
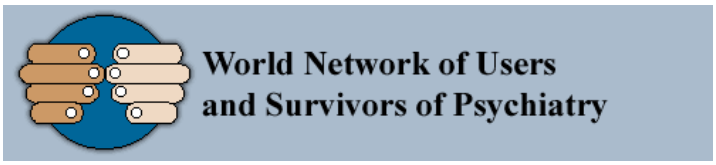



# The parallel report of Japan report to CAT committee in 2013

6 April 2013

# Introduction[1]

We welcome two reports and the statement by special rapporteurs Mr. Manfred Nowak and Mr. Juan E Méndez. Especially they adopt the lens of CAT to review health care setting and the situation of people with disability in it according to CRPD for the first time[2].

In Japan as we explained in back ground information, there are too many people are locked up in mental hospitals and/or restrained or subjected to solitary confinement, these are at least cruel, inhuman or degrading treatments and some cases are torture, and medical treatments without informed consent are common practice in Japan.

We from heart wish that our parallel report will useful for members of CAT committee to review the government report. We would like committee would ask more questions in health care setting not included list of issues[3] to the government from the point of view expressed in the two reports (A/63/175 and A/HRC/22/53) and the statement of Mr. Juan E Méndez.

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[1] Organization information is in annex 3

[2] "Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment" Prof. Manfred Nowak (A/63/175)

Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Mr.Juan E. Méndez (A/HRC/22/53)

Statement by Mr. Juan E Méndez
SPECIAL RAPPORTEUR ON TORTURE AND OTHER CRUEL, NHUMAN OR DEGRADING TREATMENT OR PUNISHMENT
22nd session of the Human Rights Council
Agenda Item 3
4 March 2013 Geneva

[3] CAT/C/JPN/2

# Back ground information

## 1 In mental hospitals

1 Japan has No 1 mental hospital beds and the average of stay in mental hospitals is also No.1 in OECD countries. See attached graphs No 1, 2, and 3. There are some 300,000 in-patients in mental hospitals and there are over 110,000 in-patients staying over 5 years and furthermore there are over 36,000 in-patients staying over 20 years. The government estimated the number of people with psychosocial disability over 3,300,000 persons. In comparison with prisons, there are only some 70,000 prisoners and there are 1812 prisoners being held on indefinite detention at the end of 2011. In Japan much more people are locked up in mental hospitals longer than prisoners. Most of mental hospitals beds are not hospitals beds and they works as institutions in Japan.

2 Main compulsory hospitalization are two types in Law Related to Mental Health and Welfare of the Person with Mental Disorder[4] (hereinafter MHL), article 29[5] and article 33[6]. And there is voluntary admission in

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[4] Law Related to Mental Health and Welfare of the Person with Mental Disorder
Full Text as Amended(Law No. 94 Dated June 23, 2006)
Translated by Hiromi Shiraishi, and Sachiko Ohi
http://www.npo-jam.org/en/laws.html

[5] (Involuntary Hospitalization Ordered by Prefectural Governor)
Article 29: If a prefectural governor recognizes that a person is mentally disordered and is likely to hurt himself/herself or others because of mental disorder unless hospitalized for medical care and protection based on the result of examination under Art. 27, he/she may cause said person to enter the Mental Hospital established by the national government, etc. or the Designated Hospital.
2. The prefectural governor shall cause said person to enter the hospital under the preceding Paragraph only when said person has been examined by at least two Designated Physicians designated by him/her and the results of examination by each physician concur in that said person is mentally disordered and that he/she is likely to hurt himself/herself or others because of mental disorder unless admitted to a hospital for medical care and protection.

article 22-3, 4 but in fact it is not voluntary admission because there is the item to stop the discharge for 72 hours and the administrator of the mental hospital can take the procedure to compulsory hospitalization[7]. The number of compulsory hospitalization by article 33 is increasing and researchers think that it is because of hospitalization of people with dementia[8]. See attached graphs No.4 and No.5

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[6] **(Hospitalization for Medical Care and Protection)**
**A**rticle 33: The administrator of the Mental Hospital may cause the following person to be hospitalized without his/her consent so long as the person responsible for his/her protection consents to such hospitalization:
I: The person who is judged to be mentally disordered based on the examination by the Designated Physician, who needs hospitalization for medical care and protection, and who is not in a state for hospitalization under Art. 22-3 for treatment of his/her mental disorder;
II: The person who has been transferred under Art. 34-1.

[7] (Voluntary Hospitalization)
Article 22-3: The administrator of the Mental Hospital shall endeavor to hospitalize a Person with Mental Disorder based on his/her consent, when causing hospitalization of said Person with Mental Disorder.
Article 22-4: When a Person with Mental Disorder voluntarily hospitalizes himself/herself, the administrator of the Mental Hospital shall inform in writing to said Person with Mental Disorder at the time of his/her admission the matters related to the request for release, etc. under Art. 38-4 and other matters prescribed by the Health, Labour and Welfare Ministerial Ordinance, and shall receive a document stating that he/she is entering the hospital voluntarily.
2. The administrator of the Mental Hospital shall release the Person with Mental Disorder who has voluntarily entered the hospital (hereinafter referred to as "Voluntary Patient"), if he/she so requests.
3. In the event prescribed in the preceding Paragraph, the administrator of the Mental Hospital may choose not to release said Voluntary Patient for seventy two (72) hours at maximum if the result of examination by the Designated Physician reveals the need to continue hospitalization for medical care and protection of said Voluntary Patient irrespective of the provisions of said Paragraph.

