

MASTER



Human Rights and Mental Patients in JAPAN

Report of a Mission
on behalf of
The International Commission of Jurists
and
The International Commission of Health Professionals

INTERNATIONAL COMMISSION OF JURISTS

box 31/15

Human Rights and Mental Patients in JAPAN

Report of a Mission
by
Dr. T.W. Harding, Judge J. Schneider, Dr. H.M. Visotsky
and
Dr. C.L. Graves (Mission Secretary)

on behalf of

The International Commission of Jurists
and
The International Commission of Health Professionals

CN 916

The ICJ permits free reproduction of extracts from any of its publications provided that due acknowledgement is given and a copy of the publication carrying the extract is sent to its headquarters at the following address:

P.O.Box 120, CH-1224 Chêne-Bougeries/Geneva, Switzerland

Contents

| | |
|-----------------------------------------------------------------------------------------------------------|----------|
| Introduction..... | 5 |
| CHAPTER I | |
| The Development of Japanese Psychiatry..... | 8 |
| Mental Hospital Scandals in Japan..... | 15 |
| The Involvement of the ICJ and the ICHP..... | 21 |
| Method of Work During the Mission..... | 23 |
| CHAPTER II | |
| Mental Health Services in Japan — The Current Situation With Special Reference to Human Rights | |
| Introduction..... | 26 |
| The Basis of Evaluation..... | 28 |
| Organisation and Administration..... | 31 |
| The Pattern of Mental Health Services..... | 33 |
| Mental Health Personnel..... | 36 |
| Costs of Mental Health Care..... | 38 |
| CHAPTER III | |
| Comprehensive Mental Health Services in a Modern Industrialised Society | |
| Introduction..... | 40 |
| Judicial Issues..... | 40 |
| System for Reimbursement of Treatment Costs..... | 41 |
| Training, Certification and Accreditation..... | 42 |
| Hospitalisation and Alternatives to Inpatient Care..... | 44 |
| Recommendations for Future Developments and Planned Policies for Improving Psychiatric Care..... | 49 |
| CHAPTER IV | |
| Legal Protection of Mentally Disordered Persons | |
| Introduction..... | 54 |
| United Nations Declarations..... | 56 |
| Council of Europe Recommendation No. R (83) 2..... | 57 |
| The Constitution of Japan..... | 58 |
| The Human Rights of the Mentally Ill..... | 60 |

| | |
|--------------------------------------------------------------------|----|
| Advocacy..... | 67 |
| Coordinated Community Cooperation..... | 69 |
| Mental Health Legal Services..... | 71 |
| Human Rights Authority..... | 72 |
| The Mental Health Act of Japan..... | 73 |
| Introductory Comments and Concerns..... | 73 |
| Objective of the Act..... | 74 |
| Problems Related to the Definition of Mental Disorder..... | 74 |
| Problems Relating to Admission and Discharge Procedures..... | 76 |
| Voluntary Admission..... | 76 |
| Forced or Involuntary Hospitalisation..... | 76 |
| Conclusions and Recommendations | |
| The Current Situation..... | 80 |
| Immediate Steps to Be Taken..... | 83 |
| Reform of the Mental Health Law..... | 84 |
| Improvement and Re-orientation of Mental Health Services..... | 84 |
| Improved Education and Training in the Mental Health Field..... | 86 |
| Annex 1 | |
| Documentation Received by the Mission..... | 87 |
| Annex 2 | |
| Organizations Interviewed by the Mission..... | 94 |

Introduction

Following several reports alleging serious violations of the human rights of patients in Japanese mental hospitals, which received world-wide publicity, the International Commission of Jurists wrote to the Prime Minister of Japan in May 1984 suggesting that the Japanese government might wish to consider appointing an independent Commission to enquire into the treatment of mental patients and the legislation relating to it. As no reply was received, the International Commission of Jurists decided to respond to a request made to it in September 1984 to send a mission to Japan to enquire into these matters and to report with recommendations. The request was made by a Japanese lawyer, Mr. Etsuro Totsuka, on behalf of the Japanese Fund for Mental Health and Human Rights.

Since the mission had to include psychiatric as well as legal experts, the International Commission of Jurists invited the newly-formed International Commission of Health Professionals to co-sponsor the mission, which they kindly agreed to do.

A mission was accordingly selected composed of

- Dr. T.W. Harding, Head of the Division of Legal Psychiatry at the University Institute of Legal Medicine, Geneva, and a former official of the World Health Organisation specialising in legislation concerning mental patients;
- The Honourable J. Schneider, Presiding Judge County Division Circuit Court of Cook County, Chicago, Illinois, a leading expert on U.S. mental health law with over 20 years experience of the law, policies and practices governing mentally disordered persons, and Adjunct Professor of Law, Northwestern University Law School, Chicago;

- Dr. Harold M. Visotsky, Professor and Chairman, Department of Psychiatry and Behavioural Sciences, Northwestern University Medical School, Chicago; Director, Institute of Psychiatry, Northwestern Memorial Hospital, Chicago; Director, Center for Mental Health and Psychiatric Services, American Hospital Association.

Dr. Charles L. Graves, Executive Secretary of the International Commission of Health Professionals, acted as Secretary of the mission.

The mission stayed in Japan from May 4 to 16, 1985, and was able to visit several mental hospitals as well as have discussions with the Ministry of Health, psychiatrists, social workers, nurses, occupational therapists, and representatives of many organisations and individuals concerned with mental patients.

The mission was welcomed by the Japanese Ministry of Foreign Affairs, and received the active cooperation of the Ministries of Justice and Health and Welfare.

The sponsors of the mission join with its members in thanking the Japanese Government for this cooperation and wish to express their appreciation for the time given by many people to assist them in their task.

The conclusions and recommendations of the mission were published in July 1985 and released to the press. This report seeks to describe the present system for mental health treatment in Japan and to explain the considerations which have led to these recommendations.

The mandate of the mission did not include investigation of individual cases of alleged human rights abuses or improper treatment. However, the members of the mission comment that "the present structure and function of the Japanese mental health services create conditions which are conducive to inappropriate forms of care and to serious human rights violations on a significant scale". Their recommendations are aimed at new approaches which could create conditions in which the human rights of mentally ill persons would be fully respected and in which human and effective care would be provided.

The views expressed in this report are, of course, the views of the very highly qualified members of the mission. The sponsoring organisations offer them to the Japanese Government and people in the hope that they may be of assistance to them in the current review of their mental health system.

Both the conclusions of the members of the Mission and an outline of their report was agreed by them before leaving Japan. Each member was

made responsible for drafting one of the chapters, the final text was agreed by them all. This procedure accounts for occasional duplication.

Charles L. Graves
Executive Secretary
International Commission
of Health Professionals

Niall MacDermot
Secretary General
International Commission
of Jurists

Chapter I

The Development of Japanese Psychiatry

It is claimed that the first Japanese physicians were of regal birth and that an emperor chose 20 of his sons to become physicians, who followed medical teachings based on Japanese methods. Buddhism and Chinese medical techniques were introduced later, by Buddhist priests coming to Japan from Korea in the sixth and seventh centuries A.D. A system of medical education then developed, based upon Chinese medicine.

In the 10th-century Japanese medical textbook *Ishinho*, the only mental disorders recognised were psychoses and epilepsy, and the origin of these diseases was considered cardio-vascular. But such diseases were taken seriously, as illustrated by the fact that the royal princess Keiko, third daughter of the emperor Gosanjo, afflicted by mental illness, was sent to a Buddhist temple where she became cured by taking holy water. The temple later became a popular shrine. From 1069 to 1074 the Daiwan Temple in Iwakura served as the first foster home for the mentally ill, and hostels began to be built nearby where the patients stayed. In 1884 these hostels were integrated into the Iwakura Asylum.

Japanese medicine of the 15th and 16th centuries emphasised seeking a balance between the "yin" and "yang" among the body's elements. The balance was brought about through the use of herbs, a proper diet, and a relief of fluid congestion through acupuncture or moxibustion. But Western medicine, particularly Portuguese and Dutch, reached Japan in the 16th century, and brought about considerable changes. However, the teachings

received from China regarding filial piety and the veneration of ancestors still influenced the views about life and death of the Japanese people, and such considerations had a great influence on the acceptance of Western medical science.

At the time of the Meiji restoration (overthrow of the Tokugawa shogunate, and restoration of the power of the imperial family in 1868 with the introduction of an era of Westernization) the Japanese medical profession turned towards the West and especially Germany for its models. Professor Kure, regarded as the founder of modern psychiatry in Japan, having graduated from Tokyo University, studied in Vienna, Heidelberg and Paris between 1897 and 1901. He served as professor of psychiatry at Tokyo University from 1901 to 1925, where he introduced the Kraepelinian system of psychiatry. From then neuropathology became the fundamental basis of Japanese psychiatry. Noguchi's discovery in 1913 of the spirochete *pallidum* in the brain influenced the profession even more towards neuropathology as its principal area for research.

Before World War II Japanese psychiatry was biologically-oriented. Insulin shock treatment (introduced in 1934) and electroconvulsive therapy (introduced in 1938) constituted the main psychiatric treatment until psychotropic drugs were introduced in 1954. Departments of psychiatry in each university followed their own disciplines : neuropathological studies in Tokyo University, psychopathology in Kyoto, psychotherapy of neurosis in Jikei University, studies of depression in Kyushu University, psychoanalytic studies in Tohoku University, etc. Also, genetic studies of families and twins, and prevalence surveys of mental disorders were carried out in several areas of Japan and all these were influenced by German psychiatry as well.

After the end of World War II, a new analytically oriented psychiatry was introduced, and the interest in psychoanalysis and psychotherapy widened. Studies in new fields were initiated : psychosomatic medicine; community, hospital and child psychiatry; alcohol studies; epilepsy; electroencephalography; medical rehabilitation; and social psychiatry.

The Japanese Society of Psychiatry and Neurology annual meeting in 1969 revealed a growing controversy between the traditional Kraepelinian biologic psychiatry and the psychosocially oriented psychiatrists, and resulted in a vote of no confidence in the council members. There followed many years of turmoil in the departments of psychiatry in the universities. The biologic psychiatrists, however, continued to hold a position of authority¹.

Three post-war developments influenced considerably the development of psychiatry in Japan : the Japanese *Mental Health Act* of 1950; the large impression made upon the Japanese population by the attempted assassination of U.S. ambassador Reischauer by a former mental patient in 1964; and the "Income Doubling Plan for the Decade" announced by the government in 1960.

It had been the practice prior to World War II for mental patients to be locked in their own rooms under police custody, and the prevalent attitude was stigmatization of mental patients, a belief that mental illness was hereditary, and a feeling of shame if such a patient turned up within one's own family. The Mental Health Act provided for involuntary hospitalisation of mental patients by the order of the provincial governors, or following a request by the relatives of sick persons (so called "consent admission" — see discussion in Chapter III), but with almost no guarantees offered to the patients themselves for a review of their case or release from the hospital if they became better. At the same time the assassination attempt on the ambassador had produced a feeling of national shame and the culpabilization of mental patients. After this, the government had augmented *per capita* subsidies for compulsorily-admitted patients from 50 % to 80 %. The situation was further complicated, as far as the rights of the patients were concerned, by the "Income Doubling Plan" which, in the mental hospital field, encouraged a rapid growth of private mental hospitals.

Under the terms of the Medical Service Law of 1948 (amended 1948-1962), any licenced doctor could establish a private clinic. As part of the Japanese recovery planning after the War, he could be assisted by the "Medical Care Facilities Financing Corporation" system. With the rapid growth in the numbers of mentally ill people following upon mass movements to cities and industry in the post-war period² the private mental hospital sector found itself soon caring for almost 80 % of the mental inpatients of Japan. The fact that the growth of the private mental hospital sector was tied to the encouraged Japanese economic recovery, may have worked against the introduction of necessary guarantees for the protection of the mental patients. In theory, each private mental hospital was "not for profit" (Medical Service Law, chap. 2, para. 4) but in times of financial difficulty, as far as the administration of the hospital was concerned, it might turn out that a reduction of services to patients would prove to be a great temptation³.

The way the Japanese Association of Psychiatric Hospitals describes

the rapid growth of the private mental hospitals after World War II is as follows (this association groups 1,100 out of the 1,259) private mental hospitals in Japan) :

"In 1954, through a national investigation, it was discovered that 12 times more that the number of (existing) psychiatric beds (35,000) were actually in demand. Later, through the generosity of government investment, psychiatric beds increased to 85,000 in 1960. At that time, psychiatric hospitals were basically engaged in solely admitting patients, and the treatment activities were rather poor. The main method consisted of electroshock and insulin shock. Psychosurgery was still being practised as well. Among the psychiatric departments in medical schools, the study of the physical backgrounds of mental disorders was more popular that the actual treatment. In 1955, pharmacotherapy was introduced to Japan, and psychiatric hospitals have gradually changed their natures from asylum to medical hospitals. Psychotherapy - individual and group - were accepted also...

"Throughout the 1970s young psychiatrists were influenced by the thought of anti-psychiatry and the idea of a therapeutic community gave impetus to opening up the wards. On the other hand, that idea raised confusion among psychiatric treatments. There were severe confrontations between traditional and young psychiatrists who insisted on anti-illness and anti-institution. In this matter, many psychiatric hospitals were prosecuted. The Japanese Society of Psychiatry and Neurology has not yet recovered from the difficulties of that period...

"Psychiatric patients are divided into two groups: one group consists of the patients who can leave and the other group... of patients who stay in the hospital for a prolonged period of time. The reason why they aren't allowed to leave the hospital is mainly because of the refusal of the family to take care of them, or lack of social facilities. Recently, instead of active psychiatric rehabilitation, many patients end up staying for so long a period of time that many of the psychiatric hospitals face great difficulty in accepting new patients."⁴

In their statement before the ICJ/ICHP mission, this organization criticised the public sector in mental hospitals for tending to send most criminal patients to the private hospitals⁵ and also criticised the USA

system which they say is "turning many patients out onto the streets".⁶

This organization maintains that the growth of the private sector was inevitable, that this sector copes with psychiatric problems which other institutions will not care for, and that long stays in hospital are necessary because the society does not accept the return of the patients who have recovered.

If 87 % of the psychiatric hospital beds are private⁷ this is partly due to the limited development of the public sector. Representatives of provincial (public) hospitals told the ICJ/ICHP mission that low budgets and inadequate provisions in the health insurance system for mental patients make it very difficult to develop the necessary outpatient facilities and rehabilitation programmes⁸. On the other hand, the Ministry of Health and Welfare has been promoting such outpatient mental health centres in each prefecture (according to the terms of the Mental Health Act). A report from the Ministry of May 30, 1979 claims that 38 mental health centres have been created "where knowledge of mental health is disseminated and where research and surveys, complicated or difficult consultations, are given. It is expected such facilities will be further increased in number... besides, rehabilitation services have been tried out at those prefectural hospitals which function under the provisions of the Mental Health Law. It is hoped that day-care facilities will be added to these hospitals."⁹

But the lawyer Etsuro Totsuka (founder of the Fund for Mental Health and Human Rights in Japan), commenting upon such rehabilitation institutes as listed in the Mental Health Handbook issued by the Ministry of Health and Welfare, points out that only 12 such facilities are in operation (cf. pp. 86-95 of Handbook) namely : four rehabilitation institutions for the ex-mentally disordered, seven day-care institutes and one mental health institute for adaptation to community life. Totsuka claims that "community-based psychiatry has not been intensively encouraged. The number of twelve facilities is almost nothing, if we consider the number of in-patients (330,000), the number of mental hospitals (1,585) and the total population (120 million)". He also claims that the total budget for community psychiatry is declining, that for 1984 being 17,302 million yen less than that for 1979.¹⁰

In a paper delivered before the 70th general meeting of the Japanese Society of Psychiatry and Neurology held at Nagoya City, April 30, 1973, Dr. Seiichi Toida of the National Musashi Care Centre says the following about the situation in Japanese mental hospitals :

"Japanese psychiatry especially after 1955 has supposed to have made a modern development as regards drug therapy, social living learning therapy and community psychiatry but, viewed as a whole, it should still be regarded as a system which has developed to oppressively control mental patients. Such a kind of development, although including subjective goodwill and many good efforts on the part of psychiatric workers, is nevertheless the result of socio-economic trends defining the conditions of the psychiatric services and the government policy giving precedence to public order over the benefits to the patients."

Moreover, Dr. Toida claims the *Ikyokukozasei* (a University medical department lectureship system) is contrary to the interests of the patients. This is because within the system certain professors hold power and control the practice of medicine and medical service through the supremacy of academic research.

In addition, the hospitalization of many patients without their consent is encouraged by a general expectation in society that the psychiatrist's function is the maintenance of the safety of society rather than the well-being of the patients. Many psychiatrists take this society-given expectation for granted, or are not aware of its implications¹¹.

In summarising the historical development of Japanese psychiatry since World War II, the following facts are relevant :

The number of beds in mental hospitals is increasing. The total reached 320,068 by 1983, with 9,217 beds in national hospitals, 17,074 in prefectural and metropolitan hospitals, 8,136 in municipal hospitals, 6,159 in semi-public hospitals and 279,482 (87 %) in private and other hospitals.

Involuntary admission (by local governor's order, or by consent of relatives) is over 75 % (under articles 29, 33 and 34 of the Mental Health Act). About 70 to 80 % of the mental hospitals are administered with a closed ward system.

The occupancy rate of beds is constantly over 100 %, meaning that over-crowding is common. The average length of stay has been gradually increasing (448 days in 1966, 536 days in 1984). For patients hospitalised involuntarily by the local governor's order, the average length of stay in 1978 was 2,396 days and in 1983, 2,963 days. In 1977, in Tokyo, over 50 % of all inpatients stayed in the hospital for more than 1,095 days.

Moreover, distribution of mental health services has not been con-

trolled or planned. For the Tokyo region, for example, the majority of beds are clustered in a region which is two hours away from the city centre.

Notes

1. J. Yamamoto and M. Kato, "Japan". In : *World Studies in Psychiatry*, vol. 2, No 2. World Studies in Psychiatry, P.O. Box 3150, Princeton, New Jersey 08540.
2. Cf. Kotaro Nakayama, "Psychiatric Care Delivery Patterns and Economic Policy After World War II in Japan". In: *World Psychiatric Association Regional Symposium, Kyoto, April 1982*, pp. 26-30.
3. Cf. Hiroshi Yokoyama, "The Influence of Financial Difficulties Upon Psychiatric Treatment in Japanese Mental Hospitals". In: *World Psychiatric Regional Symposium, Kyoto, April 1982*, pp. 105-107.
4. "Opinion In Reference to the ICJ Review". Japanese Association of Psychiatric Hospitals, May 10, 1985, 20 pp.
5. *Ibid.*, p. 5.
6. *Ibid.*, p. 12.
7. *Ibid.*, p. 13.
8. Meeting with the "Association of Local Government Hospitals. Sub-Committee in charge of Mental Hospitals" on May 15, 1985.
9. "Mental Health in Japan". May 30, 1979, prepared by the Mental Health Institute of the Ministry of Health and Welfare.
10. Etsuro Totsuka, "Japanese Laws on Mental Health and Human Rights", Part II. 23 May 1985. pp. 1-2.
11. Seichi Toida, "Forced Hospitalization and Psychiatrists". In: *Psychiatria et Neurologia Japonica* 76 (12) pp. 816-818 (1974).

