

INTERNATIONAL COMMISSION OF JURISTSMISSION TO STUDY HUMAN RIGHTS OF PSYCHIATRIC PATIENTSCONCLUSIONS AND RECOMMENDATIONS, APRIL 1992

1. Introduction

The first International Commission of Jurists' (ICJ) mission to study the human rights of psychiatric patients in Japan took place in 1985. Its report emphasized the divergence of Japanese mental health services from those in other industrialized countries. While most countries had been reducing the number of hospitalized psychiatric patients by reducing the length of stay and by providing effective rehabilitation and care in the community, Japan had been steadily increasing the number of beds in psychiatric hospitals. These beds were filled with patients, the majority of whom stayed in hospital for long periods of time. Furthermore, Japan's existing mental health legislation did not provide any effective protection of patients' rights. There was also a striking deficiency in the human resources and programs available for rehabilitation and community care.

The second ICJ mission took place shortly after the important revision of the Mental Health Law enacted in September 1987. The report of the second mission expressed guarded optimism about the legal reforms, as well as noting the increased awareness of the scope and seriousness of the problems of providing comprehensive mental health care. Nevertheless, it was also noted that the day to day conditions for over 300,000 hospitalized patients had hardly changed at all, and concern was expressed about the lack of resources for human rights protection and service development. The second mission expected that voluntary admission should become the norm and that the average length of stay in hospital would fall progressively. The mission suggested that a model for comprehensive mental health services should be developed and evaluated for a defined geographical area.

The 1988 mission also expressed concern about the absence of an effective system of inspection and standard setting for psychiatric hospitals, the lack of adequate infrastructure for the Psychiatric Review

Boards (PRBs), and the persistence of discriminatory measures concerning the mentally ill in many national, prefectural and local laws.

The third ICJ mission in April 1992 takes place after the 1987 reforms, which became effective in July 1988, have been in force for nearly four years. A further revision of the law is envisaged in 1993, and the process of consultation is already underway. The adoption by the United Nations General Assembly on December 17, 1991 of a set of principles for the protection of persons with mental illness and for the improvement of mental health care (referred to below as "the UN principles") provides a clear standard for human rights protection and care for the mentally ill in Japan.

The third mission notes with satisfaction:

- (1) the dedicated and enthusiastic efforts by many individuals and groups to bring about changes, notably in the Division of Mental Health of the Ministry of Health and Welfare, professional associations, psychiatrists in both the private and public sectors, and lawyers and mental health workers both in hospitals and in community settings;
- (2) the fact that the number of psychiatric beds has stabilized at about 28 beds per 10,000 population, and the rate of bed occupancy has fallen to below 100%;
- (3) the reduction in the average length of hospital stay which, however, is still very high by international standards;
- (4) the fact that voluntary admissions now make up a major proportion of hospital admissions;
- (5) the widespread acceptance of the need to move progressively toward more community-based care and to provide sufficient resources for such developments. The experience gained in the Tokachi area of Hokkaido demonstrates the feasibility of a coordinated mental health care system to provide continuity of care; and
- (6) the establishment of a framework for the protection of human rights of individual patients by setting up PRBs in each prefecture.

Nevertheless, many elements still give rise to serious concern, notably:

-- (a) the serious lack of resources, arising from the discriminatory nature of reimbursement of mental health care and welfare payments for the mentally ill as compared to other ill and disabled people;

-- (b) the fact that about 30% of patients hospitalized at any time could be discharged and immediately cared for in the community, if adequate facilities existed;

-- (c) the fact that several of the U.N. principles referred to above are not currently respected by Japanese legislation and practice;

-- (d) the present ineffectiveness of the PRB system, which stems from their lack of independence and inadequate resources;

-- (e) the lack of coordination among the various public and private agencies necessary to provide comprehensive and continuous care of the mentally ill;

-- (f) the large number of voluntary patients who are admitted to locked wards;

-- (g) the widespread use of seclusion;

-- (h) the insufficient numbers of mental health professionals and absence of (or insufficient) certification of various professional groups;

-- (i) government subsidies which encourage building new facilities rather than providing human resources; and

-- (j) the outdated nature of the "hogogimusha" system. This places unfair burdens on family members by requiring that they assist and support the treatment of mentally ill relatives, that they prevent these patients from harming themselves or others, and that they protect the patients' financial interests. However, the system does not grant the "hogogimusha" the necessary powers or establish adequate resources to support these

functions. Furthermore, the role of the "hogogimusha" in hospitalization of the mentally ill person under Article 33, or in agreeing to treatments such as sterilization, creates an ambiguous relationship between the mentally ill person and his family, and undermines the self-determination of patients.

