November 27, 2016

Request to Visit Japan in 2017

Dear United Nations Human Rights Council,

Committee for realizing the visit of the United Nations Working Group on Arbitrary Detention to Japan in 2017
Kizunasya 2-39-3,Chuo,Nakano,Tokyo 164-0011 Japan
phone +81 80 1036 3685
Fax +813 5942 7626
e-mail nrk38816@nifty.com
contact person Mari Yamamoto

1. Introduction

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

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

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

inclusion and participation in the community with persons with psychosocial disabilities (section 3).

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

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

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

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

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

Case of G

G, who lived in the Taito district of Tokyo and received public assistance, began to suffer from insomnia. He consulted with a caseworker at a welfare center, and the caseworker told him to go a clinic.
G said to his psychiatrist at the clinic, "I would like to have a medical examination in a big hospital." The psychiatrist wrote a letter of introduction and told him to submit it to the ward office. Following the psychiatrist's instructions, he submitted the letter to the office.

In January 2011, the caseworker came by taxi and took him, who didn't know

where he would be taken, to Utsunomiya Hospital.

Soon after arriving at the hospital, he was examined by a psychiatrist. The psychiatrist said, “I will cure you. I have cured hundreds of thousands of people and have given lectures [this expression means the psychiatrist wants to convey that he is a famous psychiatrist]. You do not have a disease and will be cured soon.” However, the psychiatrist didn’t explain the diagnosis or cure plan.

Without explanation, he was taken to a locked word. It was dirty and smelled ward. Some inpatients were left in diapers. From the outset, he had no intention of being hospitalized. He forcefully demanded that he be discharged. Then, a nurse gave him an injection, rendering him half conscious. He couldn’t remember what happened after that.

For the next three months, G was put on medications that kept him only half conscious. He couldn’t walk without help and sometimes wore diapers. When he resisted nurses’ orders, they would increase his medication or inject him. He gradually learned to be well-behaved and inconspicuous. As a result, he was no longer injected.

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

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

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

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

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

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

In the following case, B was hospitalized for more than 60 years without support for

discharge from hospital staff or the government. In 2010, there were 36,584 inpatients who had been hospitalized more than 20 years. Indeed, it is not uncommon for inpatients to be hospitalized for several decades. Such neglect by hospitals or the government should be regarded as arbitrary detention.

Case of B

In the 1950s, following an incident, B was diagnosed as schizophrenic and involuntarily admitted to a psychiatric hospital (compulsory admission). He has intellectual disabilities.

B's psychiatrist changed his admission form from compulsory to voluntary. Thus, B could be legally discharged any time he wanted. Yet, he has been hospitalized for more than 60 years, and there seems to be no active support for his discharge.

His condition is stable and there is no medical need for hospitalization. However, he is over 80 now and can't imagine life outside the hospital. He doesn't want to be discharged because he's had no relationship with the outside world for such a long time.

When his attendant talks about discharge, B becomes silent, and he gets angry when the attendant mention a discharge against his will. B seems to think the hospital is only where he belongs and discharge would drive him from his home.

4. Involuntary admission based on incompetency

Involuntary admission based on incompetency is a system in which a person with psychosocial disabilities is involuntarily admitted based on incompetency and examination by a qualified psychiatrist and with the consent of a close family member or a guardian (section 33, clause 1, of The Mental Health and Welfare Act). This system carries a high risk of abuse and since people can be forcibly hospitalized according to the will of their families, even if they resist the admission.

As a safeguard, a person with psychosocial disabilities can appeal for discharge to a prefectural governor. However, in 2014, only 104 of 2,455 requests for discharge or improved treatment were accepted. In other words, the safeguard is ineffective. There is no justification for a system that deprives the liberty of persons with psychosocial disabilities, carries a risk of abuse, and has insufficient safeguards.

Case of U

When U sought public assistance at a welfare center in the Shinagawa district of Tokyo, a staff member took him to a mental clinic. A psychiatrist at the clinic asked, “Have you been admitted in psychiatric hospital?” and he said yes. The psychiatrist

replied, “So, you should be admitted.” After the examination, U was sedated by injection and taken to Utsunomiya Hospital by a caseworker from the welfare center.

U was then examined by a psychiatrist at Utsunomiya Hospital. The psychiatrist said, “You should be hospitalized for a year,” but did not explain the diagnosis. U was then hospitalized as a voluntary admission.