Mental Hospital Scandals in Japan

The previously outlined history of psychiatry in Japan shows the potential for abuse in the system. The occurrence of such abuses was revealed in various "scandals" in mental hospitals occurring during the post-war period¹. *The Clark Report*, prepared by Dr. D.M. Clark, consultant in Mental Health at the World Health Organization in 1968, stated that

"Japan has now over 800 mental hospitals, 80 % founded since 1945. Most are new institutions where people — doctors, nurses, patients — are still working out a way of life. Some are doing this very well, but the writer has been informed that others are not. It was also learned that about one-third of the mental hospitals fall well below desirable standards of comfort, hygiene and physical medical care, not to speak of specialized psychiatric care or social therapy, and that these problems are particularly bad where the medical director or his nurses are without previous psychiatric experience or where the proprietor, anxious for a return on his investment, is putting pressure on the medical staff to increase income by over-crowding the institution".²

The scandal in the Hototukai hospital in Utsonomiya city (120 miles north of Tokyo in Tochigi Prefecture) attracted world-wide attention and was one of the main causes of a discussion about Japanese mental hospitals in the 37th session of the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities held in Geneva, Switzerland in August 1984. The affair also coincided with discussion in the same Sub-Commission of "Guidelines, Principles and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill-Health or Suffering from Mental Disorders" which were prepared under the leadership of the special rapporteur, Mrs. Erika Irene Daes. In the 1983 session of the Sub-Commission, Mrs. Daes had in fact presented studies on mental health legislation in various countries, including Japan³.

In mid-March 1984 two patients died as a result of maltreatment in the Utsonomiya hospital, and an investigation began under the Tochigi prefectural medical department and the Utsonomiya police office. The following day the Utsonomiya judicial department began an investigation, and the scandal was discussed in the Japanese parliament. Several days later some lawyers, including E. Totsuka, appealed to the Tokyo

High Court for the release of the patients being held in the hospital, and the Ministry of Health and Welfare agreed to cooperate in investigating the hospital. The Japanese Society of Psychiatry and Neurology decided to send a team to visit the premises.

The Tochigi prefecture medical officials announced their findings: extreme shortage of medical staff in the hospital. The provincial police ordered a post-mortem examination of the deceased patients: later, five nurses were arrested on grounds of having inflicted injuries on the patients: finally, the prefectural government decided to re-examine the psychiatric condition of all the patients in the hospital to see if hospitalization was necessary.

The following month the director, Bunnoshin Ishikawa, resigned. He had previously refused to receive the commission sent by the Japanese Society of Psychiatry and Neurology. Two weeks later he was put in prison on the grounds of breaking laws related to medical practice.

Meanwhile, the Director of Public Health in the Ministry of Health and Welfare, Mr. Masumi Oike, testified before the Committee on Social and Labour Affairs of the Japanese Diet, on April 4, 1984, about the investigation. Mr. Oike revealed that in Utsonomiya hospital 58 inmates had died in 1981, 79 in 1982, 74 in 1983 and 11 in 1984 - a total of 222 deaths over four years. According to the death certificates issued by the hospital doctors, only 19 unnatural deaths had occurred during this period, and the local police confirmed only eight unnatural deaths in the same period. Suspicion reigned concerning all the other deaths, which were much more numerous than the expected level of deaths due to old age.

As a result of these discoveries, on 30 May 1984, the International Commission of Jurists wrote to the Japanese prime minister Yasuhiro Nakasone, in order to call for the establishment of an independent tribunal to control mental hospitals in Japan. During the August session of the UN Sub-Commission (*supra*), the International League for Human Rights (based in New York City) criticised the Japanese government for failure to "fulfil its obligations under international law... Although abuses in mental hospitals have been brought to the attention of the Japanese government since 1970, to date the government has been largely indifferent to the dangers of abuse and exploitation faced by those detained on grounds of mental illness. It steadfastly refuses to make legally mandatory more stringent standards for determining whether compulsory hospitalization is necessary and it fails to extend constitutional protections to mental detainees."⁴

The League also stated that international norms such as those presented in Mrs. Daes report, could help guide the Japanese government to alter the injustices⁵.

In answer to this, a representative of the Japanese government at the UN Sub-Commission meeting responded :

"Although a few ill-treatment cases in mental hospitals have been reported in Japan, these cases are extremely exceptional, and it is hardly conceivable that mental hospitals in Japan are all in a similar situation."

The statement continued with a description of the system of provincial supervision of the hospitals and rights guaranteed to the patients to appeal to the governor or through the courts. It mentioned a government circular notice for "reinforcement of supervision on mental hospitals" and "new guidelines" which would help guarantee the mental patient's right to "communicate with or meet any person he wishes, including lawyers, a right guaranteed under the Constitution of Japan".

Finally, the statement claims that the Japanese Mental Health Act does not violate the International Covenant on Civil and Political Rights (a charge made by the International League for Human Rights).

In response, the International League for Human Rights, in a telegram to Prime Minister Nakasone on September 17, 1984, discounted the statement that "abuses are extremely exceptional", in mentioning an article appearing in *Seishin Iryo* (Medical Journal) No 51, May 1984, in which other hospitals are accused, for example, Juzenkai, Kurioka, Yasuda, Ito, Nakamura, Akita and Yamatogawa hospitals. And since the Utsonomiya scandal, major incidents of abuse of the mentally ill have been reported in the press at the following institutions: Tanaka, Jomo, Narita and Seijuji hospitals.

The League also complains that "officials routinely fail to investigate deaths or other suspicious incidents occurring in mental hospitals".

Moreover, the League claims in its message to the Prime Minister that the Japanese observer at the UN Sub-Commission wrongly stated that the percentage of mentally ill persons detained involuntarily was only 12.3 %. In fact, this figure refers to those detained under Article 29 of the Mental Health Act. But those detained under Articles 33 and 34 are also "involuntary" patients detained following a report to close relatives and a decision by a psychiatrist.⁶

Following the revelation of deaths in Utsonomiya hospital, other irregularities were found there: for example, that the director B. Ishikawa used unqualified persons to administer X-ray examinations, intravenous drips, and injections and to take electroencephalographs.⁷ Moreover, some employees without a licence had performed autopsies on the brains of six dead patients. Also, this hospital had illegally obtained at least 24 million yen in nursing fees from the prefectural government, giving false information about the number of nurses employed.⁸

On 27 March 1985, Dr. B. Ishikawa was sentenced to one year in prison and a 300,000 yen fine for having forced hospital inpatients to work as unlicensed medical technicians and nurses. He also violated the law regulating nursing practice, the Midwife Law and other laws. The judge, Tokio Fujii, ruled that

"Ishikawa had considered profits first and foremost in the management of the hospital and ignored the fundamental human rights of patients. What Ishikawa had done to the inpatients was quite improper for a doctor although extenuating circumstances should be fully taken into account. (For example, he played an active role in accepting at the hospital many serious cases of mental disease refused by other hospitals and mental clinics.) In order to cut personnel expenses, Ishikawa had decided to reduce the number of medical technicians and nurses."⁹

The results of the psychiatric re-examination of patients in Utsonomiya hospital made by the local Tochigi provincial governor's order, were as follows (April 19, 1984) : (1) Of the 382 patients who had been hospitalised involuntarily through the consent of their nearest relatives, it was judged necessary to hospitalise 284 and unnecessary to hospitalise 98. Of these 98, nine required no medical treatment at all. (2) Of the 161 patients who had been hospitalised involuntarily by local governor's order, it was judged necessary that 47 be hospitalised involuntarily, 114 did not need to be hospitalised involuntarily but needed to stay in hospital for medical care and it was unnecessary to hospitalise 14, of whom two needed no medical care at all.¹⁰

E. Totsuka, member of the Committee on Human Rights of the Daini (second) Tokyo Bar Association, in an August 1984 interview given to *The Asahi Shimbun* newspaper, said that he and ten other lawyers had sought writs of *habeas corpus* to release over 500 patients from Utsono-

miya Hospital, but that their efforts were hampered by an inability to see patients face to face and thus find out how many were being forcibly detained. He mentioned that some hospitals had about one quarter of the required number of doctors and nurses on duty, and there were too many patients in many of the hospitals. "The root cause of the tragedy is money. Mental hospitals owned by big corporations are big revenue generators. In Japan, 85 % of the beds for mentally ill are owned by private institutions. Hospitals keep prescribing medication for their patients and make a fortune from health insurance."

Consequently, overcrowding an institution and constant prescription of drugs has become a normal practice. Some hospitals Totsuka said, "rounded up tramps from some of Tokyo's stations, committed them, and got rich from their care."

The Japanese government, in particular the Ministry of Health and Welfare, has taken "a lackadaisical approach". Some Diet members, upon being asked to recommend to a hospital director that the concerned lawyers not be stopped from meeting the patients, told the lawyers that "the doctors at the hospitals should decide." However, Totsuka claimed "under the Japanese Constitution, a detained person has the right to see a lawyer."¹¹

Another expert, the psychiatrist Dr. Isao Hirota, of the Sanmaibashi Hospital, Ota, in commenting upon the Utsonomiya scandal and the present situation of mental hospitals in Japan, says that

"Japan is paying dearly now for a breakdown in traditional methods of dealing with its social outcasts. Japanese mental hospitals have become clearing houses for the unemployed, the aged and for students unable to cope with the demands of Japan's rigid and competitive educational system... people are being 'turned into' mental health problems. In any society there are those who cannot adjust. In Japan, people don't give them time to adjust."¹²

Notes

1. For the situation in an unnamed mental hospital in the early 70s, we are indebted to the book "Japanese Mental Hospital" (*Rupo Seishinbyoto*). Translated by Totsuka, Holcombe, Holmes, Ueno and Kosaka. Asahi Shimbun Publishing Co. 1982.

2. D.H. Clark, "Assignment Report November 1967 - February 1968." Regional Office for the Western Pacific. World Health Organization, 30 May 1968. 29 pp.
3. Human Rights and Scientific and Technological Developments. United Nations Economic and Social Council paper E/CN.4/Sub 2/1983/17/Add.1 July 1983.
4. Sub-Commission on Prevention of Discrimination and Protection of Minorities. Thirty-Seventh Session. Agenda Item 9. August 15, 1984.
5. Ibid., p. 5
6. For a summary of the telegram, cf. International League for Human Rights press release, Monday, 17 September, 1984.
7. Reported in *The Japan Times*, April 27, 1984; March 27, 1985.
8. Reported in *The Japan Times*, October 28, 1984.
9. Reported in *The Japan Times*, March 27, 1985.
10. E. Totsuka, "Development of Utsonomiya Hospital Scandal", 5 pp. (paper presented to ICJ/ICHP mission to Japan, May 1985).

The Involvement of ICJ and ICHP

In its *Review* of June 1984, the International Commission of Jurists raised the question of the adequacy of the Japanese Mental Health Act for the present situation of mental hospitals, in an article entitled "The Mentally Ill in Japan". Already in May 1984 the ICJ had written to Prime Minister Nakasone urging the establishment of an independent tribunal to control the hospitals. The ICJ had also been one of the major sponsors of the "Guidelines, Principles and Guarantees for the Protection of Persons Detained on Grounds of Mental Ill Health or Suffering from Mental Disorders", which is before the UN Sub-Commission (*supra*) .

In autumn of 1984, the ICJ was invited by the Japanese "Fund for Mental Health and Human Rights"¹ to "come to Japan and investigate the real violations of human rights here", and "to report the facts internationally, especially at the United Nations". In consultation with lawyer Etsuro Totsuka, of the Fund, Mr. Niall MacDermot, secretary-general of the ICJ, agreed to form a mission, and subsequently wrote to the Foreign Minister of Japan, Shintaro Abe, on 21 December 1984, describing the mission's programme and membership :

"As you may know, the International Commission of Jurists published in its *Review* in June 1984 an article expressing its concern about the condition of patients in some of the mental hospitals in Japan. As a result of this, the Commission and the International Medical Commission (IMC) have been asked by some lawyers in Japan to send a mission to your country to examine and report on the rights of mental patients.. The IMC is a newly erected organization which the ICJ has helped bring into existence. It is composed of leading doctors and other health workers seeking to promote health and human rights in all countries of the world".²

The members of the mission were then named, and their qualifications given.

Mr. Macdermot continued :

"It is our intention that the mission should operate in a discreet manner, avoiding publicity and sensationalism. Their objective will be first and foremost to study as far as they can (1) the legislation governing the treatment of mental patients, in particular involuntary

patients, and (2) the practice in psychiatric hospitals, with a view to presenting any recommendations which they feel able to offer in the light of their experience."

A list of hospitals proposed for the visit was included, for the consideration of the government.

After a series of negotiations between the ICJ, ICHP, the Fund for Mental Health and Human Rights, and the Japanese government, the latter agreed to receive the mission, suggesting only that the number of hospitals to be visited be increased, "in order that the mission may ascertain more fully and precisely the actual conditions of psychiatric treatment and the system followed in Japan."

Subsequently, the list of hospitals to be visited was modified upon mutual agreement.

News about the mission was known to the Press at the time of the annual session of the UN Human Rights Commission in Geneva in February 1985. The daily newspaper *Yomiuri* reported the proposed ICJ mission and that of Disabled Persons International on 23 February 1985 in an article entitled "Mental Institutions under UN Probe".

The joint ICJ/ICHP mission to Japan included the following three experts:

Dr. Harold Visotsky, Prof. of Psychiatry, Northwestern University Medical School, Chicago, Illinois (USA). Director, Institute of Psychiatry, Northwestern Memorial Hospital. Director, Centre for Mental Health and Psychiatric Services, American Hospital Association. Chairman, Department of International Relations, American Psychiatric Association.

Judge Joseph Schneider, presiding judge, Cook County Circuit Court, Illinois. Member of President Carter's National Commission for Mental Health. Presided for many years over the local court with jurisdiction concerning mental patients.

Dr. Timothy Harding, Head of the Division of Legal Psychiatry, Institute of Legal Medicine, University of Geneva and a former official of the World Health Organisation.

The experts were accompanied by *Dr. Charles Graves*, doctor in theology, Executive Secretary of the International Commission of Health Professionals, who acted as secretary to the mission.

Method of Work During the Mission

The mission took place from 5 to 16 May, 1985 in Tokyo and nearby provinces. The programme was organized by the Japanese Fund for Mental Health and Human Rights, and included preliminary visits to the Ministry of Justice (Bureau of Human Rights) and Ministry of Health and Welfare (Health Service Bureau); visits to four private, one national (public) and one municipal (public) mental hospitals; meetings with provincial and Tokyo government officials, as well as members of the Supreme Court; private meetings with various organizations of private, public and municipal hospitals, psychiatrists and associations of psychiatrists, health workers, nurses, families of mental patients, mental patients and legal and juridical groups; and final visits to the Ministry of Health and Welfare, and the Ministry of Foreign Affairs.

The four private mental hospitals visited were outside Tokyo, and a certain amount of travel was necessary to see these hospitals. All the hospitals had been contacted by the Ministry of Health and Welfare, and had given agreement to the visits. Each visit began with discussions between members of the team and the hospital director and staff. On one occasion the team visited an outpatient and rehabilitation centre, associated with a municipal hospital.

During discussions with director and staff, questions were asked about the philosophy and methods of care, statistics on the patients — the type of their disease, the length of their stay etc., and the financial administration of the hospital. The Fund for Mental Health and Human Rights provided interpretations for all the visits. Some of its members participated in some of the sessions.

In one case, entry to a (private) hospital was denied to the mission, although there had been a preliminary agreement made through the Ministry of Health and Welfare, that the mission would be received. The members of the mission had 20 minutes of discussion with a representative of the hospital director, in an attempt to be admitted, but this was of no avail. Subsequently, the name of this hospital was revealed to the press, according to a preliminary agreement between Mr. Totsuka of the Fund for Mental Health and Human Rights, and the particular hospital. (Mr. Totsuka had been officially designated by the Japanese government regarding arrangements for the mission while in Japan.) The private hospital which refused the mission had received considerable publicity through the press at the same time as the Utsonomiya hospital scandal,

for various abuses in the hospital and conflicts between administration and staff over the human rights of staff and patients.

Meetings with the Ministries took place in a spirit of mutual respect, questioning and answering on both sides, and constructive suggestions for the activities of the mission. The reception by the hospitals was in a similar spirit of courtesy and mutual assistance. Frank discussions were held on different questions raised by the members of the mission and by those who inquired about the purpose of the mission. The mission insisted again and again that it had come to Japan not to investigate or criticize individuals, individual cases or abuses, but to consult with the responsible professionals and discuss solutions to the actual situation. In such a spirit, any needless conflicts were avoided, although the mission had complete liberty to make its own judgements about what it heard and saw.

Many discussions were held with interested organizations related to mental health, mental hospitals, patients' rights, and concerns of the health professionals in the field of mental health. The suggestions of these groups — often presented in the form of printed statements prepared especially for the mission — have been widely incorporated in the Report of the mission. In the sessions with these organizations, many obscure points about the present situation of the mental hospitals were clarified, for example, how the professionals looked at their own role in the hospitals; the methods of financial administration and the system of reimbursing by the national insurance scheme for treatments given; the problems facing the hospital administrator; the system of training psychiatrists and other psychiatric workers; the daily life of the patients in the hospital and their rights; the concerns of the families of the patients; specialized concerns of the psychiatric nurses or psychiatric social workers or other staff; attitudes towards the Mental Health Act or towards the government; suggestions about reform or changes in the law, or in the administration by the Ministry of Health and Welfare; even discussions about the economic and financial situations of hospital directors, etc. This material, taken all together, provided an invaluable source for the team in its preparation of the Report and recommendations.³

Final discussions with the Ministry of Health and Welfare, Department of Mental Health concerned the findings of the mission and the interpretation of these findings. Officials of the Ministry, and representatives of the National Institute of Mental Health made every effort to acquaint the members of the team with the particular Japanese social problem of non-acceptance of mental patients by their families, which they

said prevented a diminishing of the number of patients in the hospitals and a prolonging of the days spent in the hospital. However, the Ministry believed that steps were being taken to solve this problem, and advised the members of the team not to apply methods of analysis of the situation which might be appropriate for the USA or Europe but not for Japan. The Ministry of Foreign Affairs thanked the mission for its work, and believed the results could not but help improve the situation in Japan and bring a new understanding of Japan to other countries of the world.

The conclusions and recommendations, of the mission were communicated confidentially to the Japanese government in May 1985; they were subsequently released to the press together with the Japanese Government's comments at the end of July 1985.

Notes

1. This organization was founded by the lawyer Etsuro Totsuka and others, and is chaired by Mr. Hiroshi Kashiwaga. The Fund has published a series of books on the rights of mental patients in Japan.
2. The International Medical Commission was inaugurated under the title of "International Commission of Health Professionals for Health and Human Rights" (ICHP/CINPROS) on 30 January 1985, in Geneva, where its secretariat is located.
3. The documentation received by the mission is listed in appendix A. A list of all the organizations which met with the mission will to be found in appendix B.

Chapter II

Mental Health Services in Japan: The Current Situation with Special Reference to Human Rights

Introduction

Services for mentally ill persons in Japan are diverse in terms of organisation, therapeutic philosophy, standards of care, staffing policies and human rights sensitivities. It is obviously impossible to provide a succinct and coherent account of the service pattern of a system which is essentially disparate and fragmented. This account will therefore concentrate on some key issues which effect human rights. Some degree of generalisation is inevitable in such an approach and the reader is urged to bear in mind the complexity and diversity of the system we are describing. There are many exceptions to the overall trends which have been uncovered by the mission's enquiries: in particular, a few centres were studied in which adequate levels of staffing, combined with an eclectic approach to treatment and an emphasis on rehabilitation and outpatient services provide a comprehensive and effective treatment programme for mentally ill people, even those with severe forms of illness. If such exceptions are numerically insignificant in relation to the overall mental health system, they are nevertheless of great potential importance as a source of inspiration, training and stimulus for the development of new approaches to mental health services, as recommended in a subsequent chapter.