[8] In 2010 one year number of new compulsory hospitalized inpatients.
Article 29　5,706 persons
Article 33　198,487 persons
Data from patients report

3 Compulsory hospitalization system works very arbitrarily in Japan even if we supported compulsory hospitalization system in MLH[9]. Why is the number of compulsory hospitalization much different between prefectures? There is no official answer and there are no measures to solve it. See the attached graphs No.6,7,8 and 9

- The number of new compulsory hospitalization
  Article 33
  Over 4 times difference between the smallest and the largest
  Article 29
  Over 17 times difference between the smallest and the largest
- The number of compulsory hospitalized in-patients
  Article 33
  Over 4 times difference between the smallest and the largest
  Article 29
  Over 3 times difference between the smallest and the largest

4 About 37 % in-patients are in locked wards.
In-patients in 24 hours locked up wards 193,243 persons
Others 115,372 persons
The number of solitary confinement and restraint are increasing and some 9000 in-patients are restrained or same 9000 in-patients are put solitary confinement. Furthermore the set of restraint and solitary confinement is used as emergency admission or so called acute phase as if the routine manual. See Graph No.10 and No.11
There is no official data of how long each in-patients are subjected to restrain or solitary confinement but Dr. Michishita S who was a staff of Aragaki mental hospital in Okinawa confessed that there was the in-patient restrained over one year in the TV program by Ryukyu Broadcasting Station on 26 June in 2012 and also he said that 20 in-patients from 270 in-patients were restrained though they are not so long. He explained reason why restraint was that older in-patients were

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[9] There are many people who are dangerous to injure themselves or others or who need to medical treatments and protection but no one who are not labeled as mental disordered can be compulsorily hospitalized. It is clear discrimination against people with psychosocial disability and compulsory hospitalization by any MHL naturally becomes arbitrary.

likely to fall down and restraint was to prevent it.
We can understand such state is from that a number of psychoactive drugs are given at the same time (polypharmacy) for older patients. Regrettably polypharmacy and many doses are common practice in Japan not only for older people but it is problematic especially to older people.
There is the report by Dr. Asai K group and they researched the term of solitary confinement and restraint. They researched 240,000 mental health hospital beds in 1996 and reported that 34.7 % of solitary confinement is over one month and 59.3 % of restraint is over one month.

5 In Japan some cases are reported that restrained in-patients are found dead because of pulmonary embolism[10] or people who are walking to mental hospitals become not to be able to walk because of long restraint. Restraint is terrible to especially older in-patients.
Long restraint are killing and disabling people and it makes severe pain for all people.[11]

6 There are no official data of compulsory medical treatments in Japan, because we have no items to legalize compulsory medical treatments and also no items of the rights to refuse medical treatments in MHL. We have also no patients' right legislation and there is no written clear concept of informed consent in any legislation.
But in fact there are many compulsory medical treatments in the mental hospitals by threatening that refusal of treatments means longer solitary confinement or compulsory hospitalization. Also there are compulsory treatments with the consent by family members, and most psychiatrists think that family members' consent without patients own consent is informed consent and it is common practice.

7 In Japan there is no iron bars at the windows of most mental hospitals but we cannot open windows widely and we are suffering from bad

[10] There are no official data of death by restrain but in 2004 media reported that 4 restrained in-patients have died of pulmonary embolism for 5 years in Tokyo.
[11] See, Annex 2 testimony by Ms. Hashimoto