One day, the psychiatrist suddenly announced, “You will be hospitalized as an involuntary admission based on incompetency.” He didn’t understand the need for admission and asked to be discharged. But the psychiatrist said, “Stay in the hospital and do farming [in the hospital as a treatment]” and didn’t consider the request.

U consulted with a lawyer and appealed for discharge to the Tochigi prefectural governor. However, Tochigi prefecture decided U should remain hospitalized as an involuntary admission based on incompetency because he was perceived to have a “minor anomaly of the cerebellum” and “insufficient intellectual ability.” Both “symptoms” were never “cured,” and U continued to be hospitalized as an involuntary admission based on incompetency.

5. Involuntary admission based on dangerousness

In the case of involuntary admission based on dangerousness, a person is involuntarily admitted to a designated psychiatric hospital, by the authority of the prefecture government, after more than two qualified psychiatrists examine the person and determine that he or she is psychosocial impaired and dangerous to self or others (section 29, clause 1, of The Mental Health and Welfare Act). According to existing domestic laws, people who aren’t perceived as psychosocial impaired can’t be involuntary hospitalized or treated, even if they are dangerous to self or others. In short, involuntary admission based on dangerousness to self or others is a discriminatory treatment that forces hospitalization based on actual or perceived psychosocial impairments.

As shown in the case below, involuntary admissions based on dangerousness occur that are neither valid nor necessary.

Case of Y

On March 10, 2015, Y was working in a bank as a temporary employee. However, she was troubled by her superior’s abuse of authority and planned to resign by the end of the month. She consulted the public employment security office about the matter. They said, it would be better for her to get a medical certificate from a psychiatrist and apply for unemployment benefits, encouraging her to be examined in a psychiatric

hospital. Y went to a mental clinic, told the psychiatrist about her insomnia, and was prescribed sleeping pills. At that time, she had no diagnosis.

Shortly afterward, on March 15, Y had words with her husband, while drinking alcohol in the second-floor living room of their house. She doesn't clearly remember why the dispute began, but it was something minor (e.g., her husband was being cold toward her). As they argued, he nearly struck her. She promptly grabbed the phone and called the police with intention to warn him. The police answered, but she hung up without saying anything. Angered by the call, the husband tore the wire from the telephone. Y and her husband pushed and shoved each other. Then, as Y tried to go to the porch to escape her husband, he violently pulled her back into living room.

The police eventually arrived and rang the front-door buzzer. The husband said, "They have come, haven't they," and went down-stairs to open the door. As the husband and the police ascended the stairs, Y heard her husband say, "My wife may jump off porch," to which the police replies, "She won't die if she jumps from the second floor." When her husband came to the living room and Y promptly went to the porch, the police found her, restrained her, and took her to the police station.

By the next day (March 16), Y had sobered up and was calm. However, the police had reported her to a public health center, and the Saitama Prefecture governor arranged for an involuntary admission based on dangerousness. Though a psychiatrist examined her, he asked very few questions.

Y was involuntarily hospitalized at Kawagoe-Dojin-kai Hospital for about a month. For the next a month, she was secluded and from March 16 to March 18, put in restraints.

This involuntary admission made her distrustful of mental health care. She feared that once she was labeled psychosocial impaired, no one would accept anything she said.

Though Y had irregularly visited psychiatric hospitals, she'd no prior history of being hospitalized. She had lived and worked normally just prior to her involuntary admission.

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

A person who commits serious crimes (murder, arson, robbery, rape, assault with injury), in a state of insanity, and is judged as having no responsibility or limited responsibility, can be involuntarily hospitalized and treated.

There are no limits on the term of admission. Therefore, persons with

psychosocial disabilities can be isolated from their communities for a long time.

7. Spending control by a mental health agency

Welfare centers will sometimes recommend that a person receiving public assistance who can't control his or her finance be examined at a day-or-night care center managed by a mental health clinic.

Enomoto Clinic has five clinics in Tokyo prefecture. It provides a service called psychiatric day/night care mainly involving a meal and recreation to persons with psychosocial disabilities, morning to night, Monday through Saturday. Most people who use the clinic receive public assistance. In some cases, the clinic controls its users' money and gives them daily allowances for food or living expenses for example, 1,000 JPY (about 10 USD) per a day. In such cases, people with psychosocial disabilities have no choice but to continue going to the day/night center to get the money they need to live.