One of the striking features of Japan's mental health services is that,

for all the structural weaknesses, sub-standard levels of care and inadequate protection of human rights, the seeds of reform are already present in Japan. A number of articles have been published by Japanese psychiatrists pointing out weaknesses and insufficiencies in mental health services both in the hospitals and at community level. In addition, as already pointed out, small-scale but functioning models for comprehensive programmes already exist.

Nevertheless, alongside the potential for constructive change, there seems to be a built-in inertia and resistance to reforms. Some of the factors have already been mentioned in the preceding historical outline; they will be further analysed in this chapter. From the outset, the following four points should be emphasized in relation both to everyday operation of the mental health care and to development of new services :

1. Decision-making is largely unco-ordinated and the Ministry of Health plays a relatively minor role in operational control and possible reform;
2. The private sector controls a major part of the mental health services, decisions are therefore heavily influenced by financial considerations and taken independently by many different private individuals and corporations which own and operate mental hospitals;
3. There is no centrally organised system of standard setting, quality control or inspection;
4. The psychiatric professions (physicians, nurses, psychologists and social workers) lack cohesion and leadership. Serious, lasting and damaging divisions exist among psychiatrists. Although centres of excellence exist in a few universities, there is no overall conception of coherent psychiatric training oriented towards comprehensive services.

These points perhaps explain why reports made by outside consultants (Dr. Paul Lemkau and Dr. Daniel Blain in 1953 and Dr. David H. Clark in 1968) have had remarkably little effect on Japanese mental health services, despite the fact that they were received with enthusiasm and approval by the government and the profession alike. Indeed, reading the admirably concise and comprehensive report by Dr. Clark left the present mission on numerous occasions with a sense of *déjà vu*, since almost all the problems and faults so clearly described and analysed by Dr. Clark persist, albeit to a greater degree. In 1968, Dr. Clark felt that the situation was "alarming"; 27 years later the sense of alarm persists,

coupled with dismay that so little has been done and so many opportunities for change have been lost. Dr. Clark reached his conclusions on the basis of an evaluation of the effectiveness of mental health care delivery. The present report focusses on human rights issues, but it is essential to recognise the close links between human rights and service provision. The most effective way of protecting the rights of mentally ill persons is by providing a wide range of community-linked services.

The Basis of Evaluation

The fragmentary and unco-ordinated nature of Japanese mental health services has already been commented upon. As will be shown in numerical terms, the private sector dominates service provision and the bulk of resources are channelled towards hospital care.

Once this has been said, how should one proceed with the evaluation of these services? Private services are not necessarily good or bad; fragmentation and diversity may present certain advantages over monolithic, state controlled services. Furthermore, the proportion of mental health service resources which should be deployed on hospital care as compared to community care is by no means clearly established. What is internationally accepted is that (a) mental health care should correspond in terms of quality and availability to general health care; (b) out-patient care, including rehabilitation services, should be easily accessible financially and geographically to all patients; (c) hospital care should be linked to community services, and provided as close to patients' homes as possible; (d) treatment should have as its primary aims the relief of individual suffering, the restoration of normal functioning and the return to a social role as fulfilling and useful as possible; (e) long-term hospital care is itself harmful, leading to a well recognised syndrome of "institutionalisation" which greatly increases the problems of rehabilitation; (f) stigmatisation and rejection of the mentally ill by the general public are greatly reinforced by mental health services of a mainly custodial and institutional kind separate from services for non-psychiatric illnesses.

It seems reasonable to assess to what extent services in Japan correspond to these desiderata. In so doing, the approach to evaluation will be that outlined in a publication commissioned by the Commission of the European Communities on *Evaluation of Health Care* (Holland, 1983). In this volume the following definition of evaluation is provided:

The evaluation of health care can be defined as the formal determination of the effectiveness, efficiency, and acceptability of a planned intervention in achieving stated objectives.

The effectiveness of an intervention is a measure of the technical outcome in medical, psychological, or social terms. Efficiency is an economic concept which refers to the costs of intervention relative to effectiveness. Finally acceptability refers to whether the intervention is professionally and/or socially satisfactory and adequate. The problems and approaches to evaluating these different aspects of health care will be discussed in more detail later.

Evaluation is therefore a complex issue which involves the assessment of many aspects of health care including the programme, personnel, expenditure, the health-care system as well as the outcome. Evaluation may concentrate on one or more of these aspects. In the present time when resources for health care are finite the emphasis is increasingly on evaluating efficiency. Evaluation often compares two or more procedures producing similar outcomes. In this case evaluation again is likely to concentrate more on efficiency and acceptability than on effectiveness.

In the case of mental health services in Japan it would seem that "process evaluation" is more appropriate than "outcome evaluation", since the parameters of outcome are exceedingly difficult to define in this field. Nevertheless, according to the simplified model of a health care programme presented by Holland (see figure 1), process evaluation is only possible if programme objectives are clearly stated. As Holland points out succinctly: "If there are no objectives, there is nothing to evaluate". In the Japanese mental health programme, such objectives have not been clearly formulated, at least not in operational terms. For these reasons, the internationally accepted minimal objectives of mental health services set out above can be regarded as "assumed objectives" for the purposes of our evaluation.

In the same book, a chapter devoted to the evaluation of mental health care, lists as useful in evaluation data :

1. which can be used to estimate current needs and predict *future trends in mental morbidity*;
2. concerning *inpatient populations*;
3. concerning *outpatient populations*;

4. indicating *interaction with related or parallel services*;
5. concerning *mental health legislation*;
6. about type and amount of *mental health care provided by non-specialist services*;
7. about *costs of care*.

In view of the scope and purposes of our study, we did not consider points 1 and 7 in any detail. Considerable amounts of data, essentially hospital based, are available on point 2, while data on points 3, 4 and 6 are very thin. Point 6 is considered in the next chapter.

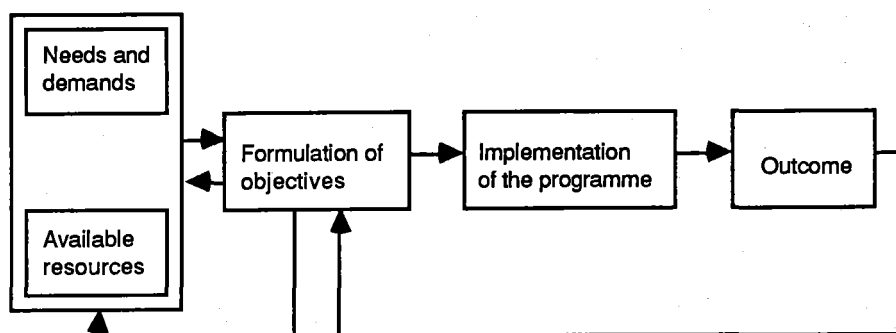


Fig. 1. A model of a health-care programme

In addition, we propose to use a comparative approach, because since virtually all mental health services are imperfect in some respect, any conclusions on Japan's services in terms of internationally accepted standards and desiderata should be relativised by reference to conditions in other industrialised nations. For such comparisons, the principal source will be data from European countries provided by WHO's Regional Office for Europe; two reports (May, 1976; Freeman et al. 1985) give a longitudinal perspective to such comparisons and allow a comparison of trends as well as of the current situation.

To summarise, the basis of our evaluation of mental health services in Japan is to use the data provided by the Ministry of Health and other official bodies and professional associations, as well as observations made during the mission's visit to assess the extent to which mental health care corresponds to internationally accepted objectives.

Organization and Administration

Overall responsibility for mental health services in Japan is vested in the Ministry of Health and Welfare. Attached to the ministry is the National Institute of Mental Health which has primarily advisory and research functions. Neither of these two bodies administer services directly on a national scale, but the National Musashi Research Institute, financed and administered directly by the ministry provides beds for 660 psychiatric patients. The staffing ratio is well above the national average for psychiatric hospitals, but is nevertheless below the norm for general hospitals (1 doctor per 16 beds). In this hospital, which is meant to serve as a centre of excellence and to set an example, standards of care are acceptable but over 60 % of patients have been hospitalised for over 3 years and only about 12 % of patients are admitted on a fully voluntary basis. The rehabilitation service is rather limited and out-patient care is provided to some 250 patients at any one time.

The Ministry maintains and publishes regular statistics on mental health care: these are concerned mainly with hospital care and are based on the geographical location of the hospitals rather than on patients' homes. Since many patients are hospitalised at a great distance from their homes, information about mental health care needs of communities is difficult to assess from such statistics. Limited information on out-patient care is also provided but almost nothing is known about the presentation and treatment of psychiatric disorders in general health services.

The Ministry carries out no inspection or direct monitoring of mental health services. At a national level no such function exists.

A number of prefectures operate some mental health services, usually in the form of a prefectural mental hospital. The prefectures also have a legal responsibility to carry out regular inspections of psychiatric facilities. It seems clear that few prefectures have staff resources sufficient to make such inspection meaningful. In fact, most prefectures have no separate mental health bureau. An important exception is the Tokyo Metropolitan Area Authority, which administers a large hospital and also runs some community services for the mentally ill, including a modern rehabilitation centre. The Authority's mental health bureau has also set up a Commission of Re-evaluation for review of compulsorily detained patients on request. Nevertheless, of some 26,000 psychiatric beds in the Tokyo metropolitan area, nearly 23,000 are provided in private hospitals. These are mainly situated in peripheral areas, because of the high land

prices in the central areas. There is no system of sectorisation or formation of catchment areas in the Tokyo area and patients are often admitted a great distance from their homes. This is symptomatic of the services throughout Japan. Nowhere could we find health authorities with a clear psychiatric service policy with integrated services for a given population. Rather, families of the mentally ill are left to fend for themselves in seeking out appropriate treatment which is nearly always offered on an in-patient basis.

A comparison with countries in Europe shows that, in a number of countries, Ministries of Health have established a clear policy of comprehensive services, multidisciplinary teams and sectorization. Although Freeman et al (1985) (*supra*) express some disappointment about progress in Europe over the decade 1972-1982, they describe a general acceptance that ministries should actively promote such approaches. In France, for example 800 multidisciplinary sector teams have been established, each team being responsible for a population of 70,000. Integration and co-ordination of services have also been enhanced in the United Kingdom though decentralised planning at district level (pop. 250,000). In Sweden, local teams (psychiatrist, psychiatric nurse and social worker) cover areas of about 30,000 population, and in Norway devolution of services to county level is also being pursued.

In marked contrast, we observe that the health authorities in Japan, both local and central, adopt essentially a passive role to the development of mental health services. Some statistical monitoring is carried out and an overall policy of encouraging out-patient and rehabilitation services is adopted. Implementation of such a policy remains largely a dead letter, except for limited changes to re-imbursement of certain forms of out-patient care. On the other hand, subsidies offered by prefectural governments appear to encourage the growth of in-patient facilities, without apparent reference to local population needs. Ad hoc, piecemeal and unco-ordinated development, largely financed through private resources with public subsidies, appear to be increasing the reliance on in-patient care and not leading towards a pattern of comprehensive, locally available services.

It should be noted that the mental health service administration reflects very exactly the whole Japanese health care system in which private hospitals are responsible for a major part of all health care. Rates of hospital-based care have risen steadily since 1953 for somatic disorders and notably hypertensive disorders, cardiovascular disorders and cerebro-

vascular disease. Tuberculosis and leprosy are the only disorders for which significant decreases in hospital-based care have occurred over the same period. In general, preventive health care and community health services are rather poorly developed in Japan; furthermore out-patient care by private physicians is much more extensive for somatic than for psychiatric disorders.

Ministry officials indicated that in general it is very difficult for administrators to control the supply of beds and of other treatment resources. "Planning" is said to be on the basis of "free enterprise and competition", with low interest loans available and little government control.

The Pattern of Mental Health Services

It is very difficult to get a clear picture of how patients suffering from psychiatric disorders in Japan usually make contact with health services and are referred to specialist services. Linkages between general health and mental health care are poorly developed and there are no systematic referral channels.

In the majority of cases, psychiatric care is sought by the family of a patient presenting seriously disabling symptoms. The crisis is partly due to the family's acute awareness of the social stigma attached to mental disorder and the widespread conviction that mental illness is largely hereditary. Through hospitalisation, the family is therefore looking for a social solution as well as for treatment for the sick person. Other cases are referred after bizarre or anti-social behaviour has led to the intervention of the police and, in some cases, the courts. In only a small minority of cases does it seem that the patient himself spontaneously seeks care.

Choice of hospital and the legal basis of admission are influenced by financial considerations (see discussion on "costs of mental health care" *infra*). Patients are often hospitalised at considerable distance from their homes and visits by family members are therefore difficult and infrequent. This appears to be inevitable, due to the uneven distribution of mental health facilities, with a bias towards rural areas, probably because of the lower costs of land.

As has already been stated the number of beds in mental hospitals has been steadily increasing. By 1983, there were 323,004 approved beds in psychiatric hospitals, with a bed occupancy of 103 %. There was therefore a rate of 28.1 in-patients per 10,000 population. The unevenness of this rate

in the different districts (up to 50.7 per 10,000 and as low as 16.8 per 10,000) illustrates that facilities do not relate to local needs. Over the period 1974 to 1983, there had been a 21 % *increase* in the number of psychiatric beds. Many European countries have lower rates, for example England and Wales 20.5; Austria 16.6; Bulgaria 8.4; Italy 14.6. Some countries do have comparable or even higher rates, for example Sweden, France, Scotland, Ireland and Norway in the range 26.0 to 41.2 per 10,000, but in nearly every case cited there is a trend towards *reducing* the number of beds. In the period 1972 to 1982, there was a reduction in the examples cited of between 15 % and 29 % in all but one country (France) which recorded a slight increase of 4 %.

In Japan, the majority of psychiatric beds are in privately owned and administered hospitals : the proportion has risen slightly over the past 20 years, from 83 % in 1965 to 87 % in 1982. In fact, 95 % of the increase in psychiatric beds over the period 1970 to 1982, is accounted for by growth of the private sector. Over the same period, there was an increase in the number of hospitals of over 200. By 1983, there were over 1,200 private hospitals, as against about 300 in the public sector.

More than 80 % of the private mental hospitals are located in rural areas. This uneven distribution, apparently mainly for economic reasons, has already been commented upon. In the Tokyo prefecture, the most highly urbanised areas have less than 10 beds per 10,000 population, while in the least developed areas the rate is over 50 beds per 10,000 population.

Japanese mental hospitals tend to be fairly small in comparison with mental hospitals in Europe or North America. However there is a clear tendency for the average size to increase. By 1982, there were 40 hospitals with more than 500 beds. At the same time, 50 % of hospitals had less than 200 beds. In this respect Japan compares favourably with European countries where the average size is about 500 beds.

Most psychiatric patients in Japan (64 %) are kept in wards which are locked 24 hours a day. Only 25 % are nursed on wards which are not locked for more than 5 hours a day ("open wards"). In fact one fifth of private mental hospitals have *no* open wards. These figures should of course be considered in relation to the data presented elsewhere in the report on the low proportion of voluntary admissions.

The length of stay of patients appears to be bi-modal. An overall average length of stay for all hospitalised patients was reported as 536 days in 1983. However this figure is somewhat artificial since there appear to be two distinct types of hospital stay. Although 70 % of schizo-

phrenic patients are discharged in less than one year, 75 % of beds are occupied by patients hospitalised for more than a year, many of them suffering from chronic schizophrenia. A high proportion of beds are therefore occupied by long stay patients and there is a very high rate of bed occupancy. Thus in Japan there are approximately 0.7 admissions per annum for every psychiatric bed, whereas in European countries the figure is in general three of four times higher (2.1 for England and Wales; 2.5 for the Federal Republic of Germany; 2.0 for Ireland; 5.53 for Sweden). The concept of short-term admissions of between one and four weeks, accompanied by mobilisation of community resources and followed up by day care or intensive out-patient care is virtually non-existent in Japan, whereas in European countries it is becoming a major component of psychiatric care (see, for example, the description of crisis admission units and emergency psychiatric care by Cooper [1979]).

The long-stay population is therefore growing and largely accounts for the steady increase in the number of beds. The majority of the long stay patients are suffering from schizophrenic psychoses, which make up 70 % of the diagnoses of all in-patients. The relatively short-term admissions appear to be made up of patients who respond to drug therapy favourably and whose families are willing to accept their return after several months hospital treatment. As noted above, hospitalisation for brief periods (< one month) in the context of longterm out-patient care is rarely practical.

Hirota has presented data from the Tokyo area showing that the proportion of patients hospitalised for over 3 years rose progressively from 23 % in 1950 to 51 % in 1977.

Conditions within psychiatric hospitals reflect the custodial and static nature of the care provided. With a few notable exceptions, patients spend most of their time in overcrowded wards with few activities. Patients often have few or no personal possessions with them and material for writing and reading is rarely available. Few patients have access to telephones. Many have no visits from relatives and never receive letters from outside the hospital. Opportunities to purchase items for personal use are denied to many involuntary patients, who, in any case, rarely have any money for such purchases. The main component of therapy is by medication, principally neuroleptic drugs of the phenothiazine and butyrophenone group. The overall level of drug utilization and the type of psychotropic drugs used, appears to be comparable between Japan and other industrialised countries.

Rehabilitation services and alternatives to hospital care (day care,

hostel accommodation, sheltered workshops) are poorly developed in Japan. A notable exception is the day care facility recently opened by the Tokyo Municipal authorities, which unfortunately can offer care to only a limited number of patients. Moreover, the general rehabilitation and welfare services for disabled persons are not available to psychiatric patients who are therefore discriminated against in the field of employment privileges, social services and training opportunities offered to the physically disabled.

The data on out-patient care are difficult to interpret meaningfully, especially in relation to the needs of patients being discharged from hospital. Indeed one of the main weaknesses in the mental health care system is the lack of co-ordination and linkage between in-patient and out-patient care.

The rate of out-patient attendances has been rising steadily with an increase of 86 % between 1972 and 1982 (during the same period the number of in-patients rose by 23 %). This trend has been encouraged by increased reimbursement rates for out-patients attendances. It seems that this policy has created a new class of patients with less serious disorders (mainly neurotic and minor affective disorders). However, structured extramural care for psychotic patients is poorly developed.

Mental Health Personnel

Training of a high academic level is provided in several university centres for psychiatrists, psychologists and other personnel. However the training is not oriented towards community care or public health aspects of psychiatry. There is no form of nationally recognized training programme or registration for psychiatrists, psychiatric nurses or clinical psychologists. Many young, trainee psychiatrists gain much of their clinical experience in private mental hospitals as junior assistants. The orientation of their work is necessarily custodial and institutional.

There is also no organised training for occupational therapists or community psychiatric nurses.

The Medical Service Law provides for a minimum level of one physician (not necessarily a psychiatrist) per 48 beds and one nurse for six beds in psychiatric hospitals. These rates are supposedly controlled by prefectural public health authorities. The checks seem to be irregular and insufficient. Many medical staff have part-time appointments, so that controls

are difficult to carry out. In non-psychiatric hospitals the staffing minimum requirements are considerably higher (one physician per 16 beds). The overall rate of physicians in in-patient facilities is 12 per 100 beds for non-psychiatric facilities and 3.4 per 100 beds for psychiatric facilities. The latter figure includes at least half who are in fact only part time.

There are very few occupational therapists and social workers working in psychiatric hospitals (0.1 and 0.3 per 100 beds respectively).

