

Parallel report to Japan report
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Submitted by
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World Network of Users and Survivors of Psychiatry
International Disability Alliance¹

Background information

Japan is ranked no 1 for the highest number of psychiatric hospital beds and the average length of stay in psychiatric hospitals of OECD countries.²

97% of the budget on mental health care in Japan is invested into medical treatments and 71 % of budget in psychiatric hospitals (and 90% of the beds are in private psychiatric hospitals) and only 3% on community mental health care. And the number of forced admission to psychiatric hospitals and also the number of restraint and seclusion is both increasing while the government reformed of mental health legislation many times.

In psychiatric hospitals, the human rights of persons with psychosocial disabilities are systematically violated by forced and arbitrary detention/hospitalization, non-consensual medication, including over drugging³, physical restraints, solitary confinement, frequent violence and deaths by beatings and violence perpetrated by staff and non-accountability and impunity of

¹ Organisation detail See annex 1

² There are 300,000 inpatients in psychiatric hospitals and over 110,000 patients staying for over 5 years and over 36,000 inpatients staying over 20 years. 19 % beds of world psychiatric hospital beds are in Japan. About 40% of inpatients in psychiatric hospitals are compulsory hospitalised.

³ Recently the government introduced the policy to stop polipharmacy through medical insurance fee but the policy excluded inpatients treatments and there is also a big loophole that so called experienced psychiatrists can prescribe polipharmacy. If you visit psychiatric hospitals, you can find many inpatients are suffering from side effect of drugs. Over drugging is common practice in psychiatric hospitals and it is used as the chemical straitjacket. In Japan, there is no legislation of informed consent so there is no data on how many and how long forced medical treatments are performed.

both private and public hospitals (very rarely if any action is taken, it is limited to holding the staff person responsible), leaving persons in psychiatric hospitals without any remedies nor redress; as there are no effective complaints mechanisms nor monitoring of both public and private psychiatric hospitals.

There is no basis in the law of free and informed consent, or patients' rights, particularly when it comes to mental health care and persons with psychosocial disabilities who face entrenched discrimination leading to forced treatments and treatment based on the consent provided by family members. In Japan, free and informed consent rarely exists for people with psychosocial disability.

Comments for Question 11 of Lists of Issue

Replies of Japan to the list of issues in paragraphs 88 to 93

How easily people are forced to be hospitalised into psychiatric hospitals

Why the number of forced admissions and also the number of restraint and seclusion are both increasing

Although there are these articles in the Act on Mental Health and Welfare for the Disabled (hereinafter the ACT) that the government explained in para 88 to 93, recently there are not negligible cases that a psychiatrist refuses voluntary admission for a person who wants to stay in hospital voluntarily and takes the forced admission procedure for him/her to obtain a high medical fee. There is the rule of medical fee that 60% of beds in the emergency ward should be occupied by forced hospitalised patients to get the highest medical fee. The labour union of psychiatric hospitals disclosed this practice of psychiatric hospitals management and criticised it. The number of forced admissions has been increasing⁴.

⁴ The number of new forced admissions by article 29 had been increasing over 3 times from below 2000 cases in 1987 to 6,685 cases in 2012 per year and the number of new forced admissions by article 33 has been increasing about 2.5 times from 84,227 cases in 1996 to 209,547 cases in 2012 per year.

When the bill of the revised ACT was discussed on the Diet, the Minister of Health, Labour and Welfare, Mr. Tamura declared that the revised ACT would not decrease forced admission and forced admission would provide good opportunity to receive necessary medical treatments. While Japan ratified CRPD in 2013, the government has no policy to decrease forced hospitalisation by the revised ACT.

One of the requirements of Article 29 in the ACT that the person is “deemed as likely to hurt him/herself or cause damage to other people due to his/her mental disabilities” is very wide. To cause damage to others includes defaming and in the penal code defaming is publishing the fact no matter the truth or falsity. Persons were sent for a psychiatric exam for article 29 admissions, after one handed leaflets to the passers-by on the street which accused the psychiatric hospital of ill treatments or another reported human rights violation of the psychiatric hospital to the Human Rights Organs of the Ministry of Justice which led to an inquiry of the hospital. The latter is the case that one did his duty as a citizen. These two cases resulted in not forced admission, but the individuals were labelled as having a personality disorder by the psychiatrists’ exam.

We people with psychosocial disability have no right of freedom of speech and it violates ICCPR article 19.