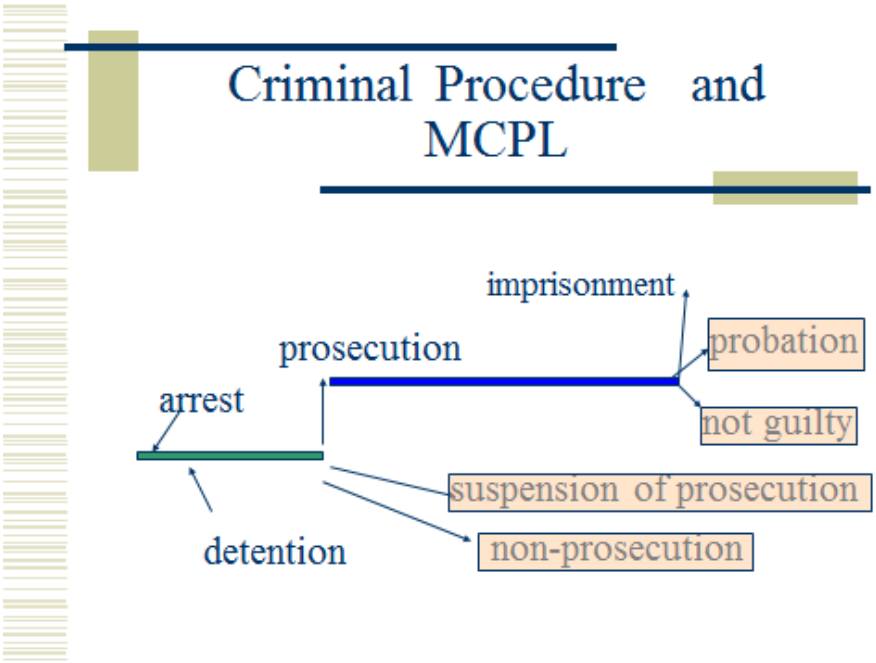
ventilation and bad smell. Locked up people have only a few or no time to fresh air and in some cases for many years. In-patients have no right to fresh air.

# 2 Special legislation against so called mental disordered offenders

8 "Medical Care and Probation of Person who commits a seriously hurting act against other person in a state of insane or quasi-insane mind" (translated by Dr. Nakayama.K hereinafter MCPL ) was enforced in 2005.

It is the first security measure legislation in Japan and we have special hospitals and community treatment order for the first time. How dose MCPL works? The government explains that MCPL is for good medical treatments and rehabilitation for the target people. But 7 years practice betrays the explanation.

See the picture as below; people who are decided as pink colored status are the target of MCPL.



Target population: People with mental disabilities who committed the crimes of homicide, arson, robbery, rape, sexual assault or mutilation and were found "NGRI" or were found "Diminished Capacity" and placed probation. Treatment is indefinite compulsory institutionalization to special hospitals or outpatient who is under probation or conditional for 3 to 5 years.

Criterion for special treatment is likely to commit a target crime again because of a mental disability which caused "NGRI" or "Diminished Capacity" unless involuntarily committed on an inpatient or outpatient basis.

Court decision; Decision makers is a psychiatrist and a judge in a district court and with expert witness. In this process due process clause in Constitution[12] does not apply. People who are sent to MCPL procedure before prosecution cannot challenge the suspected crime in the court, and we are afraid that there might be cases that innocent people are deprived of liberty and restricted human rights in the community by MCPL.

9 MCPL makes the criteria of compulsory hospitalization wider and longer than it by MHL article 29 and 33. For instance before the court decision people are almost always deprived the liberty for examination and compulsorily hospitalized for 2 or 3 months though there are no reasons as required by article 29 and 33.[13]

Decision of discharge needs the conference and members of it are not only hospitals staffs but the probation office staff, the community health center staff, the community service staff, the local government staff etc., so it is too difficult to have it frequently and in fact they can

[12] Constitution Article 31. No person shall be deprived of life or liberty, nor shall any other criminal penalty be imposed, except according to procedure established by law.

[13] In one case the person who was arrested of sexual assault when he hugged with one woman for a short time, was decided as not the target of article 29 and he was not hospitalized then he used his psychiatrist and the sheltered workshop in the community. But suddenly 7 months after the arrest he was called by the public prosecutor and told that he was the target of the MCPL. Then he was subjected to compulsory hospitalization for examination and to solitary confinement in the mental hospital for 3 months.

have the conference only every 3 or 4 months. After the in-patient's psychiatrist think that it is the time to discharge, it sometimes takes over 2 or 3 months to waiting the conference. This waiting time never happens in MHL system. And it is same to release out-patients from community treatments.

There are some cases that the judge of the court does not allow the discharge of the person even when psychiatrists, the institution and the conference decided he/she has already not needed hospitalization.

Article 29 and article 33 of MHL require discharge when psychiatrist decided no need of hospitalization in principle and there is no party to stop discharge except psychiatrists, though in fact there are many cases that psychiatrists do not comply with MHL.

10 Form the enforcement of MCPL to 15 November 2011 the number of admission to special hospitals is 1241 persons.

There are 28 special hospitals and 707 beds and there are 430 hospitals and clinics which are designated for out-patients by MCPL on the end of 2012.

In 2008 the average of stay is 603 days and median is 620 days but in 2011 average is 748 days and median is 807 days. Furthermore these people have experienced detention for examination 2 or 3 months, so average of detention is over 800 days to 830 days in 2011 and it expressed the tendency the stay period has become longer and longer. It is much higher than average stay in MHL mental hospitals. And 3 persons are subjected to solitary confinement over one year[14].

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# 3 Illegal detention centers by private sectors

11. We cannot get full information but there are institutions run by private sector which detained people illegally. *The target is the people who are* labeled as troublesome people by family members and cannot be hospitalized by MHL or long enough as family members' demand.