In Table 1, we present a comparison between Japan and Scotland on staffing levels in mental health facilities; the Scotland figures are based on the 1983 survey by McCreadine et al (1985); the Japanese date is for 1982 and is based on a study by Hirota (1985).

| | JAPAN | SCOTLAND |
|------------------------------|-------|----------|
| Staff per 100,000 population | | |
| Physicians | 6.9 | 9.1 |
| Trained nurses | 34.7 | 103.0 |
| Occupational therapists* | 0.1 | 4.8 |
| Social workers | 0.7 | 2.7 |

* including OT aides

Table 1

This analysis is most interesting since we see that while medical staffing is comparable, there are three times more nurses in Scottish psychiatric services than Japanese and the differences in occupational therapists and social workers is of an even greater order.

The evaluation of manpower levels and distribution in Japanese psychiatric services is not easy since few statistics are available and there are no recognized qualifications for specialists in this field. Nevertheless our analysis confirms the impression given by data on out-patient and in-patients services: staffing is not sufficient to provide active therapeutic

and rehabilitative programmes. The approach adopted is one of custodial care and medication.

Costs of Mental Health Care

The annual health budget in Japan is 15 trillion yen or 6.5 % of national income. Mental health care makes up 7.2 % of the total health budget. This proportion is lower than for other developed countries. Only 0.8 % of the health budget is devoted to out-patient psychiatric services. Thus in the mental health sector only 12 % of the budget is devoted to out-patient care, whereas 52 % of the total health budget is spent on out-patient care.

Japanese health insurance provisions are complex, there being at least seven categories of health insurance. Re-imburement levels are at 90 % for employees and from 50 % to 70 % for family members in out-patient care, rising to 80 % for in-patient care. Payments are determined by a point system according to recommendations to the Ministry of Health by the Central Social Insurance Medical Council with tripartite membership (Japanese Medical Association, employers/employees and public interest groups). Although the points system has been modified to encourage out-patient psychiatric attendances, it does not yet cover effectively occupational therapy or rehabilitation services. Re-imburement levels are higher for patients subject to involuntary hospitalisation. There is therefore a financial disincentive for patients and their families to seek voluntary care. This is reflected in pressures from families on hospital doctors to maintain long-term hospitalisation under involuntary status. Either voluntary care or discharge to the community would impose an additional, and often substantial, financial burden on the family.

References

- COOPER J.E.: Crisis admission units and emergency psychiatric services. *Public Health in Europe No 11* WHO/EURO Copenhagen (1979)
- FREEMAN H.L., FRYERS T., HENDERSON J.H.: Mental health services in Europe: 10 years on. *Public Health in Europe No 25*, WHO/EURO Copenhagen (1985)
- HIROTA H.: Characteristics of mental health services in Japan. Personal communication (1983)

HOLLAND W.W. (Ed): Evaluation of Health Care (sponsored by the Commission of the European Communities), Oxford University Press (1983)
McCREADINE R.G., AFFLECK J., ROBINSON A.D.: The Scottish survey of psychiatric rehabilitation and support services. *British Journal of Psychiatry* 147 289-294 (1985).

CHAPTER III

Comprehensive Mental Health Services in a Modern Industrialised Society

Introduction

The care of the mentally ill is surrounded with prejudice, fear, stigma, and ignorance. The pain of relatives and friends is exceeded only by that of the patient who in a bewildering environment is maltreated and extruded from society.

As has been shown, in Japan, the path embarked upon by the specialties in psychiatric care has lagged severely behind other medical specialties. Each new decade brings its own priorities and pressures on decision-makers within a nation. Western societies have moved slowly and ponderously in designing their limited programmes for the mentally ill. But as Santayana states, we must not only learn from our own histories, but from the histories of others; otherwise, we are doomed to repeat history and all its errors. Each nation wishes to assure the most enlightened and progressive medical care for its citizens. Each nation wishes to keep alive a spirit of hope for recovery or rehabilitation for all patients within its health care efforts. What have been the issues to date facing the Japanese mental health care system ?

Judicial Issues

Issues of human and legal rights protecting the individual in need of evaluation and treatment for mental disorders and MH are discussed in

detail in Chapter IV. Some significant issues, however, must be discussed in the treatment-planning context.

To enable a decision to be taken whether to commit a person to a mental hospital as an involuntary patient an assessment must be made *inter alia*: of the patient's need for protection; of the risk of potential harm to the patient; of the risk of potential harm to others; and of the patient's ability to care for himself.

After the study and assessment of the condition of the patient the commitment evaluation is presented to a judge with recommendations for discharge, hospitalization, or alternatives to hospitalization. The commitment process is more than an assessment of dangerousness; it is a thorough examination and detailed study of the patient with recommendations for treatment.

The judicial process not only provides for the protection of human rights but also allows those treating the patient to avoid playing the role of the "protectors" of society and clarifies their function both for their own benefit and for that of the patient. Judicial review provides the examination of the diagnostic and treatment plans, in order to reduce custodial care where active or positive treatment can be provided. Decisions for custodial care or protective custody are related to this, but are separate adjudications. Judicial review for commitment need not be a heavily formalized process. Rather, a tribunal of two or three individuals can review the evidence and reports which are significant to the commitment process.

System for Reimbursement of Treatment Costs

In this area, the determination of economic incentives toward meeting effective system designs is most important. If the economic incentives are interpreted or designed to emphasize custodial, or low treatment levels of inpatient care, then all types of alternative care will not grow or flourish. Where there are few, or even a single source of reimbursement, this can grossly distort the system of delivering medical care.

The growth in the number of psychiatric beds, the increasing length of hospitalization and the paucity of alternative psychiatric resources as outlined *infra*, are all illustrative of such a distortion. This should not be interpreted as a perjorative review of private psychiatric hospitals or inpatient treatment. Indeed, such hospitals may be the core of a system of care which provides a full spectrum of services, thereby initiating the

continuum of services necessary for the positive outcome of psychiatric treatment. The problem lies, rather, with an economically driven system which provides incentives for long-term care, and less intensive inpatient care. There exist actual disincentives (low or no reimbursement) for providing outpatient treatment. This, incidentally, is true in some Western countries, but in the last analysis, such disincentives are not cost-effective and are wasteful of the nation's resources as, for example, potentially productive citizens languish in the backwater of hospital wards.

Training, Certification, and Accreditation

a) **Training:** The training of psychiatric physicians should be a critical priority for improving psychiatric care. Formal training with organized curricula and practical experience provide the professional experience necessary to turn out competently trained physicians.

b) **Certification:** Certification examinations enhance the professionalism and discipline necessary for a high quality system of care. Similarly, organized and specialized training in nursing, social work, occupational therapy, vocational rehabilitation, and clinical psychology with advanced degrees leading to licensure, and certification is desirable.

c) **The Accreditation Process:** Standards for accreditation reflect the dynamic growth and change that have occurred in the fields of psychiatry, mental health, and substance (drug or alcohol) abuse. They represent a process of development of standards that includes input from a wide range of health-care professionals throughout the country, for whom these standards are prepared. The standards which are used to accredit facilities by a National organization, whether it be a Governmental organization or a free-standing, non-profit organization, accommodate a variety of settings, treatment philosophies, and related professional staff patterns. These standards are used to assess the quality of psychiatric, mental health, and substance-abuse care in both inpatient and outpatient facilities. Institutions seeking accreditation are evaluated for compliance with the applicable standards in a Manual prepared for such an accreditation review.

Organizations which prepare accreditation manuals or studies, usually make a review and consider the most useful and appropriate standards for evaluating and approving the quality of care provided in adult, child, and adolescent psychiatric programmes including those regarding alcoholism and drug abuse patients.

A brief account of the organization of accreditation in the United States will provide a concrete example.

The organization has four sections:

1. The first section has to do with facility management and includes standards covering such topics as professional staff organization, personnel, and high quality assurance.
2. A second section reviews such issues as patient management which concerns the implementation and the documentation of the intake process, the assessment, the treatment plan and the special treatment procedures.
3. The third section — patient services — covers various components of the service delivery system.
4. The fourth and final section has to do with the physical plant management, which contains standards related to safety, to sanitation and to a therapeutic environment.

It is important to recognize that a facility's self-evaluation is as important a part of the accreditation process as a review by the accrediting agencies' surveyors. Instruments or documents presented as part of an accreditation process are an ideal self-evaluation tool.

After a facility has identified the standards applicable to its particular operation, it can easily rate its level of compliance with these standards by using indicator levels such as 1) substantial compliance, indicating that the facility's operations fully meet the intents of the standards as evidenced by performance and by documentation, 2) partial compliance, indicating that the facility's operations address the intent of the standards but continued refinement and upgrading of procedures or documentations are needed before it achieves substantial compliance, 3) non-compliance, indicating that the facility's operations do not meet the intent of the standards.

How one goes about evaluating compliance or the extent of a facility's compliance can be assessed by the following means :

- 1) Statements from authorized or responsible facility personnel.
- 2) The presentation of certification, or other documentation of compliance provided by the facilities.
- 3) Answers to questions concerning the implementation of a standard, or examples of implementation, which will enable a judgment of

compliance to be made.

- 4) And finally, on-site observation by surveyors.

Hospitalization and Alternatives to Inpatient Care

Economic factors, more than any other single factor, affect choices of different forms of mental health care. No health-care system can afford to hospitalize patients for long periods in inpatient units as a routine part of the psychiatric services. Rather, studies are currently showing that short-term intensive or active treatment, followed by a linked after-care treatment programme, is a much more cost-effective as well as treatment-effective regimen. When patients are placed in hospitals with either low levels of or no active treatment, the economics of long-term hospitalization, as a routine practice, is both costly and inconsistent with modern psychiatric care.

The acute treatment process should be as intense as each case requires. The inpatient unit as a treatment resource is only one resource from a full spectrum of treatment elements which can be chosen for clinical patients. The treatment plan is the determining factor concerning which resource or combination of resources is to be provided to give maximum benefit to the patient. This is a coordinative document which has input from the social worker, the psychiatrist and the rest of a clinical team.

The shift in the locus of care from institution to community has, in many countries, created a significant shift in the clinical profile of the patient populations managed in the community. The traditional image of the chronic patient in the community, who is in late middle-life or old age, and withdrawn, has now been replaced by younger patients, who can live in independent or semi-independent living situations, group homes, or residences. When supervised by case managers, these patients, for the most part, make effective adjustments to the communities. These may be cost-effective solutions but, more importantly, the effects on dignity, destigmatization, and the maturity of the managing society are impressive. Industrialized societies, such as the United States and Japan, cannot afford to lock away large numbers of their citizens in warehouses for the mentally ill. The effects of such policies are economical neither in financial terms, nor in lives. The spectre of inhuman treatment, dehumanization of both patients and staffs hangs continually over the heads of the decision-makers. Scandals are just one step away from the potential

tragedies.

Community resources provide a wide range of settings, ranging from the most restrictive and intensive, to the least restrictive. They include the following:

- 1) Nursing facilities for patients requiring medical and skilled nursing care, as well as intermediate-care facilities having a lower staff/patient ratio.

- 2) Group homes, where people can live in residential centres or group facilities.

- 3) Personnal-care homes, which are less labour intensive with less emphasis on treatment within the facility.

- 4) Foster homes, where patients can live with individuals who can care for their socialization and social-patterning.

- 5) Natural family placement, i.e., placement back into the family with support-systems from the psychiatric resource centre.

- 6) Patient housing, i.e., patients living together under the guidance of a case manager.

- 7) Independant living.

A brief description of each of the resources follows*:

Nursing facility. This is an institution, and not truly a residence. Skilled nursing facility beds, however, can be used as alternatives to hospitalizations. In such a facility the psychiatric coverage by a psychiatrist is less emphasised than that of the nursing personnel.

Group home. This class of residence encompasses facilities referred to as half-way houses or hostels, group-care homes or residential homes, and transitional care facilities. They usually provide 24 hours of continuing care a day, 7 days a week. The groups of patients may range from 10 to 15 adults living in the same building, with a staff that supervises their programmes, and whose primary focus is on the group process, and an emphasis on psychosocial rehabilitation. This is accomplished through such activities as group therapy for the residents, community meetings, and participation in the management of the facility or household. Group homes can be used for crisis intervention or for relatively short-term settings for

* See also Table on pp. 52 and 53.

those patients who are unable to remain either in their own homes or in the hospital.

Personal care home. This type of residence includes facilities such as board-and-care homes (boarding homes) congregate-care facilities and community-care homes. Personal care homes are residences run by a proprietor unrelated to the residents. They serve 4 to 6 adults, or 4 to 8 adults who are mild to moderately disabled. The primary programme focuses on the maintenance of current levels of functioning and on support. Personal care homes provide 24-hour on-sight supervision with staff appropriate to the needs of those accepted for placement. Psychiatric treatment and social rehabilitation are not part of this function, and may be arranged with clinics and centres.

Foster home care. This category includes such facilities as family home care, crisis home, domiciliary care homes or respite homes. A foster home is really a full-time residential care programme provided by a family unit living in its own home and usually for a small group — 1 to 4 adolescents, or adults. These patients are unrelated to the family. The programme focuses on treatment based on a family model and the emphasis is on residents being integrated as much as possible into the core family. Support is available to the foster parents, and formal linkages with community mental health programmes or hospitals must be provided. The nature of the population depends on both the community needs and the foster family's wishes and expectations.

Natural family placement. Many mental patients remain with, or leave the hospital to live with, their immediate family or relatives, and these arrangements may also be facilitated by coverage from the base facility. Mental health workers or professionals should be available to support this natural network by home visits and by office consultation, both for the patient and the family. Consultation and treatment are made through the local community services.

Satellite housing, or semi-independent housing. This consists of semi-independent living arrangements in which 1 to 4 patients may occupy an apartment or a house in the community. These are either leased by an agency that helps to establish the individual in the placement, or owned by the agency. These agencies are responsible for providing ongoing assistance, and also arranging financial support regarding provisions for psychosocial rehabilitation and for treatment and programming into day hospitals or job training. Daily living expenses are provided by the social welfare systems.¹

A number of studies have demonstrated that many patients in the acute stages of psychiatric illnesses can be treated as effectively, more economically, and in a shorter time, in a community setting, as compared with those admitted to inpatient settings. Such care has also proved to be less alienating or disorganizing than admissions to psychiatric hospitals. This is not to say that admissions to psychiatric hospitals are not a useful part of the spectrum of services required to treat psychiatric illnesses. Inpatient stays should be limited to those periods when :

- the protection that an inpatient unit can provide is essential for the management of seriously suicidal or homicidal patients;
- the patient's behaviour is so disorganized as to require heavier doses of medication than can be safely given outside the hospital. This is particularly true of manic-depressive patients and disorganized schizophrenic patients;
- there is a need for intensive nursing care and related medical services which preclude treatment in a community residence.

The transition from hospital to community should be part of an organized treatment plan and facilities such as half-way houses, and group homes may be alternatives to prolonged hospitalization. Patients who no longer need hospitalization and do not require the physical care given in nursing homes (but are so psychosocially dysfunctional as to be incapable of living in the community without special support) may be placed in suitable community residences. The goal of such placement is to promote and maintain the highest level of functioning of which the patient is capable, to prevent regression and to promote a constant search for increased functional training.

Many research projects have pointed out that community care results are as good, if not better, for the chronically mentally ill than customary inpatient hospital treatment. There is abundant evidence that community care is no more expensive than institutional care. While community care may not necessarily provide the economic savings over inpatient care, it does provide for both the dignity of the patient and operational improvement of his social capacities. Studies of the economics of health-care systems show that 25 percent of all hospital days concern mental disorders and that 70 percent of all funds expended for psychiatric care are spent on inpatient care. It is likely, however, in the next decade, that alternatives to 24-hour hospital care will grow, given the strong financial impetus

towards an introduction of various payment strategies and methodologies which relate to critical episodes of care rather than a day-by-day, week-by-week or month-by-month reimbursement.

These alternatives, of course, include the whole range of outpatient treatments — the various psychotherapies, namely individual or group therapy, family therapy, the use of psychopharmacology, and ambulatory care. Home care, intermediate-care facilities, supervised apartments or shelters are all alternatives to hospitalization or are resources to be used after a short-term intensive inpatient treatment. The opportunity to develop an array of continuous services using the most current proposals in the system could achieve both goals — those of saving and of improving the quality of care.

Most of the serious illnesses are long-term and the clinical approach requires the whole range of medical, psychiatric, psychotherapeutic, and rehabilitative and social service opportunities. Responsibilities for both funding and assuring these opportunities should be fixed within the overall system of psychiatric care. Psychiatric care, like much of medical care, is more than just the contractual relationship between patient and physician. It is a system of care with physicians and non-physicians working together to develop comprehensive approaches.

A critical factor has to do with providing easy access to care. There should be no financial barriers to diagnosis and early treatment. There are currently major unmet needs for mental care in many communities, and the heavy expenditure on inpatient care for long periods deprives other patients of access to treatment, thereby increasing both the load of chronicity and the possibility of complicating the progress of the illness. There are patients who require long term and intensive treatment. However defining this population more carefully and providing the care system for them is a priority, as is the financing of insurance for individuals in this group.

Much has to do with politics. There is a widespread absence of political support for community treatment for a number of reasons. Mentally ill patients are usually extruded from our communities because of prejudice and fear and also ignorance, about their illness. Hospitals are generally assumed to be the best places for treating major illnesses including psychiatric ones. Early in our history, patients and the public have come to expect that serious mental illness will be dealt with in hospitals. This reflects not only a positive force but can also lead to an out-of-sight/out-of-mind attitude. Therefore, alternatives to psychiatric hospitalization

tend to be unacceptable because they run contrary to convention. Attitudes toward the mentally ill still reflect a vast degree of social stigma. One recent study found them to be the most stigmatized of all the disabled groups. It is often suggested that the reason for institutionalizing psychiatric patients is the unacceptable feelings they evoke in us.

There are a variety of financial incentives for hospitalizing psychiatric patients. The simple fact is that hospitals gain money from inpatient care while losing money on outpatient services. Again, this situation results largely from the structure of reimbursement patterns. While it may be that alternatives are not used because there are financial pressures from hospital administrators and some insurance incentives simply to fill the hospital beds it can also be said that social determinants create reasons for these alternatives not being used. The family and the community prefer hospitalization, and this leads to increased pressure for hospitalization. Alternative care is usually intensive and may involve a residential non-hospital component. Outpatient coverage by reimbursement is rarely sufficient to cover professional fees, and never covers residential care. On the other hand, a patient is economically unproductive while he is in hospital and his job skills may deteriorate from lack of practice. His social life is limited to relationships with other patients and other hospital personnel. Very often if other people from within the hospital or outside try to be with him, hospital personnel interpose themselves. This restricted life limits a patient's confidence about being able to live outside the hospital. The longer he is in the hospital, the more dependent he is on the hospital and the more likely his "career" will be that of a mental patient.

Hospitalization promotes social regression and the attendant costs of having induced institutional behaviours. Past hospitalization becomes the most powerful predictor of subsequent hospitalization. Hospitals teach people how to be hospital patients more than how to function in the community.

Recommendations For Future Developments And Planned Policies For Improving Psychiatric Care

In the last analysis, the quality of a system of care is dependent on its funding and reimbursement modes. These flow from policies which determine the resources, the reimbursement scheme, and the incentives within a

health care system designed to care for significant portions of the population. Careful attention to cost effectiveness, adequately trained resources, and a meaningful system of review through certification-accreditation, audits, peer review and an advocacy system (attention to the redress of rights complaints) will provide a meaningful sophisticated system of care.

If we are to suggest improvements for the mental health system in Japan, we must recognize that the predominant funding of psychiatric care is at an inpatient level. This is not only manifested in the number of psychiatric beds, but also the length of stay. The incentives to inpatient stays for alarmingly long periods of time are truly impressive and seem unduly distorted.