In Japan it is the common practice that the police question the person on the streets, and when there is a big event as a foreign ministers conference or an international sports event etc., many people experience these questions, and in some cases people with psychosocial disability become in panic and resist the police, then they are picked up for obstructing official duties. In these cases, some people are easily sent to psychiatric hospitals and forced to be hospitalised by the ACT.

By article 29 of the ACT two designated psychiatrists examine a patient, but they can consult each other on their examination so it is not a double check system.

By article 33 of the Act only one psychiatrist exams him/her and furthermore one psychiatrist who belongs to a hospital, which takes a forced admission patient exam one, so these practices are not independent exams. There is only the obligation to register the forced admission to the local government for a hospital manager and the local government only checks the paper form and no substance checks of forced admission.

The Revised ACT enforced from this April makes article 33 admission easier and any family members⁵ can agree to the admission but if he/she thinks that hospital treatments is not good or

⁵ Family member are not limited ones living with the patient but grandfather, aunt, any member can agree with the admission though he/she has not seen the patient for a long time

the hospitalisation is not necessary and wants to withdraw the agreement, it is impossible. The family member or the patient should complain to the Psychiatric Review Board for the discharge from the hospital.

Why does article 33 of the ACT require family member agreement?

There is no hearing system or proceedings of the person concerned with an independent body when forced admission starts.

In fact, there is a large disparity of the prevalence of forced admissions across different prefectures. This is the evidence which demonstrates how the forced admission is arbitrary detention⁶

The government claims that the Psychiatric Review Board (hereinafter PRB) is the third party and it works to check forced admission, so the ACT and its implementation do not violate Article 9 of ICCPR.

But PRB has no own independent office and staffs. Local government mental health and welfare centres take the role of the offices of PRBs so they are not an independent third party. Furthermore, all board members have another profession and especially psychiatrist members are employed by psychiatric hospitals.

Because of shortage of board members and staffs it takes one month to visit and hold a hearing of an inpatient after one appeals to the board even when one is subjected to restraint or seclusion.

The periodic examination is only a paper exam written by psychiatric hospitals where an inpatient is hospitalised and there is no hearing system for it.

There are less than 90,000 complain cases every year to PRB though there are some 300,000 inpatients. It tells us how inpatients' rights of free access to the PRB are violated, though it is forbidden by the ACT and also how they are not well informed of PRB or they know well PRB is

⁶ The number of new compulsory admissions per population by prefectures
Article 33 Over 3 times difference between the smallest and the largest
Article 29 Over 16 times difference between the smallest and the largest
The number of compulsory hospitalized inpatients per population by prefectures
Article 33 Over 4 times difference between the smallest and the largest
Article 29 Over 16 times difference between the smallest and the largest

not effective.

There is a 3% rate of successful appeals of involuntary hospitalisation and a 0.007% rate of discharge of the periodic examination of PRB.

In Japan seclusion and restraints set are practiced as if it was a routine work in the emergency ward and the number of use of restraint and seclusion are both increasing⁷.

Surprisingly, over 11% of the seclusion and over 15 % of the restrain are practiced to “voluntary admission patients” as of 30 June 2011.

Why are these treatments for “voluntary admission patients” overlooked? Because the PBR can review the treatments of voluntary admission patients, but it is not obligation so they are neglected and some old fashioned hospitals take “voluntary admission” form only to prevent paper works even though persons do not want to stay in hospitals. And also there is no independent monitoring system such as National Preventive Mechanism required by OPCAT.

MCPL

The government reply did not mention the forced admission by “Medical Care and Probation of Person who commits a seriously harmful act against another person in a state of insane or quasi-insane mind” (hereinafter MCPL).

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 better medical treatments and rehabilitation for the target people.

MCPL is the discrimination and indefinite detention system by forecast of subsequent offense and anyone cannot forecast future.⁸

⁷ The number of seclusion is increasing from 7673 cases in 2004 to 9283 cases in 2011, and the number of restraint is increasing from 5242 cases in 2004 to 9254 cases in 2011 as of 30 June 2004 and 2011 research by the government .There is no official data on how long people are subjected to seclusion or restraint, but some psychiatrists confess that there are inpatients who are subjected to restrain for over one year or locked up in seclusion rooms for over 10 years.