[14] Journal of Japan Psychiatric Hospitals Association vol.31 No.7 July 2012 "present condition and problem of MCPL" 46-52 Ando.K, Nagata.K and Hirabayashi.N

On 1 September 2011 Mr.Honda took Shindo Gakuen to the civil court. In June 2006 he was kidnapped by 4 staffs of Shindo Gakuen and locked up for 3 years. He could run away from it in September 2009.
Shindo Gakuen is Non-Profit Organization recognized by Cabinet Office and it has long history of scandals for example -a person was beaten to death in 1985 and 3 persons in it were dead by fire in 1988. But now it has website to get inmates.

12. If we are browsing internet service, we can find many websites of institutions run by such private sectors. Shindo Gakuen case is a tip of iceberg.
And the government takes no effective measures to stop such business. We asked Ministry of Health Labour and Welfare to research one business corporation Tokiwa Mental Health Office[15]. It is run by Mr. Oshikawa who is famous of patients carrying service to mental hospitals and now he runs the same type of center as Shindo Gakuen and we are afraid it is an illegal detention center because they declared on their website that there is the rule to control going out of the institution. And furthermore on the website he calls for customers that he can introduce to mental hospitals which detain patients for life.
But the MHLW did not any answer until now including whether they start the research or not.

[15] http://www.tokiwahoken.com/

# List of issues prior to the submission of the second periodic report of Japan (CAT/C/JPN/2) and the report by Japan

13. In reply to the issues raised in paragraph 1 of the list of issues (CAT/C/JPN/Q/2), the government report paragraph 1 to 3 does not mention the problem in mental hospitals.
    In many cases people with disability especially people with psychosocial disability cannot be recognized as the victim of the crime. Ill treatments or torture is not recognized as the crime. There is prejudice that people with psychosocial disability have no legal capacity and our testimony are always suspected and mental hospitals staffs are estimated that they are not crazy and have enough legal capacity and they work with good intention.

14. There are many violence and ill treatments in mental hospitals. But only a few cases are disclosed and punished by penal code, only when the in-patient got critical injury or was killed.
    One example, in Minooga Oka hospital one in-patient had been kept on 2 meters lead from the iron bars. He had been kept on lead in the dining room of the ward just alike a dog for about 10 years. Every day he ate food on the cover of the bed pan. He was casually released from the lead only for the bathing time and on the checking visit by the local government.
    After Minooga Oka hospital was shut down by the penalty to false claim to national insurance system in 2002, he could move to another mental hospital. But any authority including police or public prosecutor did not investigate or prosecute the ill treatments or torture of his experience and including others' as the crime and he and no one was not recognized as the victim of the crime and got no compensation[16]. See the attached testimony of Ms. Hashimoto. She experienced unlawful forced hospitalization and sexual harassment but she was not recognized as the

[16] The Osaka Yomiuri Newspapers reported in February 4 2002

victim of the crime.

15. There is no recognition of the ill treatments and torture so there is no compensation system for their experience. CAT committee mentioned in list of issues on paragraph 18-a) about the compensation for ill treatment and torture in prison, and the government replies to it but there is no recognition of them in mental hospitals.

16. Furthermore there is no recognition that restrain or solitary confinement or compulsory hospitalization is ill treatments or torture between government officers, staffs of mental hospitals including psychiatrists and civil society, especially if the procedure is legalized by MHL.
But in general, threatening to use compulsory hospitalization, restraint and solitary confinement works as "mental torture" to control patients. Legalized kidnapping and locked up by MHL are threat for us all.

17. In Japan we have no items of free and informed consent and no formal definition of free and informed consent in any legislation as we explained Para 6 in our paper. So there is no recognition that medical treatments without informed consent are ill treatments or torture. Especially if it is medical treatments by psychiatrists in mental hospitals, it is recognized as the authorized medical procedure by good intention and it is recognized as treatments for in-patients best interests.
Reason why we are forced to be hospitalized is we have no legal capacity to consent to hospitalization and also to medical treatments, so we have no place to challenge the medical treatments without our own consent.
We have no case that medical treatments without free informed consent including psychosurgery or ECT in mental hospitals are punished by penal code.

18. In reply to the issues raised in paragraph of the list of issues, the government report paragraph 214 to 218.
These languages do not explain the situation of restrain and solitary confinement in Japan as we reported paragraph 4, and 5 and graphs No.10, and No.11 in our report.
Why are so many people restrained and subject to solitary confinement

for very long periods of time? Why is the number of restraint and solitary confinement increasing? The government did not answer.

19. The government explained article 36 in the report paragraph 214. But in fact the restriction of activities in mental hospitals is not last resort. There are 85,219 in-patients voluntary admitted by article 22-3 and 4 are in the ward locked up for 24 hours a day. Over 48% of voluntary admission in-patients are locked up. (on 30 June data from patients report

20. In the training and renewal education to get the license of the designated psychiatrist, there is no subject of Constitution, international human rights treaties including CAT. Their knowledge of human rights is very poor and it naturally influence to their judgment of restriction.