While inpatient care is an extremely important element in the treatment of patients, the heavy emphasis on this mode of treatment unbalances the system. It increases the stigma and the bias against mental illness. It prejudices the society as to the "dangerousness" of such individuals, and it creates a heavy dependence on involuntary hospitalization. Whether such admissions are managed judicially, or whether the patients are simply "volunteered" by their families, the end result is the same — an increase, or maintenance, of a heavy stigmatization, and an enormously expensive but ineffective system of care.

Alternatives to inpatient care, or the use of limited inpatient care followed by an array of outpatient programmes, alternative living arrangements and linkages with other agencies, as for example, the welfare services are generally scarce.

A further limitation is the lack of organized curricula for the psychiatric professions at the medical school and post-graduate training levels. This is further accentuated by the lack of a certification process for psychiatrists. Both curricular content supervision and certification, complemented by residency experience, would stimulate the use, and the broadening, of alternatives to inpatient care.

An industrialized modern society like Japan cannot afford to avoid the responsibilities of modern health care for its citizens. Life styles are changing for all societies, and the planning required to reduce disability and chronic illness and ineffective and expensive uses of resources, are incumbent upon all who bear the mantles of leadership.

References

- BRAUN P.B., KOCHANSKY G., SHAPIRO B. et al., "An Overview The Institutionalization of Psychiatric Patients: A Critical Review of Outcome Studies." *The American Journal of Psychiatry*, vol. 138, pp. 736-749.
- KEISLER C.A. "Mental Hospitals and Alternative Care: Non-Institutionalization as Potential Public Policy for Mental Patients." *Journal of American Psychologists*, Vol. 37, pp. 349-359.
- Joint Commission on Accreditation of Hospitals Manual, Joint Commission on Accreditation of Hospitals, Chicago, Illinois 60611.

Note

1. The American Psychiatric Association, Report of the Task Force on Residential Services. See Table on next page: "Table 1 — Types of Community Residences."

Table 1. Types of Community Residences

| Type of Residence | Psychiatric Time on Site | On Site Staff Full Time 24 Hrs | On Site Staff Part Time | Clinical Linkages Required |
|-----------------------------|----------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Nursing facility SNF or ICF | Part time on site for evaluations, consultations, emergencies, staff supervision, and treatment planning | Nursing staff constant | Medical and mental health professionals and para-professional support staff | 24 hr. ER and medical care |
| Group home | Part time on site for emergency intervention, staff consultation, supervision, and training | MH professionals and para-professionals trained in group process and rehabilitation techniques | Support staff appropriate to treatment goals | Full range MH and social svcs. CMHC Hospital Private practitioner, Foreman |
| Personal care home | X | Manager, proprietor and staff appropriate to programme | Home visits and consultations by MH professional or MHW | Formal with facilitation of referrals and linkages |
| Foster home | X | Foster parents and family living in own home | Home visits by MH prof. of MH dependent on client or parent needs | Formal CMHC, and social service agency |
| Natural family placement | X | X | As above | Informal and as needed at option of family |
| Satellite housing | X | X | Supervision as needed from sponsoring agency | Formal with sponsoring agency |

Courtesy of American Psychiatric Association, Washington, D.C.

Table 1. Types of Community Residences

| Programme Focus | Level of Disability | Size of Population | Length of Stay | Licence Required |
|--------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------|------------------------------------------|----------------------------------------|
| Medical, nursing, protection | Severe | Variable | Long term but can be used for short term | Yes |
| Psychosocial rehabilitation through group process and milieu | Moderate to mild | Adult 8-15 Adolescents 8-10 | Variable depending on programme | Yes |
| Maintain level of functioning and support improvement | Moderate to mild | Variable (depending on size of facility and staff) | Variable (short term to lifelong) | Yes |
| Treatment based on family model | Severe to mild depending on family skills | Child 1-4 Adolescent 1-2 Adults 1-4 MR = 1-2 | Variable (as above) | Placing agency evaluation and approval |
| Reintegration and maintenance; support for family | As above | X | X | X |
| Independent living | Moderate to mild | 1-4 per unit | Variable | No |

CHAPTER IV

Legal Protection of Mentally Disordered Persons

Introduction

It has been estimated that there are 450 million people throughout the world who suffer from a serious physical or mental disability or impairment. Although the vast majority live in developing countries substantial numbers live in countries such as Japan, the United States and European countries which have developed their technological achievements to a remarkable degree and have achieved a relatively high standard of living and economic well being. Unfortunately, common prejudice, (both conscious and unconscious) discrimination, insensitivity to the needs of the disabled, tradition and archaic laws have led to an avoidance of concern about the human rights of the disabled. Within this large group of disadvantaged persons are persons whose human rights and treatment concerned the ICJ/ICHP Mission — disabled persons suffering from mental disorders.

New treatment concepts for the mentally ill make it urgent that new initiatives be taken to revise the laws relating to the mentally ill. Psychiatry, psychology, social work and other professional disciplines have developed new techniques aimed at integrating disabled persons into the mainstream of society and providing opportunities for them to achieve their optimum potential.

The goal of this report is to outline ways which would ensure that mentally disabled persons are given the equal protection of the law and that they are treated fairly and humanely, with the least possible

restriction on their freedom. The central theme which runs through the recommendations of the Mission is respect for the worth of the individual, the right to receive adequate services and the individual's right to minimal restraints by government in restricting his liberty or self-determination.

The primary focus of the Mission's work related to the mentally ill, although some recommendations relate to problems of drug abuse, drug addiction, alcoholism, and the mentally retarded.

It would be fair to say that as a result of new developments in the treatment of the mentally ill and new developments in concern about their human rights Japan's present Mental Health Law is obsolete, does not offer adequate protection of human rights and requires a comprehensive revision.

The world as we know it today is extraordinarily different from the world of yesterday. Technological achievements, the interdependence of nations, mass communication and the free flow of ideas and people among democratic countries stand in stark contrast to the time when a nation could barricade itself from influences beyond its borders.

The laws of any nation must now be measured against international principles some of which have the force and effect of treaties and others which give new directions and guidelines about fundamental democratic concepts.

Our observations, conclusions and recommendations relating to the Mental Health Act of Japan can best be understood after a preliminary discussion of the international principles articulated in United Nations Declarations and the Council of Europe, and by an examination of the Japanese Constitution.

Many of the recommendations may be looked upon by some as establishing new human rights; however, they might better be viewed as new efforts to enforce rights already inherent in the United Nation's Charter, the international Covenants and the Constitution of Japan. The prevailing mood in the democracies of the world is to require openness, honesty and greater accountability on the part of government toward its people. The Mission's recommendations include provisions to ensure not only improved treatment and the protection of human rights, but also improved techniques to monitor both governmental and non-governmental treatment facilities. Some of the recommendations designed to accomplish this goal reflect innovations which have been tried in other nations. They include the provision of legal services for the mentally ill, access to review by an

independent tribunal, as well as the development of human rights committees, and other forms of advocacy.

United Nations Declarations

In consideration of the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms of members of the human family, the United Nations Covenant on Civil and Political Rights was promulgated and Japan became a State Party to the Covenant.

Article 9 of the United Nations Covenant on Civil and Political Rights is particularly relevant to certain critical parts of the Mental Health Law of Japan. Article 9, paragraph 1 prohibits arbitrary detention and further provides that no one shall be deprived of liberty except by procedures established by law. Article 9, paragraph 4 provides that anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court in order that the court may decide without delay on the lawfulness of his detention and to order his release if the detention is not lawful.

Article 14, paragraph 1 provides that all persons shall be equal before the courts and tribunals and shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law.

In furtherance of the principles set forth in the Universal Declaration of Human Rights, and the International Covenants on Human Rights, the United Nations promulgated the Declaration on the Rights of Mentally Retarded Persons, and subsequently the Declaration on the Rights of Disabled Persons. These declarations reinforce the principle of the universality of human rights. At present draft "Guidelines, Principles and Guarantees for the Protection of persons detained on grounds of mental illness — or suffering from mental disorders" are being considered by the Subcommission on Prevention of Discrimination and Protection of Minorities of the United Nations Commission on Human Rights. When adopted, these guidelines will establish important principles protecting the rights of the mentally ill. The proposed United Nations guidelines are consistent with the recommendations embodied in this report.

Recommendation No. R (83) Adopted by the Committee of Ministers of the Council of Europe (1983)

In 1977 the Parliamentary Assembly of the Council of Europe adopted Recommendation 181 which emphasized the need for better legal protection of the mentally ill, especially those who were subject to measures relating to involuntary hospitalization. A committee of experts was convened to identify specific mental health issues lending themselves to legislative harmonization at a European level.

The committee studied cases in the European Court of Human Rights arising out of the European Convention for the Protection of Human Rights and Fundamental Freedoms. In the *Winterwerp vs. United Kingdom* case decided 24 October 1979 the Court judgment stated :

"... It is essential that the person concerned (mentally ill patient who undergoes involuntary placement) should have access to a court and the opportunity to be heard in person or, where necessary, through some form of representation..." (paragraph 60 of the *Winterwerp* judgment of the European Court of Human Rights).

On 5 November 1981 the Court, in *X vs. The United Kingdom*, decided, *inter alia*, that there was a breach of Article 5, paragraph 4, of the Convention. The Court found that, although X had access to a Court which ruled that his detention was "lawful" in terms of English law, a judicial review as limited as that available in the Habeas Corpus procedure, while adequate in regard to emergency measures taken for the detention of persons on the grounds of unsoundness of mind, was not a sufficient guarantee for human rights concerning a continuing confinement such as the one undergone by X until 1976.

The committee of experts in its report also noted with particular interest that all member states wished to improve the treatment and protection of the mentally ill who were subject to involuntary placement and the report concluded that this objective could best be implemented by a harmonization of laws at a European level. It was also recommended that all member states should re-examine their treatment facilities and hospital conditions in order to introduce further improvements. As a result of the report by the committee of experts the Committee of Ministers of the Council of Europe on 22 February 1983 adopted Recommendation No. 5 (83) 2 which recommended that governments of the member states should

adapt their laws to the rules set forth in the Recommendation or adopt provisions in accordance with the rules when introducing new legislation. The scope of Recommendation No. R (83) 2 is quite comprehensive and any person, organization or government interested in protection of the mentally ill could benefit from studying the recommended rules and the explanatory memorandum. A detailed review of the specific rules recommended is beyond the scope of this report except to indicate that the conclusions and recommendations of the Mission are consistent with Recommendation No. R (83) 2. Recommendation No. 5 (83) 2 deserves to be viewed as a significant milestone reached by democratic states in highlighting fundamental needs and rights of the mentally ill, which are universally applicable irrespective of national boundaries, or cultural or social differences.

The Constitution of Japan

On November 3, 1946 the Constitution of Japan was adopted, which laid the legal foundation for the new Japan. The Constitution proclaims that the Japanese people desire to occupy an honoured place in an international society striving for the preservation of peace, and the banishment of tyranny, slavery, oppression and intolerance for all time and for a recognition that all people have the right to live in peace, and freedom from fear and want. The Constitution further proclaimed that no nation is responsible only to itself and that the laws of political morality are universal. The Japanese people pledged their national honour to accomplish these high ideals and purposes using all their resources.

Many of the articles of the Constitution relate to fundamental human rights and these provisions are relevant to the protection of the rights of mentally ill persons and must be considered.

Articles 11 and 12 of the Constitution state that the people shall not be prevented from enjoying any of the fundamental human rights which are to be considered as eternal and inviolate. Such guaranteed freedoms and rights shall be maintained by the people and they shall refrain from any abuse of these rights.

Article 13 provides that all persons shall be respected as individuals and that the supreme consideration in legislation and in government affairs shall be the furtherance of the individual's right to life, liberty and the pursuit of happiness, to the extent that this does not interfere with

the public welfare.

Article 14 underscores that all of the people are equal under the law and that there shall be no discrimination because of race, creed, sex, social status or family origin.

Article 18 prohibits any person from being held in bondage of any kind, in involuntary servitude, except as a punishment for crime. Article 19 protects the freedom of thought and conscience. Article 20 provides that no censorship shall be maintained and that the secrecy of any means of communication shall not be violated. Article 25 establishes the right to at least minimum standards of wholesome and cultural living and that Japan shall promote social welfare, security and public health.

Article 31 provides that no person shall be deprived of life or liberty except according to procedures established by law. Article 32 insures that no person shall be denied the right of access to the courts. Article 34 requires that no person shall be arrested or detained without being at once informed of the charges against him or without the immediate privilege of counsel; nor shall he be detained without adequate cause; and upon demand of any person such cause must be shown in open court in his presence and in the presence of his counsel. Article 35 protects the rights of all persons to be secure in their homes except when a valid warrant is issued by a competent judicial officer.

Articles 97, 98 and 99 emphasize the supremacy of the fundamental human rights guaranteed by the Constitution and that no law, ordinance or act of government, which is contrary to the provisions of the Constitution, shall have legal force or validity. The Emperor or the Regent, ministers of state, members of the Diet, judges and all other public officials have an obligation to respect and uphold the Constitution.

Before any examination of the legal aspects of a mental health system, it is important first to emphasize the basic objectives of any mental health law. First, the law must support and advance the therapeutic goals of mental health treatment. Second, the law must be a safeguard and a protection of the legal rights of the individual while at the same time protecting society from serious physical harm. There need not be a dichotomy between these two aims.

The United Nations International Covenant on Civil and Political Rights, ratified by Japan, sets forth fundamental human rights. On a national level the Japanese Constitution sets forth the supreme law of the land. The rights protected under the Japanese Constitution are consistent with the rights protected under the United Nations Covenant. There is no

incompatibility between the objectives set forth or the language used in these two important documents.

It is essential to examine the Mental Health Law of Japan to ascertain whether it conforms to the requirements of the Covenant and the Constitution. It is also necessary to examine the present pattern of psychiatric care delivery in Japan in order to determine whether it conforms to the Covenant, the Constitution and the Mental Health Act.

The Human Rights of the Mentally Ill

The Mission believes it necessary to define clearly in a statute rights of mentally ill persons. The present Mental Health Act and other related Japanese laws make reference to certain rights but they are vague and ill-defined in relation to the mentally ill. Establishment of the rights of mentally ill persons will protect them both in institutions and in the community. It is also necessary to regulate certain modalities of treatment utilized by professionals in treating mentally disabled persons, such as psychotropic medication, electro-shock treatment and other forms of treatment, and the general utilization of restraints and seclusion. A balance should be sought between the needs of clinicians to provide adequate and necessary treatment and the rights of patients who may object to such forms of treatment. The Mission recommends that detailed provisions, dealing with specific areas which need protection, be incorporated into a new Mental Health Act. Although the drafting of such provisions is the responsibility of the Japanese legislature, we set out below a set of specific rights which could be applied without delay to the Japanese mental health services. These should be regarded as concrete suggestions liable to be modified according to expert psychiatric and judicial opinion in Japan. Nevertheless we would underline that in the context of an industrialised society with democratic ideals, these guarantees should be regarded as a statement of minimally acceptable rights.

Rights of the Mentally Ill

1. *No patient shall be deprived of any rights, benefits or privileges guaranteed by law, on account of the receipt of mental health treatment.*

Commentary

The full import of this statement should be read in conjunction with our earlier analysis in this report concerning rights protected under the Japanese Constitution, the United Nation's Charter, and the International Covenants.

It has been called to the attention of the Mission that there are many laws and administrative regulations which discriminate against the mentally ill. Although no specific statutory changes are recommended by us in this area, we recommend in general that these statutes be reviewed and that invidious discrimination against the mentally ill be eliminated from them.

2. *No patient shall be presumed incompetent, nor shall such person be held incompetent except as determined by a court. Such determination shall be separate from proceedings held to determine whether a person is subject to involuntary hospitalization.*
3. *A patient shall be provided with adequate and humane services in the least restrictive environment, pursuant to an individual treatment plan, which shall be formulated and periodically reviewed with the participation of the patient to the extent feasible and, where appropriate, such patient's parent or guardian. A professional, qualified by training and experience, shall be responsible for overseeing the patient's treatment.*

Commentary

This section incorporates the following important features :

1. The requirement of an individual treatment plan. Mental health professionals have come to recognize the importance of a plan tailored to individual needs of a mentally ill person. A programme that has therapeutic value for one patient may be of no benefit to another.
2. The right to be treated in the least restrictive setting possible is an important element of the right to adequate and effective mental health care.

The "least restrictive" alternative is the combination of therapeutic and preventive intervention and (a) is conducive to the most effective and appropriate treatment and care that will give the mentally ill person a realistic opportunity to improve his or her level of functioning; and (b) is no more restrictive of a patient's physical, so-

cial, or biological functioning than is necessary to achieve the legitimate governmental purposes of protecting society and providing mental health treatment and care. In balancing the interests of the individual, his or her family, and the government, a determination of "less restrictive alternatives" must consider and weigh a number of factors, including : the environmental restrictiveness of the treatment setting; the psychological or physical restrictiveness of the behavioural, chemical or biological treatments given, clinical variables, including the person's own behaviour as it relates to legal criteria for involuntary hospitalization; relative risks and benefits of various treatment alternatives; the extent of family and community support available in the person's environment; the quality or likely effectiveness of the alternative care and treatments given; the duration of the treatment; the likelihood that a person may pose a risk to public safety; the availability, cost and accessibility of alternative treatment and care; the likelihood or not, of the patient's cooperation or compliance with the conditions or alternative treatment programmes; and the mechanisms for monitoring and reviewing the patient's compliance.

3. Encouraging the participation of the patient in the formation and review of the plan helps him to understand its objectives, procedure, and rationale which will contribute constructively to the progress of the treatment. Here it is essential that there be a periodic review of the treatment plan in order to respond to the patient's current needs, to control the implementation of the treatment plan, and to assure that the initial treatment plan is not forgotten.

In the interest of continuity of care, the assignment of clinical responsibility to one member of the treatment team is necessary.

4. *A patient who resides in a mental health facility shall be permitted, unimpeded, private and uncensored communication with persons of his choice by mail, telephone and visits. The patient shall be assured that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available. Writing materials, postage and telephone usage funds shall be provided in reasonable amounts to patients who are unable to procure such items.*

Reasonable times and places for the use of telephones and for visits should be established in writing by the administrator.

5. *Every patient who resides in a mental health facility shall be permitted to receive, possess, and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided herein.*

The health professional responsible for overseeing the implementation of a patient's treatment plan may, with the approval of the administrator, restrict the right to property when necessary to protect such patient or others from substantial harm. When a patient is discharged from the mental health facility, all of his personal property which is in the custody of the facility, shall be returned to him.

Commentary

There is no legitimate justification for depriving a patient of the custody and control of his own property unless the patient has been adjudicated incompetent to manage it.

6. *A patient may use his money as he chooses, unless he is a minor or prohibited from doing so under a court guardianship order. Any money of his deposited with a mental health facility shall not be used by the mental health facility, any earnings attributable to a patient's money shall accrue to him.*

When a patient is discharged from a mental health facility, all of his money, including earnings, shall be returned to him.

7. *A patient may perform labour to which he consents if the health professional responsible for overseeing the implementation of the treatment plan for such patient determines that such labour would be consistent with such plan. A patient who performs labour which is of any consequential economic benefit to a mental health facility shall receive wages which are commensurate with the value of the work performed, in accordance with applicable laws and regulations. A patient may be required to perform tasks of a personal housekeeping nature without compensation.*

Wages earned by a patient shall be considered money which he is entitled to receive.