Such spending control is done without the consent of the users. In addition, it isn't clear whether there is any medical necessity or efficiency in these controls.

Case of "I"

"I" is a 65-year-old man living in Edogawa who receives public assistance. In June 2014, "I" started attending day/night care at Enomoto Clinic to treat alcohol addiction.

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

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

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

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

8. Restraint by a private transfer agency

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

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

Case of Z

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

9. Restraint during admission

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

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

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

Case of H

H is a woman who has suffered from bipolar disorder for a long time. Following an overdose, she tried to hang herself at the hospital. As a result, on January 31, 2007, she was taken to Tottori Medical Center as an emergency transfer. H opposed the admission, but a psychiatrist examined her and decided to hospitalize her as an involuntary admission based on incompetency.

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

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

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

Sincerely yours,

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

Members;

Ikehara Yoshikazu (lawyer)

Uchida Akira (lawyer)

Uchida Hirohui (professor of Kobegakuin Univercity)

Utsunomiya Kenji (lawyer)

Kirihara Naoyuki (Japan National Group of Mentally Disabled people)

Gokan Kazuhiro (lawyer)

Sasaki Nobuo (lawyer)

Satomi Kazuo (lawyer)

Shibata Jun (lawyer)

Sekiguchi Akihiko (Japan National Group of Mentally Disabled people)

Takagi Shunsuke (psychiatrist)

Takiyanagi Youko (National Union for Personal Assistant)

Hasegawa Toshio (professor of Kyorin Univercity)

Hasegawa Yui (Kyoto Prefectual Univercity/Japan Society for Promotion of Science Research Fellowship for Young Scientist)
Yamazaki Koushi (professor of Kanagawa Univercity)
Yamamoto Mari (World Network of Users and Survivors of Psychiatry)

We endorsed the letter

Aomori Human Rights Recovery
Center for Prisoners' Rights
DREAM FACTORY
Homeless Advice and Action Network
Iryouhogonyuuin wo Kangaerukai
Japan National Group of Mentally Disabled People
Japanese lawyers and citizens network for the medical aid of welfare and human rights
Mr.Suzukito Tomoni Idounojiyuuwo Torimodosukai
Nagoya Syougaijisya Seikatutokyouiku wo Kangaerukai
OKAYAMA PUBLIC LAW OFFICE
Saitama Seishiniryouwo Kangaerukai
Shinsinsoushto Iryoukansatsuhou wo Yurusuna Netowork
Society of Shiho-Shoshi Lawyers Promoting Supported Decision-Making for the Aged and Handicapped
Space Peer
Yadokari support Kagoshima Transforming Communities for Inclusion in Asia
World Network of Users and Survivors of Psychiatry

Aisu Katsuya
Amakawa Yuki
Ando Kiyoshi
Andou Nobuaki
Arima Hideo
Goto Mikiko
Hasegawa Yukie
Hashimoto Makiko
Hayashi Takehumi
Hosoi Kiyokazu
Hukushima Kenta
Hunabashi Hiroaki
Ichikawa Kiyomi
Inubuse Masayoshi
Ito Kasumi
Ito Norihiro
Izawa Yuichi

Kato Makiko
Kato Michihiro
Kihara Kazuko
Kim Ugi
Kimura Akiho
Kobayashi Ritsuko
Koga Norio
Kurumizawa Shin
Mae Keiichiro
Matsuda Ichiju
Miyata Kiyoshi
Morioka Chikako
Morita Yoko
Muto Mitsumasa
Nakagawa Motomitsu
Nishida Emiko
Nishitani Kumiko
Okabe Kosuke
Okawara Yasutaka
Ono Yoshihiko
Otomi Naoki
Sagihara Yuka
Sato Takashi
Sawada Chie
Sawamura Toshihiko
Shinkai Takao
Shirataki Yasuko
Sugawara Kazuyuki
Takabayashi Shigeo
Takami Motohiro
Takezawa Koichi
Tezuka Mako
Tomioka Taro
Uchibori
Yamakawa Yukio
Yamashita Hiroshi
Yamazaki Susumu

Yoshida Akihiko
Yoshikawa Takehiko