21. The number of solitary confinement and restraint is increasing. About 9000 in-patients are restrained and same number of in-patients put to solitary confinement and it continues for long time as we explained paragraph 4 and 5 and graph No.11.in our report. Also in MCPL special hospitals 3 in-patients from 707 in-patients are subjected to solitary confinement for over one year.(see paragraph 10 of our report)
This number expressed also solitary confinement and restraint are not practiced as last resort.

22. Paragraph 215 of the government report explained the criteria of restraint , but these are too wide and ambiguous, does the concept “acts of self-injury are highly likely” apply to “likely to fall down” as one psychiatrist explained in TV program? (see paragraph 4 of our report) And who can judge if “hyperactivity or disquiet is *noticeable*” or not with objective evidence? Naturally the judgment of designated psychiatrist depends on each subjective one.

23. Paragraph 216 of the government report said that there is the record of restraint. Yes there is the record and legislation orders medical documents must be kept for 5 years. But there is no systematic research or review system and no effective measure to decrease the number and

the term of restraint, for example there is no system that the third party reviews it. Then the number of restraint is increasing.
For example see paragraph 14 of our report, one in-patient who was kept on lead, was casually released when the local government visits the hospital to review. It is the regular review and not spot check, so many mental hospitals prepare to receive the review and of course the local government is not the third party.

24. Japan does not ratify OPCAT and there is no system of the third party monitoring system, though there is not enough but The Penal Institution Visiting Committee for prison system but there is no such system for mental hospitals. There are no measures to protect people from ill treatments and torture in mental hospitals in Japan.

25. Paragraph 217 of the government report explained the Psychiatric Review Board, but we all knew it does not work effectively.
In 2009 for one year the number of reviewed request to improve the treatments is 265 and the result of the review is that only 12 cases - only about 4.5 % - should be improved. Is it the evidence how the restriction of the activities is run appropriately?
No.

26. In Japan 90 % mental hospitals beds are in private mental hospitals, so local governments heavily depend on private mental hospitals in their mental health policy.
The Psychiatric Review Board is not independent from the local government and it has not independent office and own secretary. The Psychiatric Review Board cannot work as the third party or independent tribunal body.

27. In most prefectures half or over half of the board member is psychiatrists. Most of psychiatrists are employed by mental hospitals or are hospitals owners or clinic owners. They cannot contribute to effective peer review but work in favor of their peers.

28. In-patients including compulsory hospitalized ones do not have the very

limited right of free legal service and there is no patient's right advocacy system in general. And in fact restrained or solitary confined in-patients cannot write a letter and send it or cannot call the telephone to the Board. Also the psychiatrist can stop the visit of the person responsible for patient's custody to the in-patient[17], so he/she cannot know the

[17]MHL orders all "mental disordered people" who are the target of MHL should have person responsible for protection, and

**Section 1: Person Responsible for Protection**

**(Person Responsible for Protection)**

**Article 20:** The guardian, the curator, the spouse, the person exercising parental power or the person responsible for support shall become the person responsible for protection of the Person with Mental Disorder.

Provided, however, anyone falling under any of the following items shall not be appointed as a person responsible for protection of the Person with Mental Disorder:

I: A person whose whereabouts is not known;

II: A person who has brought or ever brought litigation against said Person with Mental Disorder, his/her spouse and lineal relative(s);

III: The legal representative, the curator or the assistant who has been dismissed by the Family Court;

IV: A person who has been declared bankrupt;

V: A person who is of legal age but for whom a custodian or a curator is appointed;

VI: A person who is a minor.

**2.** When there are more than one person responsible for protection, their order of assuming responsibility shall be as follows. Provided, however, if there is recognized a special need for protection of the person in question, the Family Court may change the order upon application by an interested party in respect of a person other than the guardian or curator:

I: The guardian or the curator;

II: The spouse;

III: The person exercising the parental power;

IV: The person appointed by the Family Court from among those responsible for support except those described in the preceding two items.

**3.** Change of the order under the proviso of the preceding Paragraph and appointment under Item 4 of said Paragraph shall be deemed as the matters described in Class A, Para. 1 of Art. 9 of the Law for Adjustment of Domestic Relations (the Law No. 152 of 1947) as far as application of said Law is concerned.

**Article 21:** If there is no person responsible for protection under the items of Para. 2 of the preceding Article or such person is unable to perform his/her duties, the mayor of municipality (including the head of special ward; the same applies hereinafter) having jurisdiction over the place of residence of

treatments of the in-patient and the person who is responsible for patient's custody is almost always family member and he/she often hesitates to claim to the hospitals because he/she depends on hospitals and psychiatrists. Then the number of the request to the Board is only 265.

29. Paragraph 217 of the government report also mentioned "it is possible to file a request for review pursuant to the Administrative Appeal Act with the Minister of Health, Labour and Welfare. In addition, it is also possible to file a lawsuit pursuant to the Administrative Case Litigation Act." Yes we can, but it is rare cases in-patients win the procedure of the Administrative Appeal Act, and lawsuit pursuant to the Administrative Case Litigation Act.(see the testimony of Ms.Hahimoto annex 2)

30. And also only a few people can file a lawsuit, because many lawyers hesitate to become the representative of people with psychosocial disability due to discrimination. It is very hard to find the representative lawyers especially for poor in-patients. Access to legal service is very limited if one is locked up in mental hospitals.

