without consent. They appeared to be the staff of a private transfer agency that Z's family had employed, and the duplicate key seemed to have been provided by his family. The men bound Z's body, pulled him from the room, and practically dragged him out to a car. The restraints prevented escape. He was taken to a psychiatric hospital and involuntarily hospitalized as an involuntary admission based on incompetency. Even though he received scratches and bruises from the transfer agency's violent method, the hospital did not treat the wounds.

9. Restraint during admission

According to domestic law, when a psychiatrist with a specific license, called a "qualified psychiatrist," examines a person admitted to a psychiatric hospital, he or she can have the person secluded or restrained for more than 12 hours (section 36, clause 3, of The Mental Health and Welfare Act.

Seclusion and restraint occur daily. According to a survey, on June 30, 2013 of 297,000 persons with psychosocial disabilities admitted to psychiatric hospitals, 9,883 were secluded and 10,229 were restrained. It is clear that seclusion and restraint are readily used in the mental health system (see section 5 above).

As described below, there may be cases in which treatments involving restraint deprive the dignity of persons with psychosocial disabilities.

Case of H

H is a woman who has suffered from bipolar disorder for a long time. Following an overdose, she tried to hang herself at the hospital. As a result, on January 31, 2007, she

was taken to Tottori Medical Center as an emergency transfer. H opposed the admission, but a psychiatrist examined her and decided to hospitalize her as an involuntary admission based on incompetency.

H was secluded in a locked small room that had a window with iron bars. She was injected, restrained by leather belts, and made to wear a diaper. She was locked up and left alone in the small room.

That night, both male and female nurses came in to change her diaper. The male nurse would change her as the female nurse watched in silence. Humiliated by having her lower body exposed to the male nurse, H asked, “Why is there a male nurse?” The female nurse only answered, “There are both males and females who are nurses.” H felt she was treated not like a human but as an object, severely deprived of her dignity.

H was examined by a psychiatrist and discharged in the afternoon on February 1, 2007.

Sincerely yours,

Committee for realizing the visit of the United Nations Working Group on Arbitrary Detention to Japan in 2017

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