Commentary

This ensures that a mentally ill person is paid for the hours of work

he performs either inside or outside the institutional setting, at a rate commensurate with the work production. However, he may be required to perform personal housekeeping chores without compensation. The traditional distinction between therapeutic labour without pay and institution-maintaining labour with pay has come under increasingly severe criticism, since there are practically no tasks which cannot in one way or another, be cast in a therapeutic light by an institution, just as many such tasks benefit the facility. The use of extraordinarily cheap patient labour is extremely susceptible to abuse and is thus deplored. The value of a just compensation to patients is increasingly recognized by professionals as possibly promoting therapeutic goals by giving a sense of dignity and purpose to the patients' work. Such compensation will minimize feelings of inadequacy, powerlessness and persecution, which are so often present in patients and their illnesses.

8. *No generally accepted mental health services, including but not limited to medication, shall be given to a patient without his knowledge and unless he is given an opportunity to refuse such treatment.*

Notwithstanding his right to refuse, generally accepted treatment may be given in order to prevent a recipient from causing serious physical harm to himself or others or to prevent a serious deterioration of his mental health likely to lead to long lasting disability or to threaten his bodily integrity. Each patient's medication regimen shall be reviewed at least every two weeks by a physician.

Commentary

Rules relating to the administration of treatment in non-mental hospitals are universally accepted. Except in emergency cases, before a person is administered treatment or an operation is performed, the doctor must obtain the consent of the patient or, if the patient is incompetent, he must obtain the consent of the guardian or a person legally authorized to give consent. In the absence of an adjudication of incompetency regarding a mentally ill patient, this rule should apply. Drawing a distinction between the physically ill and mentally ill is justified only where the latter is incapable of giving or withholding consent. It is recognized that where the mentally ill person poses a physical threat to himself or others, it may be necessary to administer medical and other treatment, even when there is an objection by the patient, but this is in order to prevent dangerous behaviour.

9. *Restraint shall be employed only upon the written order of a physician except as provided herein. No restraint shall be ordered unless the physician, after personally observing and examining the patient, is clinically satisfied that the use of restraint is justified to prevent the patient from causing physical harm to himself or others.*

Commentary

"Restraint" means the partial or total immobilization of any one or more limbs by mechanical means. The definition applies only to "mechanical" restraint, rather than to "physical" restraint, a term which is subject to excessively broad interpretation. The rationale concerning the rights regarding the use of restraints and seclusion are similar. Frequent reports of abuse of restraints and seclusion require an express statement of standards to insure that restraints and seclusion are used only for therapeutic measures and never to punish or discipline a patient or as a convenience for the staff.

The written order of the physician shall state the events leading up to the need for the restraint and the purposes for which such restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for such length of time. No order for restraint shall be valid for more than eight (8) hours. If further restraint is required a new order shall be issued by a physician, pursuant to the requirements provided herein.

In the event of an emergency requiring the immediate use of restraints, it may be ordered temporarily by a person qualified by training and experience only where a physician is not immediately available. In such event, a written order of a physician shall be obtained pursuant to the requirements hereinabove as quickly as possible, but in no event longer than four (4) hours after the initial employment of such emergency restraint. Such four (4) hour period is a maximum one and the lapse of time is not to be routinely utilized.

The person who orders restraint shall inform the clinical director in writing of the use of restraint as soon as practicable. The clinical director shall review all restraint orders daily and shall inquire into the reasons for the orders for restraint by any person who routinely orders them.

Restraint may be employed during all or part of one 24 hour period. Such period commencing with the initial application of the restraint. However, once restraint has been employed during one 24 hour period, it shall not be used again on the same patient during the next two following

calendar days without the prior written authorization of the clinical director. Restraint shall be employed in a humane and therapeutic manner. Specifically, unless there is an immediate danger that the patient will physically harm himself, restraint shall be loosely applied to permit freedom of movement. Further, the patient shall be permitted to have regular meals and toilet privileges free from such restraint, except when freedom of action may result in physical harm to the patient or others.

10. *Seclusion may be used only as a therapeutic measure to prevent a patient from causing physical harm to himself or others. In no event shall seclusion be utilized solely to punish or discipline a patient, nor is seclusion to be used as a convenience for the staff.*

Commentary

"Seclusion" means the retention of a patient alone in a room with closed doors which he cannot open. The commentary under Restraints is also applicable to Seclusion.

11. *No patient shall receive convulsive therapy or psychosurgery, without his written and informed consent. The same provision shall apply to any experimental form of treatment.*

Commentary

Although it was not the intent of the Mission to investigate individual cases of the abuse of human rights, a number of cases were reported where patients were subjected to unusual, hazardous and experimental treatment without the informed consent of the patient. It is common knowledge that thousands of persons in years past have been subjected to psychosurgery, particularly lobotomies. The requirements of informed consent are well defined. Informed consent is the exercising of an individual's free choice following disclosure of adequate information about the proposed treatment, and a list of the available alternatives, and the attendant risk of each. Although it is difficult in some cases to determine whether a patient is competent to give or withhold informed consent, a mentally ill person, like any other, cannot be assumed to be incompetent only on the basis of an administrative determination. When the competency of any person to get or withhold informed consent is at issue, the appropriate forum for the determination is the courts.

12. *A medical or dental emergency exists when delay for the purpose of obtaining consent would endanger the life or adversely and substantially affect the health of a patient. When a medical or dental emergency exists, if a physician or licensed dentist who examines a patient determines that the patient is not capable of giving informed consent, essential medical or dental procedures may be performed without consent. No physician or licensed dentist shall be liable for a good faith determination that a medical or dental emergency exists.*

Commentary

This provides an exception to consent requirements. It concerns the case where the life or health of the person would be in jeopardy if medical or dental procedures were not employed sooner than would be required to get approval from a parent, guardian or court for the procedure. It grants the physician or dentist performing the procedure immunity from liability for his determination in good faith that a medical emergency does, in fact, exist.

13. *Every patient upon admission to a mental health facility, either as a voluntary or an involuntary patient, shall be given a copy of a statement of his rights. A copy shall be prominently posted on every ward within a mental health facility.*

Advocacy

It is crucial that any imaginative proposals assuring treatment for the mentally ill must include advocacy and monitoring components. Existing data made available to the Mission strongly point out the absence of adequate legal advocacy, independent advocacy, indigenous advocacy and effective monitoring components in the Japanese mental health system. Independent advocacy is not only essential when liberty is in jeopardy but also when needed services are being denied. Mechanisms are also necessary to involve both professionals and consumers, as well as certain techniques to investigate complaints of alleged abuses against the mentally ill.

Some 93.6 percent of persons who have been hospitalized have been subjected to infringement of their liberty due to an alleged mental illness. These persons have had no access to any independent form of assistance

and representation. The testimony heard by the Mission demonstrated that too many people are being confined for treatment but are not, in fact, given adequate treatment. Too many persons are hospitalized in a closed or restricted setting, unnecessarily, because no one is there to advocate an alternative. Too many suffer in silence because no one is there to voice the needs of those who cannot speak for themselves.

Advocacy should be developed on all government levels - in the legislative, the executive and the judicial branches. It is essential for the enforcement of human rights of the mentally ill that an independent legal advocacy be provided, when necessary, and that a forum be established where these rights may be adjudicated. A vigorous legal service avoids paternalism and works to express their preferences. Increasingly, supporters of the mentally disabled are convinced that constitutional abuse and inappropriate services will cease only when patients are viewed as mental health consumers and provided with access to fora to enforce their rights.

It is not suggested that all advocacy implies advocacy by attorneys in a tribunal or court. An open and responsive administrative procedure can be a much faster, more flexible and less formal means of screening complaints. Such administrative grievance procedures within institutions connected to statutory services, must, however, be subject to judicial review.

There must be effective checks and balances where liberty is involved. Hospital administrators and officials of the Ministry of Health and Welfare have pointed out that one significant factor, frequently responsible for long-term hospitalization, is the alienation of the patient from his family and friends. The problems of long-term hospitalization will be addressed in another part of this Report but this situation certainly calls for advocacy of a different sort. In other countries programmes have been developed which use volunteers to provide companionship, personal guidance, and emotional support to the patient in coping with problems of everyday living. The volunteer can do many things which frequently the professional does not have the time or desire to do. The citizen advocate has an important part to play within a broad scheme of advocacy, if simply to demonstrate a necessary keen human interest and concern in the hopes and fears of another human being.

Persons confined in mental hospitals due to mental illness also have interests and concerns outside their mental illness which frequently go unattended. Under the paternalistic banner of helping and protecting, the

mentally disabled are denied basic rights and benefits which are supposedly guaranteed to *all* citizens under the Japanese Constitution. The mentally ill person has unique problems relating to his disability but is also burdened with the whole spectrum of problems which people must cope with in a complex industrialized society.

Other groups throughout history have encountered inhumane treatment and deprivation of basic human rights but few as consistently as the mentally disabled. The mentally handicapped person is often unable to recognize the violation of his or her legal rights let alone take action to redress those wrongs.

Widespread public opinion presumes that the mentally disabled cannot make decisions or speak intelligently about their needs and rights. The National Federation of Families with a Mentally Ill Person in Japan (Zenkaren) and the National Association of the Mentally Ill (Ex-Mental Patient Organization) have a great deal to offer in terms of understanding the needs of the mentally ill. These organizations should have a greater voice in the development of programmes and changes in the law and in participating in the monitoring of mental health services. Experience in Japan and other countries have demonstrated that the needs of the mentally disabled are not to be responded to simply on the basis of governmental beneficence but rather on the basis of legal rights. Improved conditions and consolidation of services will only occur when persons have the power to demand and receive these entitlements. Effective representation for persons threatened with loss of liberty is possible only if these persons know they have an independent right to that representation.

Coordinated Community Cooperation

It is recommended that Community Coordinating Councils be established. The complex nature of the involuntary civil commitment process and the varied needs of persons who become subject to the process require cooperation and coordination of the various components of the mental health and justice system involved.

A Community Coordinating Council, or similar body, comprised of representatives of all components of the mental health and justice systems involved in involuntary civil commitment should be established in each community to address common problems in the commitment process and their possible solutions. The council should make every effort to encourage

participation of all agencies and groups, and to foster coordination and co-operation among the members of the council and their representative agencies and organizations.

This proposal recognizes that involuntary civil commitment proceedings involve a variety of agencies and groups. It prescribes an informal mechanism, a interdisciplinary coordinating council, whereby these agencies and groups can address problems that cannot be solved from the perspective of a single individual, discipline, group, or component of the mental health and justice systems. Ideally, the council would be comprised of representatives of the courts, mental health hospitals, community mental health centres, legal services organizations, law enforcement agencies, screening agencies, advocacy groups, and family support groups. Representatives would include judges, attorneys representing respondents, attorneys for the petitioners and the state, psychiatrists, patients, psychologists, psychiatric nurses, social workers, mental health administrators, court clerks and administrators, private citizens, advocates and police officers. The council would provide a unique forum for discussion of concern and cooperation in finding solutions in an informal atmosphere before they develop into intractable problems and formal disputes. There are strong trends in the mental health law field in general, and in the area of involuntary civil commitment specifically, toward this type of co-operation and avoidance of formal procedure in promoting improvements.

Persons who are subject to commitment proceedings are necessarily shared clients in that they are initially the responsibility of one component of the system (e.g., law enforcement or crisis intervention services) and then another (e.g., short-term mental health services and the courts) as they move through the commitment process. Also, they are shared clients inasmuch as they often do not fit the "pure types" (chronically mentally ill, mentally retarded, alcoholic, or developmentally disabled) upon which most care programmes were designed.

Within the circle of responsibility of one component of the mental health and justice systems, commitment procedures may be effective and meaningful, but the same procedures may be onerous and meaningless to another component with different goals and operations. Unfortunately in most places throughout Japan, linkages, coordination and cooperation among the various components of the mental health and justice systems involved in involuntary civil commitment are nonexistent. Informal bodies of individuals representing the various groups, agencies, and units of government involved in mental health law interactions could meet regularly

to discuss problems and solutions, pending legislation and new procedures in involuntary civil commitment and related processes. Such bodies increase informal social interactions that routinely solve the problems of social systems.

For example, requesting law enforcement officers to remain in the admission unit of a hospital with an agitated person whom the officer has taken into custody pursuant to emergency commitment statutes until that person has been examined and admitted, may seem eminently reasonable from the perspective of admission personnel, but may frustrate the officer and be contrary to law enforcement policies and procedures. Given limited resources, law enforcement agencies, in particular, may find it difficult to allow officers to attend to mentally disordered persons in this fashion for long stretches of time. This problem cries out for the kind of cooperation, compromise and practical solution an inter-disciplinary coordinating council could facilitate. Left unresolved, the problem may lead to a reluctance or even refusal by law enforcement personnel to intervene in emergency mental health cases unless an arrest can be made. This could result in a polarization of the police and mental health community, and a consequent struggle to solve the issue by litigation and legislative reform.

Thought should be given to whether a coordinating council should be established as an adjunct to local governmental units, commissions or advisory boards.

Mental Health Legal Services

No matter how wise or comprehensive our laws are, they are not self-executing. There is a vast difference between justice in the language of law and justice in reality. The mentally ill are not only a neglected group, easily exploited, but in general lack the sophistication to actively articulate or enforce their rights.

Accordingly it is deemed critical that any revision of the laws affecting the mentally ill must include advocacy and monitoring components. The Legal Aid Bureau has not offered significant services to the mentally ill. The Mission recommends a legal service be established specifically for the mentally ill. The need for legal assistance is apparent where loss of liberty may result but it is also needed to ensure an effective advocacy so that mentally ill persons may get the services they need. A legal service is necessary to guarantee mental patients' rights as well as to support the

procedural requirements contained in the Mission's recommendations. Not only are advocacy services necessary to protect the objecting person but they will also assure that persons who enter a mental health facility on a voluntary basis are genuinely consenting to treatment and not submitting to coercive influence. Persons residing in facilities for the mentally ill, whether on a voluntary or involuntary basis, have a clear need for other legal services. Admission is often a disruptive experience in the patient's life and without access to legal services, he may have a variety of unresolved legal problems which can prove to be a major obstacle to his re-adjustment within the community upon release. Although we have emphasised the need for legal services, we have also pointed out that not all advocacy services have to be performed by attorneys. There are various models of advocacy which have proved successful in other countries. But an advocacy system is essential if the rights of the mentally ill are to be enforced.

Human Rights Authority

The Mission recommends the establishment of a Mental Health Human Rights Authority. The Human Rights Authority should be seen as an important component of the entire package of recommendations of the Mission. It provides a safeguard mechanism against abuse of patients' rights guaranteed by the constitution and the proposed revision of the mental health law. The Human Rights Authority (HRA) will have the responsibility to investigate possible violations of the law. Its jurisdiction should extend to cover the patient's relationship with individuals or organizations which provide any type of services to the mentally ill. The HRA could investigate specific complaints or even initiate examination of areas which it believes might harbour abuses. This forum could help to resolve many disputes without resorting to litigation. Many issues, although capable of resolution in courts, could be negotiated through the HRA without expensive, sometimes lengthy, litigation. Further, while an attorney of the legal services represents the interest of an individual client, the HRA could examine matters from a broader perspective and be more receptive to the various points of view in a dispute. The Mission is aware that there are certain monitoring mechanisms in the present law but they have not proved effective and they are powerless to prosecute violations of the rights of the mentally ill. A national Human Rights Authority is important to establish national policy in this area. If the im-

portant monitoring function is to be effective, a number of regional human rights committees should be established. In other words, a network of human rights review and protection boards should be established throughout the nation. The Mission makes no recommendations as to the specific size of the regional boards or their number. This can best be left to those with the necessary expertise. The composition of the Human Rights Authority and the Regional Boards is critical, however. Their membership should be broadly based and include a wide spectrum of points of view and interests and they should have legal authority to enforce or prosecute violations of human rights, if necessary.

The Mental Health Act of Japan

We do not seek to impose specific choices but to allow concerned persons and organizations to adapt our recommendations to national and cultural uniqueness while protecting the human rights of the individual. No attempt will be made to examine each and every provision of the Mental Health Act or other related laws. However, certain provisions are fundamental and will be discussed because they relate to universal principles and issues, and there are serious deficiencies in the key provisions.

Introductory Comments and Concerns

In perspective the Act is a significant improvement on the pre-war Lunatic Confinement and Protection Act and the Mental Hospital Act, in which the thrust of the law was to keep mentally disordered persons in custody at home, isolated from society for the purpose of "protecting" society from them. The enactment of the Act in 1950 contains a number of improvements over earlier laws and among them was the prohibition of the practice of custodial isolation in the home. In addition, prefectures were required to provide mental hospitals, mental health consultation offices and a system for providing independent expert witnesses. The revision of the act in 1965 contains some improvements introducing mental health centres and local health councils.

Although some of the recent statutory changes appear to be attempts to provide justice, unfortunately it appears that there has been a failure

to adequately provide what the law requires. Prefectures have failed to provide the required mental hospitals and the country is primarily dependent on privately owned hospitals for mental health services. Mental health councils are not providing the planning and monitoring functions so necessary for an effective system. It has also been reported that the important provision for psychiatric examination by independent experts has not been utilized often, and the calibre and independence of the experts is not of a high professional standard.

The law also provides that the governor of the prefecture may inquire into the condition of the patient, request a report regarding the patient or arrange for independent psychiatric examinations. In practice it appears that this important potential protection of human rights is not being respected by prefecture governors or the administrative staff of the prefectures. There appears to be a lack of initiative or independence on the part of the officials responsible for this monitoring function. The Mission has repeatedly heard of collusion between prefectural officials and owners of private hospitals or a lack of assertiveness on the part of responsible officials on a national or prefectural level, so that this important function in practice is ineffectual.

Objective of the Act

Chapter 1, Section 1 of the Mental Health Act expressly provides that its purpose is to conduct medical care and treatment for mentally disordered persons and to make efforts to prevent the occurrence of mental disorders. The spirit of the law is consistent with enlightened objectives in other countries.

Problems Related to the Definition of Mental Disorder

Chapter 1, Section 3 defines a mentally disordered person as a psychotic person (including a psychotic person due to intoxication), a mentally retarded person and a psychopathic person. This definition is of critical importance because it governs who may be subject to involuntary hospitalization. Vagueness, ambiguity, lack of specificity and overly broad definition have led in other countries to abuse of the rights of persons and litigation in the courts.

The definition in Section 3 suffers from such defects. Under this defi-

nitition, all psychotic persons may be detained, even though this may not be therapeutically desirable. It has been reported to the Mission that the Ministry of Health and Welfare in the book "Seishin Eiseiho-Shokai" (page 4, Chuohoki-Shuppan, 1976) has interpreted the law to include neurotic persons in the definition of mentally disordered persons. This law inserting "... including a psychotic person due to intoxication" in the definition is not necessarily improper as a matter of law, but it has been reported to the Mission that many alcoholic persons have been detained involuntarily under the Mental Health Law even though they did not have psychotic symptoms.

The term "psychopathic" person is a classification that has fallen into disrepute in psychiatry. It is a vague, unscientific, and overly broad term which is subject to serious abuse. The Japanese Association of Neurology and Psychiatry has long recommended that the term "psychopathic" be deleted from the definition.

The inclusion of mentally retarded persons in the definition of mental disorders is undesirable. Mental retardation requires an entirely different concept of education and training and should be cared for under the "Mentally Retarded Persons Act" and not under the Mental Health Law. Admittedly there are some mentally retarded persons who are in need of mental health treatment. In those instances the Mental Health Law may be applicable as it would be for anyone else.

It is recommended that alcoholism, drug abuse and addiction not be incorporated into the Mental Health Act but be considered separately. Again, these are serious problems that require special treatment. Testimony by witnesses and reports by such groups as the Japanese Association of Psychiatric Hospitals pointed out how these types of patients disrupt treatment programmes for other patients and create an excessive burden within mental hospitals.