⁸ Target population: People with mental disabilities who committed the crimes of homicide, arson, robbery, rape, sexual assault or mutilation and were found to have “NGRI” (not guilty by reason of insanity)or were found to have “Diminished Capacity” and placed probation. Treatment is indefinite compulsory institutionalization to special hospitals or outpatient who is under

In this process, the due process clause in the Constitution article 33 and also in ICCPR article 9 does not apply. People who are sent to the 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.

MCPL makes the criteria of compulsory hospitalisation wider and longer than it by the ACT article 29 and 33. For instance, before the court decision people are almost always deprived of the liberty for examination and compulsorily hospitalised for 2 or 3 months, though there are no reasons as required by article 29 and 33 of the ACT.

Decision of discharge requires a conference to convene and members of it are not only hospitals staffs, but the probation office staff, the community health centre staff, the community service staff, the local government staff etc., so it is too difficult to have it frequently and in fact they can have the conference only every 3 or 4 months.

After the inpatient's psychiatrist thinks that it is the time to discharge, it sometimes takes over 2 or 3 months of waiting for the conference to convene. This waiting time never happens in the ACT system. And it is same to release out-patients from community treatments orders.

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 no longer needs hospitalisation. Article 29 and article 33 of the ACT require discharge when the psychiatrist decides there is no longer a need for hospitalisation in principle, and there is no party to stop the discharge except psychiatrists.

probation or conditional for 3 to 5 years.

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

Court decision; Decision makers are a psychiatrist and a judge in a district court and with an expert witness.

Replies of Japan to the list of issues in paragraph 94 to 98

Why there are many long term inpatients in Japan.

In the 60's the government adopted the policy to increase psychiatric hospital beds to protect society from "the dangerous mental disorder", then the beds in private psychiatric hospitals were rapidly increasing⁹ and many people have been compulsorily hospitalised. A big amount of beds and long stay inpatients have been created by the government policy.

Hospitalisation, especially forced hospitalisation by article 33 of the ACT destroys family relationship and if one is living in a flat and depends on social benefits and the term of hospitalisation reaches over 6 months, the government cuts the flat rent and he/she loses the flat.

Thus forced and/or long term hospitalisation easily destroys and deprives the individuals of the community living base and it is the main barrier to discharge from hospitals.

The Services and Supports for Persons with Disabilities Act is inclusive legislation for all people with disability and we appreciate it. But the government policy is problematic on three points.

One is that it puts too big weight to institutions as group homes and care homes. Many group homes and care homes are not based in the community and are run by psychiatric hospitals and some are located on the site of hospitals or beside hospitals.

The psychiatrists put as a condition of discharge that inpatients have to live in these institutions and to come to day care service in the hospitals after their discharge.

So users of these institutions cannot feel that they are discharged from the hospitals and some of them ask the staff when they could be discharged from hospitals or there are some cases that users of the group homes complain to the PRB for discharge.

The second is that the personal assistant service by the Services and Supports for Persons with Disabilities Act for people with psychosocial disability is very poor for independent living and the style of a personal assistant service is matched mainly for people with physical disability and it

⁹ From 1960 to 1980 psychiatric hospitals beds are increasing about 3 times.

does not match for people with psychosocial disability so it is very difficult to utilise and benefit from personal assistant services for people with psychosocial disability.

The third is that the budget for support of discharge from hospitals is poor, so it is very difficult for long stay inpatients to get adequate and effective support for discharge and it results in the deprivation of the liberty and right to choose where they would like to live independently or that they simply give up on being discharged from hospitals.

The special budget for support for discharge from hospitals and community living is 250 million USD, but over 86 % of it is spent on “Medical Care and Probation of Person who commits a seriously hurting act against other person in a state of insane or quasi-insane mind” and only 0.007 % of it put to support for discharge of long stay and older inpatients.

Another resource for support for discharge is from the Services and Supports for Persons with Disabilities Act, but it is too low fee to supporters and the community service to support for discharge is suffering from a shortage of budget

The Services and Supports for Persons with Disabilities Act was a good idea, but it does not have enough budgets allocated to it and therefore cannot work effectively.

The revised ACT has articles as the government reply paragraph 97 but social workers employed by hospitals cannot work as independent professionals. In many hospitals social work means to keep beds occupied and it is too difficult for them to support inpatients' discharge and decreasing hospitalisation.