The recommendations set forth below address these issues and are intended to promote more flexible and coordinated mental health care through the mobilization of community resources as well as the provision of adequate budgetary support. Legal reforms are needed to transform the PRB system into an independent procedure in accordance with principles 17 and 18 of the U.N. Principles. The work of the PRBS could be streamlined by functioning through three-member panels and by concentrating their efforts on the critical function of deciding rapidly on patients' requests for discharge or improved treatment. PRBs should be easily accessible and perceived as helpful and constructive both for patients and for the treatment teams.

In accordance with paragraphs 6 and 7 of principle 1 of the U.N. Principles, the time has come to replace the hogogimusha system with a new system of professional guardians when patients require this kind of protection. It is also necessary to provide a legal basis to prohibit all forms of discrimination against the mentally ill, in accordance with paragraph 4 of principle 1. Such a provision should be incorporated into the Mental Health Law.

The fundamental objective of both the changes in financing and organization of mental health services and the reform of the Mental Health Law should be to allow mentally ill persons to live as independently as possible within the community, and to be treated when necessary according to the principle of the "least restrictive alternative". This principle requires that patients be moved to a more supportive form of community care unless hospitalization is absolutely necessary, and be treated in open wards unless their condition specifically requires measures of security. Treatment during particularly serious phases of illness under secure conditions should be available in units integrated into existing hospitals.

2. Proposed changes in mental health services

The limited funding of mental health services at the hospital and, especially, at the community levels has impeded the progress of reforms under the Mental Health Act. Adequate funds must be reinvested as well as allocated to key elements in mental health programs.

A. Organization and Financing of Mental Health Services

1. Reinvestment of Savings Resulting from Changes Introduced by the 1987 Mental Health Act

The national government has reduced its expenditures for mental health services considerably since 1988. This is largely due to a decrease in the number of involuntary admissions under Article 29 of the Act. It is regrettable that these funds have not been reinvested in the critically-needed elements of the mental health system, particularly in rehabilitation and community care.

2. Other Required Financial Support

It is imperative that municipal and prefectural governments be required to subsidize community-based services and facilities. Such support requires a sufficient emphasis on adequate staffing as well as on physical facilities.

3. Reimbursement for Mental Health Care and Welfare Payments

A significant element of the continuity of mental health care is the linkage between hospital treatment and community-based services. It follows that both reimbursement for mental health treatment and welfare payments for rehabilitative care should be available for persons living in the community. It is unfortunate that the welfare system discriminates against mentally ill recipients by paying them approximately half of what is paid to the physically disabled. This discrimination impedes the mentally ill from fully benefiting from an array of community-based rehabilitative services.

4. Voluntary Patients on Locked Wards

Currently, over half of the patients admitted voluntarily to psychiatric hospitals are hospitalized on locked wards. This practice is inconsistent with generally-accepted treatment plans and standards of human rights. This practice should be monitored, and completely phased out within a period of no longer than five years. Under no circumstances should an informally admitted patient be kept on a locked ward.

5. Coordination of Services

The implementation of an effective mental health system requires the coordination of services at all levels of government. At the national level, this requires the coordination of the Ministries of Health and Welfare, Construction, Labor, Finance, Local Government, and others as appropriate to the support of effective mental health services. This coordination should also be reflected at the prefectural and sectorial levels.

The planning and implementation of mental health services should be provided on a sub-prefectural basis, corresponding to the provision of other health services. This provides an appropriate partnership between national and local governments in the provision of mental health care.