31. If one takes the hospital or the psychiatrists to the court in local area,

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the Person with Mental Disorder concerned, or when he/she has no place of residence or his/her place of residence is not known, the mayor of a municipality having jurisdiction over the place where the Person with Mental Disorder is currently in shall be responsible for protection.
Article 22: The person responsible for protection shall cause the Person with Mental Disorder
(excluding those being voluntarily hospitalized under Para. 2 of Art. 22-4 or those receiving continuous medical care for mental disorder at a hospital or clinic without hospitalization; the same applies to this Paragraph and Para. 3) to receive treatment and shall protect his/her proprietary interests.
2. The person responsible for protection shall cooperate with the physician in order to cause the Person with Mental Disorder to be correctly diagnosed.
3. The person responsible for protection shall comply with the physician's instructions when causing the Person with Mental Disorder to receive medical care.

one should give up all medical and welfare service in his/her area, because professionals and local government officers often united in favor of challenged hospitals or psychiatrists. It is too hard barrier for people with psychosocial disability.

32. In the list of issues of the Committee there is no item of compulsory hospitalization. But as we mentioned in background information, it is the biggest problem that people are compulsory hospitalized and hospitalized for long periods of time, as we reported paragraph 1 to 3. And there are same procedure in MHL and other system to review compulsory hospitalization as the government explained in paragraph 217. But it does not work as we explained. There is regular review system for compulsory hospitalization and request system to challenge it but, regular review is only by paper and result of the request to discharge is same as request to improve treatments[18]

# Conclusion

33. Many people labeled as mental disordered are facing discrimination and they suffering from arbitrary detention and restraint and solitary confinement in Japan as we explained back ground information and graph. The government should release them with compensation and prepare to guarantee their community living with their wish, preference as their human rights and take the measures to prevent ill treatments and/or torture.

34. We need radical change to mental health system from the point of view of CAT. The reform of mental health system should accord to the standard of CRPD and also the Special Raptures of CAT statement and report[19].

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[18] In 2009 one year, regular review of hospitalization article 33 88,503 cases and discharge is only 4 cases, article 29　2,444 cases and discharge is only 3 cases. Request to discharge 2,091 cases and discharge is only 62 cases.

[19] "Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long-

We need abolish MHL and MCPL especially the items which allow restriction of activities, restraint and solitary confinement and forced hospitalization. Forced hospitalization system inevitably results non conceptual medical treatments by threatening to use forced hospitalization or to make longer hospitalization unless we "consent" the treatments. This "consent" is not free and informed consent of course it is make upped forced treatments.

35. We need general patient's right legislation which provides clear standard of free and informed consent and protects us without any exception from forced medical treatments.

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and short- term application. The obligation to end forced psychiatric interventions based solely on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation." A/HRC/22/53, paragraph 89(b).

"Safeguard free and informed consent on an equal basis for all individuals without any exception, through legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be revised. Adopt policies and protocols that uphold autonomy, self-determination and human dignity. Ensure that information on health is fully available, acceptable, accessible and of good quality; and that it is imparted and comprehended by means of supportive and protective measures such as a wide range of community-based services and supports (A/64/272, para. 93). Instances of treatment without informed consent should be investigated; redress to victims of such treatment should be provided" A/HRC/22/53, paragraph 85(e)

"Revise the legal provisions that allow detention on mental health grounds or in mental health facilities, and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned. Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished" A/HRC/22/53, paragraph 89(d).

The Special Rapporteur elaborated on this in his statement made to the Human Rights Council on 4 March 2013: "Deprivation of liberty on grounds of mental illness is unjustified…. I believe that the severity of the mental illness cannot justify detention nor can it be justified by a motivation to protect the safety of the person or others."

36. But the government now plans to introduce the reform of MHL that simply make the compulsory hospitalization by article 33 easier and now we cannot get the bill. Everything about us without us[20].

[20] The government explained family organization and professional organizations but without us and we heard informally that the bill will be reform of article 33 and one psychiatrist can decide compulsory hospitalization and need someone of family member's consent but delete order of the person who can consent and Family court review to decide the person who can consent. See foot note 17.

Annex 1 graphs

Annex 2

Human Rights Abuse in Psychiatric Medical Front

Yoko HASHIMOTO

This report describes what has actually happened in a mental hospital in Japan, which is not an exceptional case.