The Mission is not minimizing the need for specialized treatment programmes for alcoholism, drug abuse and addiction but wishes to emphasize that it dilutes the effectiveness of the Mental Health Act for mentally ill persons and undermines the development of specialized treatment programmes.

It is recommended that a term like "severe mental disorder" be used and that it be defined in the law as follows:

"severe mental disorder" means an illness, disease, organic brain disorder, or other condition that (1) substantially impairs a person's

thought, perception of reality, emotional process, or judgment or (2) substantially impairs behaviour as manifested by recent disturbed behaviour. Mental retardation, epilepsy, alcoholism, drug abuse and drug addiction or other developmental disabilities do not, in themselves, constitute a severe mental disorder.

The value of the above definition is its recognition that it is the severity of the impairment that is important, not the diagnostic labels.

Problems Relating to Admission and Discharge Procedures

Voluntary Admission

One of the most serious defects and omissions in the Mental Health Law is the absence of an express provision allowing for a patient to request admission to a mental health facility for treatment. In every enlightened democratic country in Europe and throughout the United States respect for the individual is reflected by encouraging informed and voluntary requests for mental treatment. Information was made available to the Mission indicating that in Japan even in the case where a person desired treatment, it was recommended that the non-voluntary or compulsory provision of Articles 29 or 33 be used.

Voluntary admission should be the preferred method of receiving psychiatric treatment and this should be patterned after the usual method of receiving any other form of medical treatment. Voluntary admissions should not be for an indeterminate period but should be reviewed periodically with the patient in order for him to give consent to continued hospitalization and treatment. Provisions in the law can be made for those instances where a voluntary patient requests a discharge and the treating personnel is of the opinion that continued hospitalization is essential even if it is involuntary. In these situations, the issue as to whether the patient shall be involuntarily hospitalized shall be adjudicated by a court or independent tribunal.

Forced or Involuntary Hospitalisation

The statistics from all sources show the overwhelming use of involuntary hospitalization in Japan in contrast to the experience in most dem-

ocratic systems where voluntary admission is most commonly used and is the preferred clinical practice for achieving therapeutic objectives.

The professional papers presented to the Mission and the testimony of witnesses included criticisms of the forced hospitalization practice. They explained that, in spite of the stated enlightened objective of the law to provide humane mental treatment, this was being undermined by a policy whereby the law was being used primarily as a police or social control mechanism. It also was reported that the method of reimbursement itself discourages voluntary admissions and encourages forced hospitalization.

Article 29 on Involuntary Admission by the Governor and Article 33 on Involuntary Admission by the Person Liable for a Person's Protection accounted together for 92.6% of inpatient admissions. The average stay under Article 29 in 1983 was over eight years! The average stay of all in-patients in 1983 was 536 days!

There is no opportunity in the Mental Health Act for a person to appeal his forced hospitalization. There is no independent advocate to speak for the person. There is no independent periodic review of forced hospitalization. This severe human rights violation has led to the excessive years of hospitalization which the official statistics tragically show.

In most instances discharge of patients is left to the unbridled power and discretion of the medical administrator. Psychiatric research has shown that long term hospitalization as practised in Japan is not only a violation of human rights but is therapeutically unsound as well as being very costly.

There is currently no effective process under any Japanese law whereby a person subjected to forced hospitalization can seek redress. Persons charged with crimes have far more protection than a person who is alleged to need mental hospitalization.

The Japanese Habeas Corpus Act is an important protection to persons illegally detained. However, experience in Japan, the United States and in Europe shows that it has proved of limited value for mentally ill persons who have been detained involuntarily in mental hospitals. As pointed out in *Case X. vs United Kingdom*, previously cited in this report, judicial review as limited as that which is available by a Habeas Corpus proceeding is perhaps adequate for emergency measures but does not meet the due process requirements for the continuing confinement which mentally ill persons undergo.

Also, Article 4 of the rule under the Japanese Habeas Corpus Act

appears to be a violation of Article 9, Paragraph 4 of the International Covenant on Civil and Political Rights as well as of the Japanese Constitution because of its severe limitations as to situations where habeas corpus proceedings can be demanded.

The 3rd Petit Bench of the Japanese Supreme Court in 1971 in Hanrei Jiho, Vol. 635, page 106, placed a severe limitation on the application of the Habeas Corpus Act to persons hospitalized under Article 33 of the Mental Health Law. It would only consider it applicable if the legally responsible person or guardian objected to hospitalization or if there was an obvious error in diagnosis. Statistics furnished to the Mission indicated that habeas corpus relief was granted in only two cases in a six-year period. This is a demonstration of its ineffectiveness when we consider there are over 300,000 patients in mental hospitals.

It has been suggested that a patient may obtain relief under Article 29, Paragraph 5 of the Mental Health Law by a prefectural governor's investigation. Prefectural investigations of complaints do not appear to be effective in protecting the mentally disordered person and are rarely used unless there is a major scandal such as the Hototukai Hospital in Utsonomiya.

It has also been suggested that a person in a mental hospital might get a review of his objection to hospitalization by the Administrative Litigation Law or through the Civil Code Procedure. However, there appears to be no precedent that a person could obtain relief under these legal processes. It has been reported to the Mission that under those procedures it would take several years to get a judgment, if at all. When liberty and human rights are at stake, fast and effective access to due process is essential.

Therefore, it is the conclusion of the Mission that there is no effective review procedure for hospitalized mental patients, representing a serious denial of due process.

Under current law these patients are deprived of rights guaranteed to them by the Japanese Constitution and the UN Covenant on Civil and Political Rights.

It is the Mission's recommendation that it is essential to establish specialized independent review tribunals to review the initial hospitalization, and periodically to review the patient's condition and treatment with advocacy components and other types of monitoring and inspection.

To remedy these serious violations, the following recommendations are made for changes in the law:

1. Initial involuntary hospitalization should be reviewed by a court or a mental health tribunal. Court review is the standard procedure in countries such as the United States. Great Britain has developed mental health review tribunals which are composed of qualified lay and professional persons. Whatever form the forum takes, it must be an independent body and quickly and easily available.
2. Decisions of the court or tribunal should be reviewable by a court upon request of either party. Access to the courts is a fundamental requirement.
3. Involuntary hospitalization must be for a limited period. The indeterminate periods of hospitalization currently used in Japan are undoubtedly a major factor in the excessively long average stay in hospitals.
4. After each limited period of involuntary hospitalization there should be a further review by the court or tribunal as to the treatment plan, the need for hospitalization or any alternative plan of treatment.

Conclusions and Recommendations

The Current Situation

1. The Japanese mental health system at the present time must be regarded as being seriously inadequate in terms of the human rights of mentally disordered persons and of their treatment. This conclusion is based on statistical and descriptive information and in-depth discussions with the Ministry of Health, psychiatrists, social workers, nurses, occupational therapists, concerned individuals and many organisations, and on observations during visits to mental hospitals in both the public and private sector*.
2. The major sources of concern are:
 - (a) a lack of legal protection for patients during admission procedures, and during hospitalisation,
 - (b) a system of care characterised by a preponderance of long-term institutional treatment and a relative lack of community treatment and rehabilitation.

* The members of the Commission express their appreciation to the many people who devoted their time and provided information during their many meetings. They were received with courtesy and understanding by national authorities; prefectural officials; national, prefectural and private mental hospitals; associations and individuals. In only one instance was it not possible to carry out their work as planned, when access to a private mental hospital was denied to them by the staff of the hospital on the authority of the director, despite a request to cooperate from the Ministry of Health.

3. We refer in particular to the steadily rising number of hospitalised mental patients (over 330,000 in 1984), despite ministerial policy statements since 1965 calling for reversal of this trend.
4. A report of a WHO consultant (Dr. D.H. Clark) in 1968 did not stimulate the necessary changes. Most of his recommendations remain unfulfilled.
5. Over 80% of psychiatric beds are in private mental hospitals and therefore not under direct ministerial control. Two thirds of beds are in closed, locked wards. Patients tend to stay for very long periods.
6. Economic factors influencing hospital administrations and patient's families favour prolonged hospitalisation.
7. The mandate of the mission did not include investigation of individual cases in which human rights abuses and/or improper treatment may have occurred. Such incidents are rightfully the concern of the appropriate local and national authorities and the Japanese courts. Nevertheless, on the basis of our study, it can be asserted that the present structure and function of the Japanese mental health services create conditions which are conducive to inappropriate forms of care and serious human rights violations on a significant scale, for example: unacceptable conditions of overcrowding and poor nutrition which may lead to physical deterioration of patients and high mortality; physical abuse of patients; exploitation of patient labour; unjustifiable detention; the inability of hospitalised patients to communicate with friends and family members outside the hospital or to receive visits under reasonable conditions.
8. It should be stressed, however, that our main concern is not with individual or collective cases of abuse but with the overall system, and with opportunities for new approaches to mental health services and new forms of legislative protection in Japan. These approaches could create conditions in which the human rights of mentally ill persons would be fully respected and in which humane and effective care would be provided.
9. Many people stress the cultural specificity of Japan in terms of treatment of and attitudes towards the mentally ill. We believe that this is indeed relevant and important, but that common human needs and funda-

mental aspects of human rights transcend cultural factors. It is appropriate to assess the quality of psychiatric care as well as the marked degree of stigmatisation of the mentally ill in Japan and the social discrimination from which they suffer, particularly when contrasted with the rapid and successful shift to modern technology and management.

10. There is a tendency for all societies to exclude the mentally ill, to provide inadequate resources for their care and to stigmatise such persons beyond the period of their illness. Countries have coped with these problems in different ways. Widely varying approaches to comprehensive mental health services exist in other industrialized nations which could be studied to advantage by the Japanese authorities. Of critical importance, however, is the provision of adequate resources for rehabilitation and community based services as well as for decent levels of care and quality treatment during the necessary periods of hospitalisation.

11. Reform of the Japanese Mental Health Law is overdue. As in many countries, a complete overhaul of legislative provisions taking into account the rights of mentally disordered persons and new techniques of psychiatric treatment should be carried out. The rights set forth in the Japanese Constitution and in the International Covenant on Civil and Political Rights, of which Japan is a State Party, are at present not fully guaranteed to the mentally disordered. This deficiency should be remedied. Recent legislation in other countries could be studied with advantage, but, as in the case of services, the legislative model to be adopted in Japan would have to take into account the existing legal and administrative systems as well as the realities of Japanese society. Information on comparative mental health legislation has been made available by WHO. The Recommendation R(83)2 adopted by the Committee of Ministers of the Council of Europe (22.2.83) concerning the protection of the rights of involuntary mental patients could also be studied and applied to the Japanese situation.

12. Despite the serious problems which we have described, we are aware that there already exist in Japan:

- psychiatrists and other health workers with the necessary expertise to develop effective and comprehensive forms of mental health care;

- officials at local and national level who recognise these problems and show a willingness to study alternatives; this has also been reflected by official Japanese statements to international bodies;
- concerned citizens (for example, lawyers, journalists, social workers, patient and family groups) determined to bring about improvements for the mentally ill.

13. The efforts of such people have until now been hampered by widespread resistance, apathy and prejudice concerning the mentally ill as well as by a considerable degree of administrative inertia. Their efforts should be encouraged by the government at local and national levels, by professional associations and by international bodies.

14. Some private mental hospitals and government institutions have already developed innovative programmes with the "open door" approach to treatment, rehabilitation programmes and outpatient clinics. Such developments, which are still on a limited and insufficient scale, are an excellent basis for the further changes which are essential.

Immediate Steps to Be Taken

15. All those consulted believed that there is scope for improvement in mental health services and the mental health law.

16. The development of a modern and effective mental health system appropriate to an advanced, industrialised nation such as Japan, will take time in view of the fact that in this field, Japan lags seriously behind many other industrialised nations. As services evolve, many options will present themselves and choices will have to be made in terms of types of services and training and in the legal and judicial protection of the mentally disordered.

17. We believe the following actions constitute the minimal response to the serious problems which exist today in the Japanese mental health systems:

Reform of the Mental Health Law

to provide for:

- independent review of all cases of involuntary hospitalisation (including "consent" admission under article 33 of the present law). This review should be carried out within a short period of the admission (maximum one month) and thereafter at least twice yearly;
- the creation of an independent tribunal system capable of functioning at prefectoral level. This tribunal could be composed of members of the health and legal professions, family members of the mentally ill and other lay persons. A secretariat and adequate resources should be provided by national and prefectoral authorities to allow the tribunal to respond rapidly to all appeals and to carry out automatic reviews. Proceedings should correspond to fundamental concepts of due process;
- there should also be provision for regular inspection of all mental hospitals to check on staffing and treatment standards and to receive and investigate individual complaints. The complaints procedure should be capable of providing simple and rapid relief;
- informing all hospitalised patients of their rights as fully as possible, and giving free access by letter and telephone to the tribunal described above and to the representative of their choice (e.g. family member, friend, independent doctor or lawyer);
- assistance and advice to patients from an independent, qualified person;
- noting all incidents leading to personal injury in psychiatric hospitals and reporting them to an independent body which can investigate where appropriate. All deaths occurring in mental hospitals should be investigated routinely by an independent procedure including autopsy (except in the case of very elderly patients suffering already from serious physical disorders).

Improvement and Re-orientation of Mental Health Services

- The Ministry of Health and prefectoral authorities should provide the stimulus and the necessary resources for the develop-

ment of community care and rehabilitation programmes for the mentally ill on a wide scale.

- The system of reimbursement of health costs (the points system) should be adapted to take into account modern methods of psychiatric treatment and the needs of mental patients. There should be greater incentives for brief periods of hospitalisation than exist at present with intensive forms of treatment leading to early discharge. Significantly higher levels of reimbursement for all forms of out-patient and community care are required. Out-patient clinics attached to health centres, sheltered workshops, home visits by nurses and social workers, crisis intervention services, supervision of maintenance medication, patient clubs and all other activities providing necessary support and supervision for discharged patients should receive adequate funding from national and private insurance funds. The needs of patients currently hospitalised should be regarded as a priority for rehabilitation programmes. Within hospitals, rehabilitation programmes should also receive adequate funding.
- Health authorities should closely monitor the activities of mental hospitals with the aim of encouraging the rehabilitation of existing "long-stay" patients and of preventing unnecessarily long periods of hospital care for new patients.
- There is also scope for a significant reduction in the average length of stay of newly admitted psychiatric patients and, thereby, in the total number of hospitalised patients.
- Recognising that, after very many years of hospitalisation, some patients (particularly the elderly) will not live independently in the foreseeable future, decent levels of care and conditions of living should be provided for such patients, for example in group homes or hostels.
- Collaboration with local authorities, social services and industry will be essential to secure the necessary housing, social support and employment for former mental patients. An incentive scheme for the employment of former patients (for example, by means of tax relief) should be considered.

Improved Education and Training in the Mental Health Field

- for psychiatrists:
with special emphasis on rehabilitation, and community mental health care. There would seem to be a strong case for establishing an approved training programme for psychiatrists with a formal scheme of certification (as already exists for some other medical specialities).
- for other mental health workers:
nurses, psychologists, social workers and occupational therapists also need training and experience which are more oriented towards rehabilitation and out-patient care. At present, their skills are mainly directed towards institutional care.
- for all health workers:
training in medical ethics and the legal aspects of medicine should be strengthened to ensure better understanding of human rights issues and the contacts between the health and justice systems.
- for the legal profession:
training to improve understanding of mental health issues.
- for community leaders and the general public:
the evolution towards a mental health care system with many more patients in the community must be accompanied by health education aimed at changing public attitudes towards the mentally ill and at diminishing the stigma of psychiatric illness; mental patients with chronic disabilities should have the same rights to welfare benefits and the same access to rehabilitation services as patients with disabilities due to physical disorders.

18. We believe these changes should be regarded as a national priority. The establishment by the Prime Minister of a provisional council with broad based participation to study mental health legislation and services would be an appropriate mechanism to address this national priority.

Annex I

Documentation Received by the Mission

The following documentation was (I) received before the mission; (II) distributed by the ministries in Japan; (III) distributed by organisations during the mission; (IV) presented by individuals to the mission; and (V) general documents.

I.

WORLD HEALTH ORGANIZATION. Regional Office for the Western Pacific. Assignment Report, November 1967—February 1968 by Dr. D.H. Clark, Consultant in Mental Health. Mental health in Japan. 29 pp.

THE CONSTITUTION OF JAPAN, 7 pp.

DRAFT GUIDELINES for the Protection of Persons Suffering from Mental Disorders, Newsletter No 10, International Commission of Jurists (1981) pp 33-53; UN Doc E/CN.4/Sub.2/NGO/85.

DRAFT BODY OF PRINCIPLES, GUIDELINES AND GUARANTEES for the Protection of the Mentally Ill, or Persons Suffering from Mental Disorders. Proposed by Mme. Daes. UN Doc E/CN.4/Sub.2/1983/17 (Commission on Human Rights, Sub-Commission on Prevention of Discrimination and Protection of Minorities. 36th Session).

COMPILATION OF REPLIES by Governments, Specialized Agencies and Inter-governmental Organizations to the Special Rapporteur's Questionnaire on the Subject Matter of this Study (items related to Japan, see above «DRAFT BODY») UN Doc E/CN.4/Sub.2/1983/17 Add.1. 5 pp.

STATEMENT presented before the UN Subcommission on 20 August 1984 by the Japanese government. 5 pp.

MENTAL HEALTH ACT (Act No. 123, May 1, 1950) of Japan. Translated by Kotaro Nakayama and Nobuyuki Ono for the proceedings of the World Psychiatric Association Regional Symposium, April 1982, Kyoto, Japan. 18 pp. (with amending acts 1951-1982).

SUMMARY of Japanese Mental Health Law. Prepared by the Mental Health Institute, Ministry of Health and Welfare 1984. 12 pp.

MEDICAL PRACTITIONERS LAW. Law No. 201 of July 30, 1948. 12 pp. (with amendments 1949-1955).

MEDICAL SERVICE LAW. Law No. 205 of July 30, 1948. 36 pp. (with amendments 1949-1962).

II.

Ministry of Health and Welfare

MENTAL HEALTH HANDBOOK 1984. 261 pp. In Japanese.

Ministry of Justice

THE ORGANIZATION AND FUNCTIONS OF THE ORGANS FOR THE PROTECTION OF HUMAN RIGHTS AND LEGAL AID SYSTEM in Japan. Civil Liberties Bureau, Ministry of Justice, January 1983. 20 pp.

III.

Japanese Association of Psychiatry and Neurology

THE LAW AND RIGHTS OF THE MENTALLY ILL IN JAPAN. Proposal to Innovation. Department of Legal Issues, Japanese Association of Psychiatry and Neurology, 14 May 1980. 3 pp.

Japan Municipal Hospital Association. Department of Psychiatry

ORGANIZATION and Recent Activities. 7 pp.

THE REHABILITATION ACTIVITIES OF PUBLIC HOSPITALS in Japan, by C. Michishita. 2 pp. (In: Community Mental Health Services).

The Japanese Association of Psychiatric Hospitals

COMMENTS on ICJ Draft Guidelines. 4 pp.

OPINION in Reference to the ICJ Review, by the Japanese Association of Psychiatric Hospitals, May 10, 1985. 20 pp. + 3 tables.

THE PRESENT CONDITION OF A SMALL JAPANESE MENTAL HOSPITAL by Isao Takayanagi. 6 pp. + 10 tables.

PSYCHIATRIC SERVICE FEES IN JAPAN. The Japan Association of Psychiatric Hospitals Medical Financial Committee, April 18, 1985. 8 pp.

FROM HOSPITALIZATION TO DISCHARGE. Manual for Psychiatric Hospitals, November 1984. 52 pp. (in Japanese).

Japanese Psychiatric Nursing Association

ON PROFESSIONAL TRAINING OF PSYCHIATRIC NURSES, 9 pp.