B. Accreditation

Progressive systems of care require standards for quality, treatment, procedural guidelines, staffing patterns, and organizational structure. A body should be created to set and enforce national standards and inspect and accredit hospitals and other mental health facilities. As an interim measure, it is recommended that a coalition of public and private psychiatric hospitals set national guidelines and standards.

Ideally, this accreditation system should apply to all hospitals, both for physical and mental illness. All reimbursers should be encouraged to limit coverage to accredited facilities.

C. Human resources

The success of mental health programs is dependent on the personnel working in the system.

1. Training and Certification

Improved training, oriented toward community care and rehabilitation, should be subsidized by the government and required for all mental health professionals. Certification should be established for psychiatric social workers, clinical psychologists, and other mental health workers. Certification for psychiatric nurses and occupational therapists should be upgraded with an emphasis on community care. Standard curricula and national boards should be established for psychiatry.

2. Staffing

Hospital and rehabilitation facilities should have a greater staff:patient ratio. With the aim of successfully moving into community-based programs, the role of mental health professionals (especially nurses, who are presently under-represented in the community) should be redefined toward expanded responsibilities in counseling and in community and after-care programs.

3. Proposed changes in the mental health act

A. Admission Procedures

The Mental Health Act provides for three principal types of admission to psychiatric hospitals: voluntary admission (under Article 22-3), admission by the patient's "hogogimusha" (under Article 33), and involuntary admission (under Article 29).

1. Voluntary and Informal Admission

The 1987 Mental Health Act introduced a procedure for voluntary admission to psychiatric hospitals. However, some patients are being informally admitted under so-called "free admission", outside of the Mental Health Act. In order to incorporate all admissions within the scope of the Act, it is recommended that a procedure for informal admissions be

instituted.

2. Admission Under Article 33

Under Article 33, a person's "hogogimusha" (or the mayor in the absence of a hogogimusha) may commit him without his consent on less stringent criteria than those required for involuntary admission under Article 29. In addition to producing confusion and avoiding the more stringent requirements imposed by Article 29, the existence of two different forms of involuntary admission creates a regrettable conflict of interest between the person to be admitted and his family members. The role of the family in committing the patient may seriously impede the patient's treatment. Therefore, it is recommended that admission under Article 33 be abolished.

3. Involuntary Admission

In connection with the removal of Article 33 admission from the Act, provision should be made for patients to be admitted under Article 29 on the basis of their need for treatment alone, as well as on the basis of dangerousness. Criteria for admission under Article 29 should include those in paragraphs 1(a) and 1(b) of principle 16 of the U.N. Principles.

In addition, to further protect the rights of persons to be admitted under Article 29, that Article should provide that only one of the two admitting psychiatrists may be attached to the admitting hospital.

B. Psychiatric Review Boards (PRBs)

In order to function fairly and effectively, the PRB must be independent from the prefectural government and have its own secretariat.

1. Structure of the PRB

a. PRB Secretariat

The PRB secretariat should be composed of mental health professionals and lawyers, supported by clerical and professional staff. The role of the secretariat should be to perform the PRB's administrative functions, including: a) answering telephone calls and written applications from patients; and b) keeping records and statistics regarding all communications with patients, regular reviews, and PRB decisions. The

secretariat should be supervised by the PRB chairperson, who should receive a part-time salary from the prefecture.

b. PRB Members

PRB panels should be composed of three members: one psychiatrist, one lawyer, and one other person with experience in the mental health field (e.g. P.S.W.s, psychiatric nurses, psychologists, and mental health rehabilitation specialists.) These members should be appointed by the Governor upon the advice and counsel of professional organizations, family organizations, and user groups.