Although I had received treatment for bipolar disorder for over 10 years, no positive effects had been obtained from any kind of medication therapy, and my state of disease had kept on deteriorating as years went by. On the night of January 30, 2007, as I almost gave up enduring the agony of depression which had continued for more than a half year and prevented me from going to hospital, I took a larger amount of the sleep-inducing drug at hand than had been prescribed. It caused me to black out and I went on taking more and more of the sleeping pills unconsciously. I confirmed later that I had drunken off all of the medicine there. Even though the amount was below the fatal level, it was a typical case of an overdose. The next morning, on January 31 at around 8 o'clock, I was taken to Watanabe Hospital of Meiwa-kai Medical & Welfare Center (herein after referred to as "Watanabe Hospital)" by ambulance, where I had received treatment for as long as ten years. Because of my blackout, I remember almost nothing about what happened between the midnight when I seem to have started taking the medicine and the evening on the day when I was taken to the hospital. According to what I confirmed with my father afterwards, Dr. Watanabe (my family doctor) of Watanabe Hospital only said again and again to my father, who had rushed in, "Please go home," refused to provide any medical care, and disappeared quickly, although the hospital accepted me for an emergency medical treatment. At a loss, my father and I remained there without being served by the outpatient reception. Then the surgery hours were over and all the staff went home, except for only one nurse who was

staying there voluntarily. In the outpatient reception where the lights were completely dim, all we could do was remain there. In despair due to refusal of the hospital and the doctor to treat me, after 10 years of history as a patient there, at around 9:00 pm, I knotted several towels there at the treatment room, hung them from the curtain rail, and hung myself. Although I didn't have a clear intension to kill myself, unfocused desperation forced me into this action. The nurse found it at once and I had a narrow escape. But upon hearing of this, Dr. Watanabe abruptly referred me to the National Hospital Organization Tottori Medical Center (hereinafter referred to as "Medical Center"), where I had not received any treatment before. The ambulance was called immediately, and my father and I were headed for the Medical Center. Although staying in his house only a 4-minute walk away from Watanabe Hospital, Dr. Watanabe didn't appear in the hospital at all. He only seems to have given instructions to the nurse over the phone. In fact, Watanabe Hospital took an irresponsible action of handing down a patient with difficult symptoms which they weren't able to treat to another doctor who knew nothing about the course of the illness. It must be something called "abandonment of a patient." I was dumped like a piece of garbage.

At this moment, though, I had an ounce of hope. I thought that the Medical Center might provide me with the treatment that would ease my pain, which soon turned out to be a wrong expectation. In the Medical Center, Dr. Matsushima, who was on duty, saw me for the first time, interviewed me for as short as 5 minutes, and no more. It seems to me that he may have decided from the beginning to take the steps for the hospitalization for medical care and protection without assessing my condition.

In Japanese psychiatric hospitals, there is a unique practice of hospitalization called "hospitalization for medical care and protection." Hospitalization for medical care and protection is an involuntary or compulsory manner of hospitalization, for which a designated psychiatrist must make judgment on the need of hospitalization and a signature must be appended on a "consent form" by the guardian. However, my father there, who is an ordinary citizen without any knowledge on this kind of matter, didn't have an idea about the meaning of hospitalization for medical care and protection. In addition, no explanation was provided to him by doctors of the

hospital there, which ended up in his avoidance to sign his name on the consent form at the moment. As for me, who had more than enough knowledge about this sort of issue through my decade-long experience as a psychiatric patient, I could easily guess what terrible things would happen to me under this compulsory hospitalization. Although I refused and resisted, screaming to my father, "Don't sign it!" five or six hospital staff members surrounded me, took me by my arms, and dragged me to the medical ward. All my father could do was stand looking at the scene and doing nothing, although he seems to have gone home believing that they would provide with proper medical care. The fact here is that they committed this act without my father's signature on the consent form, which constitutes a serious violation of the law. Strictly speaking, their conduct could be even deemed as "illegal confinement," as stipulated in the criminal code.

After being taken to the medical ward, I was isolated in a narrow room with only a small barred window, given an injection, and left alone there with the door locked, having my hands, feet and body restrained by leather restraints and being forced in a diaper. Then, perhaps around midnight, a male nurse came into the room with a female one in order to change my diaper. It was the male nurse who started changing the diaper. The female one was just watching it, saying nothing. A man took all my clothes off from my lower body. Feeling humiliated, I tried to be calm in asking, "Why is there a man here?" Then, the female nurse answered in disgust, "There are both male and female nurses!" At this time, I felt that I was being treated not as a human being but merely as an object, with my human dignity completely destroyed.

When I woke up next morning, Dr. Matsushima abruptly said to me, "Do you (want to) leave the hospital?" and I said, "Yes." And when my father came to the hospital in the afternoon after rushing around in the morning and buying every sort of necessary things for my hospitalization, we were told that I would be discharged from the hospital, that is, the hospitalization for medical care and protection continued for only one night. Their actions of forcing me to be hospitalized, restraining me, and isolating me indicate that they judged my condition as serious enough to make them think that they couldn't save my life from being lost by any other means. However, their subsequent decision would mean that I recovered from such a critical condition in just one night. Judging from this unnaturalness, I cannot help

thinking that this one doctor on site was easily abusing the procedure of hospitalization for medical care and protection against a patient.