FOR ICJ/ICHP COMMISSION. Statement on the Utsonomiya Hospital Incidents by the «Koryusha» group of psychiatric nurses. 2 pp.

Japanese Association of Psychiatric Social Workers

A NEW CHALLENGE TO MENTAL DISORDER. by Akira Kashiwagi, Chairman of the Board of Directors JAPSW. Head, Dept. of Socio-environmental Research, National Institute of Mental Health, Japan. May 13, 1985. 7 pp.

Japan Nurses Association

JAPAN NURSES ASSOCIATION (brochure with photos).

JAPANESE NURSING ASSOCIATION (regarding the Utsonomiya hospital). 2 pp.

JAPAN NURSES ASSOCIATION. Status of Psychiatric Nurses among our members. 2 pp. (concerns Utsonomiya hospital situation).

RATIO of Psychiatric nurses to numbers of patients. Chart.

All-Japan Prefectural and Municipal Workers' Union (JICHIRO) Health and Medical Council

JICHIRO—Striding towards Tomorrow (brochure) 20 pp.

THE DEFINITE PROPOSAL to Reform Mental Health Services. January 1985. Reported by T. Asahi, Director of Health and Medical Council, JICHIRO. 5 pp.

RESPONSE to the Questionnaire on Employment and Working Conditions in Health and Medical Services. 46 pp.

National Association of the Families of Mentally Disordered «Zenkaren»

ANNOUNCEMENT of Our Points of View to the Scandalous Case of Utsonomiya Mental Hospital, April 23, 1985. 3 pp.

TO THE MISSION OF ICJ. Letter on the Matter of Involuntary Admission. (signed S. Inoui), May 1, 1985. 13 pp.

THE BURNING HOSPITAL — Sanmaibashi Hospital. Brochure on film No. 11 of Enjoji Productions.

National Association of the Mentally Ill «Zenkoku Seishinbyosha Shudan»

THE HISTORY AND ACTIVITY of Zenkoku Seishinbyosha Shudan. 4 pp.

WE APPEAL TO ALL PSYCHIATRISTS of the World. 4 pp. (paper presented to World Psychiatric Association Regional Seminar in Kyoto, protesting exclusion).

Federation of Japanese Bar Associations

RESOLUTION Concerning Human Rights in Mental Hospitals, October 20, 1984. In Japanese.

SURVEY conducted by 2nd Japan Bar Association. 13 tables. In Japanese. (about rights of patients in mental hospitals).

IV.

ASAI, KUNIHICO.

Pathways of Help-Seeking of Psychiatric Patients in Japan: A Research Study in Togane City. *American Journal of Social Psychiatry* IV, 2, spring 1984, pp. 38-44.

Les réactions des familles japonaises aux désordres mentaux. *Psychologie médicale* 1983, 15, 14, pp. 2371-2375.

Responses of Japanese Families to Mental Disorder. *International Journal of Social Psychiatry*, winter 1983, pp. 257-262.

Schizophrenic Patients and Families in Japan. By Kunihiko Asai, Asai Mental Hospital, Togane City, Chiba Prefecture, Japan. World Psychiatric Association Symposium, Helsinki, June 1984, 8 pp.

COMMISSION ON HUMAN RIGHTS AND MEDICAL ETHICS in the Department of Psychiatry, Gifu University School of Medicine, Chairman, Norio Sugita.
An Experiment on a Fetus in Gifu University. 2 pp.

HIROTA, ISOO.

Characteristics of Mental Health Services in Japan. 3 pp. + 15 tables + 4 figures + 3 appendices.

ISHIKAWA, N., SEMBA, T.

Talking About Japanese Mental Hospitals. Tokyo: Seiwa Shoten 1983, 336 pp. (In Japanese).

KANEKO, Tsuguo.

Notes on Admission of Mentally Ill in Japan. 4 pp. (by the vice superintendant of Tokyo Metropolitan Matsuzawa Hospital).

MENTAL HEALTH Administration in Tokyo. 10 pp.

MUNAKATA, T.

Sociology of Mental Health Care. Tokyo: Kobundo (excerpts, charts, 7 pp.).

NAGANO, KANTARO

Medical Treatment of Mentally Ill. Patients and Medicine in Japan. 10 May, 1985. 7 pp.

Reference Papers Regarding the Study of Deaths in Mental Hospitals in Japan. 6 pp.

NAKAYAMA, KOTARO

Current Topics in Law and Psychiatry in Japan. 10th International Congress on Law and Psychiatry, Banff Springs Hotel, Alberta, Canada, June 14, 1984. 5 pp.

Japanese Mental Health Act — Introduction and Criticism. Ninth International Congress of Law and Psychiatry at Santa Margherita Ligure, Italy, June 19-22, 1983. 9 pp.

Psychiatric Care Delivery Patterns and Economic Policy after World War II in Japan. In: World Psychiatric Association regional Symposium, Kyoto, Japan, April 1982. 5 pp.

The Role of the Psychiatrist as an Expert in Court Procedures in Japan. 4 pp.

NATIONAL MUSASHI RESEARCH INSTITUTE for Mental and Nervous Diseases (National Musashi Sanatorium). 10 pp. and map.

OHKUMA, KAZUO

Japanese Mental Hospital. (translated by E. Totsuka, B. Holcombe, C. Holmes, M. Ueno and K. Kosaka from Japanese original — Rupo Seishinbyoto, Asahi Shimbun Co. 1982).

Psychiatric Hospital — Most Progressive Line — Dowakai Chiba Mental Hospital. In: Asahi Shimbun Weekly Magazine, 7 September, 21 September 1984.

SAEKI, CHIHIRO

Problem Areas in the Mental Health Act as Seen by a Lawyer. In: *Psychiatria et Neurologia Japonica* 76 (12) December 1974. Postscript added May 1975. 33 pp.

SANMAIBASHI HOSPITAL

Outline of Sanmaibashi Mental Hospital. 4 pp.

SEMBA, T.

Case Report. In Search of New Psychiatric Treatment. *Mental Health Care in Japan*. Kagaku, vol. 48, no. 9, 1978, pp. 522-528 (in Japanese).

The Mental Hospital. Its Current Situation and Limitation. Tokyo: Seiwa Shoten 1977. 345 pp. (T. Semba et al.) (in Japanese).

Outline of Dowakai Chiba Mental Hospital. 11 pp.

Phoenix Activity. *Japanese Journal of Social Psychiatry*, vol. 6, no. 3, September 1983. pp. 162-165. (in Japanese).

Schizophrenia — In-Patient Treatment. Psychiatric-Neurological Insurance Examination Problems. Different Points of View. In: *Clinical Psychology*, vol. 14, no. 2 (in Japanese).

SEMBA, T., SUZUKI, H., NAKAMURA, H., et. al. (Dowakai Chiba Mental Hospital, Japan)

On the Rehabilitation Facilities in the Mental Hospital: Phoenix Activity as Self-Supporting System and its Background. Proceedings of the 10th World Congress of Social Psychiatry, September 4-8, 1983, Osaka, Japan. Summary.

SEMBA, T., ISHIKAWA, N.

Talking about Japanese Mental Hospitals. Tokyo: Seiwa Shoten 1983. 336 pp.

TOIDA, SEIICHI (National Musashi Care Centre, Japan)

Forced Hospitalization and Psychiatrists. In: *Psychiatria et Neurologica* 76 (12) December 1974, pp. 816-818.

TOTSUKA, ETSURO

Japanese Laws on Mental Health and Human Rights. Part I, 5 May 1985. 43 pp. Part II, 23 May 1985, 5 pp.

Development of Utsonomiya Hospital Scandal. Case Reports on Utsonomiya Hospital (4). 12 pp.

TOTSUKA, ETSURO; NAGANO, KANTARO; OZAKI, JUNRI

Patients' Rights and Consumer Movement. For the 11th IOCU World Congress in Bangkok, Thailand, 9-14 December 1984. 48 pp.

TOKYO METROPOLITAN MATSUZAWA HOSPITAL

Outline of the Hospital. 11 pp + map + photos.

Data. 11 May 1985. 7 pp. + «contract for voluntary admission» (in Japanese).

TSUKAZAKI, N., TACHIBANA, M., INOUE, M.

Legal and Ethical Problems of Psychiatric Test. In: World Psychiatric Association Regional Symposium, Kyoto, Japan, April 1982, pp. 108-109.

WORLD PSYCHIATRIC ASSOCIATION REGIONAL SYMPOSIUM, Kyoto, Japan, April 9-

- 11, 1982. Proceedings. Under the Auspices of the Japanese Society of Psychiatry and Neurology and the World Psychiatric Association. 352 pp. + 2 appendices (incl. Mental Health Act).
- YAMAMOTO, JOE; KATO, MASAOKI; VISOTSKY, H.
World Studies in Psychiatry. Japan. Vol. 2, No. 2, pp. 5-15. World Studies in Psychiatry, Princeton, NJ, 1982.
- YAMASHITA, TAKETOSHI; AKIRA, DOI
The Unconstitutionality of the Mental Health Law — Particularly with Regard to the involuntary commitment clause. In: *Psychiatria et Neurologia Japonica* 79 (4) 212, 1977 (in Japanese).
- YAMASHITA, TAKETOSHI; TERASHIMA, SHOGO; HIROTA, ISOO
The Law and Rights of the Mentally Ill in Japan. In: World Psychiatric Association Regional Symposium, Kyoto, Japan, April 1982, pp. 97-99.
- YOKOYAMA, HIROSHI
The Influence of Financial Difficulties upon Psychiatric Treatment in Japanese Mental Hospitals. In: World Psychiatric Association Regional Symposium, Kyoto, Japan, April 1982, pp. 105-107.
- YONEKURA, IKUO
Getting a Foothold in Efforts to Abolish the Commitment System. In: *Psychiatria et Neurologia Japonica* 76 (12) December 1974, pp. 828-829.
- YOSHIDA, T.; KOIKE, K.; OZAWA, I.; NAGATA, M.
Review of Ethical Problems of Experimental Research in Psychiatry in Japan. In: World Psychiatric Association Regional Symposium, Kyoto, Japan, April 1982, pp. 100-101.
- YOSHIMORI, JIRO
List of Hospital Scandals since 1960s. (by the editor of «Seishiniryō»).

V.

ASAHI SHIMBUN (newspaper)

- articles from Maibashi branch (Gumma province)
- «Mass Evasion of Psychiatric Patients. Hospital Wrong-Doing cannot be Hidden» (article on Tanaka Hospital, Gumma-ken), May 9, 1984 (in Japanese).
- «Many Illegal, Forced Hospitalisations. Tanaka Hospital, Gumma-ken. Also, Examinations by Unqualified Employees Exposed» May 22, 1984 (in Japanese).
- «Subsidies for a New Ward to Increase Number of Beds in Hospital. Subsidized Ward Room Turned into Chairman of Board Room — Tanaka Hospital. Patients Placed in other Crowded Wards to give way to Chairman of Board and Reception Rooms». May 25, 1984 (in Japanese).
- «Tanaka Psychiatric Hospital — Management of Apartment Building, 16 Families and 4 Stories. Dr. Tanaka's Association Bought this to Save his Indebted Relative. Tax Evasion Discovered. Two Ghost Companies Created to Avoid Taxes». June 12, 1984 (in Japanese).
- «Jomo Hospital Owns Ghost Companies. For Tax Reasons, Every Month Paid Large Sum to Ghost Company as 'Rent'» June 23, 1984. (in Japanese).

BAUMGARTNER, GEORGES

A Genève, la Commission internationale de Juristes s'indigne. Traitements délirants dans des asiles japonais. Tribune de Genève, 25/26/27/ mai 1985.

BETROS, CHRIS

Mental Patient Abuse Rife in Japan. Asahi Evening News (Tokyo), August 17, 1984.

COHEN, DAVID

«Institute of Pain», article by the editor of «Psychology News» in, pp. 120-130.

CURRAN, W.J., HARDING, T.W.

The Law and Mental Health: Harmonizing Objectives. A Comparative Survey of Existing Legislation together with Guidelines for its Assessment and Alternative Approaches to its Improvement. World Health Organization, Geneva, 1978. pp.

THE DAILY YOMIURI

Mental Ills Good Business. Article by Ian McArthur. The Daily Yomiuri (Tokyo) November 4, 1984, p. 5.

DONALD, JAMES

Statement from James Donald (Disabled Peoples' International), April 30, 1985. 4 pp.

HUMAN RIGHTS INTERNATIONAL REPORTER

Japan. Treatment of the Mentally-Ill. HRI Reporter 10: 1 & 2 (September-December 1984), pp. 223-224.

INTERNATIONAL COMMISSION OF JURISTS

The Mentally Ill in Japan. In: The International Commission of Jurists Review, No. 32 (June 1984), pp. 15-18.

INTERNATIONAL LEAGUE FOR HUMAN RIGHTS

Sub Commission on Prevention of Discrimination and Protection of Minorities. Thirty seventh Session. Agenda Item 9. August 15, 1984. 5 pp.
Press Release, Monday, September 17, 1984 (letter to Prime Minister Nakasone). 1 p.

JONES, BRONWEN

Rights Worker Attacks Mental Hospital System. In: The Daily Yomiuri (newspaper), Sunday May 5, 1985, p. 5.

PARINGAUX, R.-P.

Névroses nippones. La rigueur du modèle de société japonais pousse les êtres fragiles à des dérèglements extrêmes. In: Le Monde Aujourd'hui, Dimanche-Lundi 9 juillet 1984.

LA TRIBUNE DE GENEVE

Les hôpitaux psychiatriques japonais ne violent pas les Droits de l'homme... La Mission nipponne à Genève: pas de torture au Japon. Tribune de Genève, mardi 21 août 1984, p. 4.

VEITCH, ANDREW

Tests on brain of foetus provoke uproar in Japan. The Guardian (Manchester) April 20, 1985.

Annex 2

Organizations Interviewed by the Mission

The Japanese Association of Psychiatric Hospitals

The Japanese Psychiatric Nursing Association

The Japanese Association of Psychiatric Social Workers

Japanese Nursing Association

JICHIRO — All-Japan Prefectural and Municipal Workers Union

Japanese Association of Neurology and Psychiatry

Federation of Japanese Bar Associations, Human Rights Committee

National Federation of Families of the Mentally Ill in Japan — "ZENKAREN"

National Group of Mentally Disordered Persons (Zenkoku Seishinbyosha Shudan)

Association of Prefectural Hospitals, Department of Psychiatry

Japan Medical Association

Japanese Association of Community Hospitals (Dr. Hirota, Dr. Tawara)

MEMBERS OF THE INTERNATIONAL COMMISSION OF JURISTS

President

ANDRES AGUILAR MAWDSLEY

Professor of Law, Venezuela; former President Inter-American Commission

Vice-Presidents

ALPHONSE BONI

Mrs TAI-YOUNG LEE

DON JOAQUIN RUIZ-GIMENEZ

President of Supreme Court of Ivory Coast

Director, Korean Legal Aid Centre for Family Relations

Professor of Law, Madrid; Defender of the People (Ombudsman) of Spain

Members of Executive Committee

WILLIAM J. BUTLER (Chairman)

ALFREDO ETCHEBERRY

P.J.G. KAPTEYN

RUDOLF MACHACEK

FALI S. NARIMAN

CHRISTIAN TOMUSCHAT

AMOS WAKO

Attorney at Law, New York

Advocate; Professor of Law, University of Chile

Councillor of State, Netherlands; former Prof. of Int'l Law

Member of Constitutional Court, Austria

Advocate, former Solicitor-General of India

Professor of Int'l Law, University of Bonn

Advocate, Kenya; Secretary-General, Inter African Union of Lawyers

Commission Members

BADRIA AL-AWADHI

RAUL F. CARDENAS

HAIM H. COHN

ROBERTO CONCEPCION

AUGUSTO CONTE-MACDONELL

TASLIM OLAWALE ELIAS

GUILLERMO FIGALLO

LORD GARDINER

P. TELFORD GEORGES

JOHN P. HUMPHREY

Prof., Faculty of Law and Sharia, Univ. of Kuwait

Advocate; Prof. of Criminal Law, Mexico

Former Supreme Court Judge, Israel

Former Chief Justice, Philippines

Advocate; member of Parliament, Argentina

Pres., International Court of Justice; former Chief Justice of Nigeria

Former Member of Supreme Court of Peru

Former Lord Chancellor of England

Chief Justice, Supreme Court, The Bahamas

Prof. of Law, Montreal; former Director, UN Human Rights Division

Ambassador of France; former Minister of State

Pres., NSW Court of Appeal, Australia

Judge of the Supreme Court, Mauritius

Former Irish Minister of External Affairs

Advocate of the High Court, Tanzania

Judge of Int'l Court of Justice; former Pres. Supreme Court, Senegal, and UN Commission on Human Rights

Director of Legislation, Ministry of Justice, Cameroon

Member of National Assembly, Vietnam

Prof. of Law, Oslo; Member of European Commission

Former Ombudsman, New Zealand

Former Lord President, Federal Court of Malaysia

Ombudsman, Fiji

Privy Councillor; Professor of Law; former Supreme Court Judge, Thailand

Attorney at Law, Indonesia

LOUIS JOXE

MICHAEL D. KIRBY

RAJSOOMER LALLAH

SEAN MACBRIDE

J.R.W.S. MAWALLA

KEBA MBAYE

FRANÇOIS-XAVIER MBOUYOM

NGO BA THANH

TORKEL OPSAHL

SIR GUY POWLES

TUN MOHAMED SUFFIAN

SIR MOTI TIKARAM

CHITTI TINGSABADH

J. THIAM HIEN YAP

HONORARY MEMBERS

Sir ADETOKUNBO A. ADEMOLA, Nigeria

ARTURO A. ALAFRIZ, Philippines

DUDLEY B. BONSAI, United States

ELI WHITNEY DEBEVOISE,

United States

PER FEDERSPIEL, Denmark

T.S. FERNANDO, Sri Lanka

W.J. GANSHOF VAN DER MEERSCH, Belgium

HANS HEINRICH JESCHECK, Federal

Republic of Germany

JEAN FLAVIEN LALIVE, Switzerland

NORMAN S. MARSH, United Kingdom

JOSE T. NABUCO, Brazil

LUIS NEGRON FERNANDEZ, Puerto Rico

Lord SHAWCROSS, United Kingdom

EDWARD ST. JOHN, Australia

SECRETARY-GENERAL

NIAL MACDERMOT

Reports of serious human rights violations in mental hospitals in Japan prompted the International Commission of Jurists and the International Commission of Health Professionals to accept an invitation to send a mission to that country to review and make recommendations on the legislation and practices for the treatment of mental patients.

The members of the mission, distinguished experts of recognised competence in the field, had discussions with the Ministry of Health, psychiatrists, social workers, nurses, occupational therapists and representatives of many organisations and individuals concerned with mental patients, as well as visiting several mental hospitals.

They commented that:

«the present structure and function of the Japanese mental health services create conditions which are conducive to inappropriate forms of care and serious human rights violations on a significant scale.»

This substantial report of their mission ends with 18 conclusions and recommendations which identify the major areas of concern as

- a) a lack of legal protection for patients during admission procedures and during hospitalisation, and
- b) a system of care characterised by a preponderance of long-term institutional treatment and a relative lack of community treatment and rehabilitation.

*International Commission of
Health Professionals,
15, route des Morillons,
CH-1218 Grand-Saconnex,
Geneva, Switzerland*

*International Commission
of Jurists,
P.O.Box 120,
CH-1224 Chêne-Bougeries,
Geneva, Switzerland*

INTERNATIONAL COMMISSION OF JURISTS

ISBN 92 9037 032 7