The number of PRB members should be proportional to the number of psychiatric beds in the prefecture: at least one 3-member panel for every 3,000 psychiatric beds, with a minimum of five panels for each PRB

2. The PRB Process

a. The Role of Patients' Counselors

Patients should have access to in-hospital counselors, whose role is to advise patients of their legal rights, to help them address problems encountered in the hospital, to help them to decide whether to make an application to the PRB, and to help them through the PRB process. These counselors should be composed of: (a) mental health center counselors (as provided under Article 42 and 43 of the Act, with the provision that they be authorized to work in hospitals); (b) other mental health professionals; and (c) volunteers from family and other mental health support groups, who have received appropriate training.

b. Application Procedures

Patients should be able to make PRB applications either directly or through patient's counselors. Voluntary as well as involuntary patients should have the right to make applications for improved treatment (e.g. to move from a locked ward to an unlocked ward).

c. Application Processing

The PRB secretariat should respond to telephone calls and letters from patients and their counselors. The secretariat must respond to all contacts, regardless of the duration of the patient's hospitalization. The secretariat should accept both telephone calls and letters as official PRB applications.

Upon receipt of an application, the secretariat must request

from the hospital a report describing the patient's condition and treatment. The hospital must provide this report within one week to the PRB and to the patient unless the treating psychiatrist justifies to the PRB that all or part of this information is likely to be harmful to the patient's mental state or ongoing treatment. In such a case, however, the PRB panel may share some or all of this information with the patient during the review process.

The hospital report should contain the following information: (a) a description of the patient's condition, emphasizing symptoms and functions rather than specific diagnoses; (b) an individual treatment plan, including beneficial responses to medications and possible side effects, prognosis, and expected length of hospitalization; and (c) a psychosocial assessment, including an evaluation of the prospects for rehabilitation and community care (including both levels of care needed and available resources).

d. PRB Patient Interview

After the PRB receives the hospital report, at least two members of the PRB panel, including the psychiatrist, must interview the patient and any other person deemed necessary (e.g. treating physicians, social workers, nurses, and family members). In connection with this interview, the PRB shall have access to the patient's medical record. The patient may be accompanied during the interview by any person(s) of his choice (e.g. counselor, attorney, family member(s)). The patient, either directly or through a representative, must have the opportunity to make statements to the PRB members during the interview, including comments on the information contained in the hospital report.

e. Decision-Making Process

As soon as possible after all relevant information is collected, and no longer than one month from the receipt of the application, the PRB panel must make a decision. The panel's written decision must include detailed comments on the information contained in the hospital report. Every request for discharge which is not granted must be considered also as a request for improved treatment, including possible transfer to a more appropriate treatment facility. The PRB must send a copy of the written decision to the patient and to the hospital. The PRB's decision is binding on the hospital, which must confirm within one week that the decision has been enforced.

f. Appeal

All interested parties must have the right to appeal a PRB decision to a court. An appeal shall not stay the enforcement of a decision to discharge a patient, except on an emergency petition to a court.

g. Subsequent Application

A patient should be able to make a subsequent application following a PRB review, after 30 days from the initial decision.

3. Periodic Review of Hospitalization and Treatment

The PRB should delegate periodic reviews to consulting Designated Mental Health Physicians, who would work closely with the PRB secretariat. These consultants should refer cases which require further attention to a PRB panel.

4. Supervision of Seclusion

Hospitals must keep seclusion registries documenting the duration of all instances of seclusion. They must further report to the PRB all cases of seclusion over 72 hours o duration.

5. Review of All cases of Conversion from Voluntary to Involuntary Status

All cases of conversion from voluntary to involuntary status must be reported immediately to the PRB secretariat, to be reviewed by the PRB.

6. Annual Report

Each PRB must produce an annual report, available to the public, which includes statistics and details of all PRB activities. These reports should include pooled data, and not confidential information about individual patients.

C. The Hogogimusha System

The hogogimusha system should be abolished. The guardianship functions should be replaced by a public guardian system.

D. Discrimination on the Basis of Mental Illness

Discriminatory practices on the basis of mental illness (for example with regard to drivers'licenses, housing, and employment) must be prohibited in accordance with paragraph 4 of principle 1 of the U.N. principles.

E. 5-Year Review of Mental Health Act

In order to ensure the continuing effectiveness of Japan's mental health legislation, it is recommended that any revision of the Mental Health Act contain a provision similar to Supplementary Provision Article 9 of the current act, requiring review of the law five years after enactment of the modifications.