Knowing that I would be discharged from the hospital, my father hastily went to the counter for payment, when and where he was given three sheets of documents. According to him, the clerk only handed them to him and said, "Please sign and seal here and here," without giving any explanation about their content. However, the aforementioned "consent form" was contained therein. He told the clerk that he had been in such a hurry that he didn't have his seal. Then he was asked by the clerk to take the documents home and mail them back to the hospital later. I was extremely surprised to hear this from him later. The hospital staff was treating such important documents lightly in a businesslike manner without any doubt as if they were documents just for form, which is unbelievable. Out of consideration to avoid causing inconvenience to the hospital, though, my father signed and sealed the documents as instructed by the hospital and mailed them back to the hospital, without knowing what those documents meant. This act by the hospital was no better than deceiving my father, who knew nothing, into giving the consent in order to justify the documents.

In order to respond to their brutal, tyrannical and unfair human rights abuse and humiliating treatment, and restore my dignity, I filed a lawsuit against Watanabe Hospital, the Medical Center, and Dr. Matsushima in August, 2008.

At the first trial, we asserted that the defendants' conducts constituted illegal acts and sought compensation. Both Watanabe Hospital and the Medical Center didn't deny the fact as a whole that they had carried out such conducts, although they asserted the conducts were completely legal medical practice. According to their assertion, their act of forcing me to get hospitalized on an involuntary basis is reasonable medical treatment, and our side should be deemed to have given the consent on the ground that the guardian had finally signed his name on the "consent form," as stipulated in the Mental Health Act, or that he hadn't expressed any definite intension to refuse the consent even if he had not signed the form on the relevant day (implied consent).

Especially regarding the consent by the guardian, we asserted that the Mental Health Act should be interpreted strictly, and submitted the written opinion of Mr. Hirofumi Uchida, a professor of law at Kyushu University, as supporting evidence. Our side stated in detail that, in this case, the guardian didn't intend to give the consent at all, and that he could neither give nor refuse the consent, not knowing or understanding anything without any clear and sufficient explanation provided, which we proved clearly in the examination of witnesses. In the cross-examination, the defense lawyer failed to rebut the witnesses' testimonies on this point.

On May 31, 2010, however, the Tottori District Court fully upheld the defendants' claim and rejected ours in its decision. In response to this ruling against us, we immediately appealed it by submitting a petition to the Hiroshima High Court Matsue branch in June, 2010. Although we had only focused on the factual finding in the first trial, we additionally stated in the appeal trial that the provision of Article 33 of the Mental Health Act regarding the hospitalization for medical care and protection itself violates the Constitution of Japan. By right, a constitutional lawsuit must be filed against the national government. However, the Japanese trial system does not permit the addition of defendants, while the addition of claims is permitted. In fact, we succeeded in making it a constitutional trial, but failed to make it an action for compensation against the national government. In March, 2011, the High Court issued a ruling against us. In the same month, we further appealed to the Supreme Court against this ruling. On September 1, 2011, the Supreme Court dismissed our appeal and decided not to accept the case as the final appellate court. At this point, it was finally decided that we lost the case. That was the reality of justice in Japan.

(Translated from Japanese to English by Takenobu HARADA)

Annex 3 Information about Organizations

The **Japan National Group of Mentally Disabled People** (JNGMDP) is the nationwide network of individual mentally disabled people and groups of them, established in 1974. We are advocating our own human rights and our membership is only mentally disabled people and our mission is to advocate our own human rights by our own voices.

We are a member organization of WNUSP and we participated making CRPD process with WNUSP international level and national level we joined to cross disability organization Japan Disability Forum (JDF) and also we are advocating to ratify and to implement of CRPD with WNUSP and JDF

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The **World Network of Users and Survivors of Psychiatry (WNUSP)** is an international organisation of users and survivors of psychiatry, advocating for human rights of users and survivors, and representing users and survivors worldwide.42 The organisation has expertise on the rights of children and adults with psychosocial disabilities, including on the latest human rights standards set by the CRPD, which it played a leading role in drafting and negotiating.

WNUSP is a member organisation of IDA and has special consultative status with ECOSOC.

WNUSP supports its members to advocate before UN treaty bodies, and has provided expertise to UN bodies including the Special Rapporteur on Torture, the Subcommittee on Prevention of Torture and the Committee on the Rights of Persons with Disabilities. WNUSP is currently engaged with processes for review of the Standard Minimum Rules on the Treatment of Prisoners and for the development of an instrument on the rights of older persons.

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The **International Disability Alliance (IDA)** is the international network of global and regional organisations of persons with disabilities (DPOs), currently comprising eight global and four regional DPOs. Each IDA member represents a large number of national DPOs from around the globe, covering the whole range of disability constituencies. IDA's mission is to advance the human rights of persons with disabilities as a united voice of DPOs utilising the CRPD and other human rights instruments, and to promote the effective implementation of the CRPD, as well as compliance within the UN system and across the treaty bodies.

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