Under these situations the government is now planning to change the wards of psychiatric hospitals to residential institutions and move long stay inpatients from hospital wards to this institution, by this policy the government can claim that there is a decreasing number of the psychiatric hospital beds and long stay inpatients and also owners of hospitals do not lose their own interests and can get money from the institutions. These institutions will be the terminal institutions for long stay inpatients and furthermore, they will create inmates again as psychiatric hospitals had made inpatients from the 60' to the 80'. It is now the biggest problem of human rights violation in the mental health area.

Conclusion

The problems within psychiatric hospitals *cannot be solved by adopting a law on mental health*, but by:

- adopting a comprehensive law on patient's rights based on non-discrimination and free and informed consent of the individual concerned;
 - abolishing forced detention and forced treatment and prohibiting treatment based on the consent of third parties, including family members, guardians or others;
 - strengthening monitoring systems to prevent and combat torture and ill-treatment, including in private hospitals and institutions;
 - investing and developing mental health community-based services and alternatives including for older persons;
 - increasing direct support to individuals (independent of their families) in the community including social welfare, housing support to individuals in the community and sufficient and effective personal assistant service;
- which should all be developed, implemented and monitored in close and meaningful consultation and direct involvement of people with psychosocial disabilities- nothing about without us!

Recommendations

Urgently stop the plan to change and rename the hospital wards to residential institution and move long stay inpatients from wards to them. This plan is the worst human rights violation.

Take immediate actions to ensure that all medical and psychiatric treatments and hospitalisation are based on the free and informed consent of the individual concerned and incorporate free and informed consent in a comprehensive law on patients' rights which is based on non-discrimination. In particular, ensure that there is education, training and awareness on free and informed consent to ensure that it cannot be provided by third parties such as family members, doctors, guardians or others.

Take steps to develop a policy and active strategy on deinstitutionalisation and remedy the stark deficit of community-based services and invest and allocate budget and resources into developing alternatives in the community with meaningful consultation and participation of persons with psychosocial disabilities.

Take immediate steps to abolish existing laws and practices to prohibit forced treatment and forced detention on the basis of disability, including all coercive and non-consensual measures such as non-consensual medication, restraint and solitary confinement, in conjunction with deinstitutionalisation policies. And ensure the independent monitoring, investigation of complaints and prosecution of forced acts including violence perpetrated within psychiatric hospitals and provide redress to victims.

Annex 1

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 World Network of Users and Survivors of Psychiatry(WNUSP) and we participated in the drafting process of CRPD with WNUSP at the international level and at the national level we joined the 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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<http://www.jngmdp.org/e/index.php?FrontPage>

Japanese website: <http://www.jngmdp.org/>

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

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

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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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 the hospital, I took a large 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 the 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 intention 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

Incidents involving Personal Injury and Abuse in Psychiatric Hospitals in Japan

Attorney at Law Yoshikazu Ikehara

1. Case Report on an Incident involving personal injury resulting in death in a psychiatric hospital

A thirty three year old involuntary inpatient who had been secluded was kicked stamped down on the head by a psychiatric nurse on January first in 2012. His cervical vertebra was fractured. His body under his neck was paralyzed. He went into cardiopulmonary arrest because of this injury on April 27th in 2014 and died the next day.

He had been diagnosed as having schizophrenia. He was involuntarily hospitalized on September 15th in 2011. He was locked into a seclusion room on September 22nd. He was restrained on his bed from September 29th to December 5th though he was transferred to a room for four inpatients during the period. He was secluded again on December 5th.

On January first two psychiatric nurses entered into his seclusion room to change his diaper. The two nurses tried to press down him and he seemed to resist against them. He struggled and his right foot hit one of the two nurses on the belly. The nurse stood up and walked toward to his head and kicked and stamped down him on the head.

He had been suffering from a gravely side-effect of antipsychotic drug, dystonia. His neck had contracted because of dystonia. His posture seemed to draw in his chin. He was turned face up and pressed down by the nurses.

One of the nurses stamped down him on the face. Another nurse pressed down him on the lower half of the body. Then his cervical vertebra was fractured.

On January second both of his legs were paralyzed. He did not walk around in the seclusion room as he had done before. He seemed to develop symptoms of dysuria, which one of typical symptoms that can be diagnosed as having a fracture of a cervical vertebra, during the day. However none of the staff of the hospital were concerned about probability of a fracture of his cervical vertebra.

On January third all of his arms and legs were paralyzed. He lost a deep tendon reflex, kneecap reflexes and Achilles' reflections. A psychiatrist supposed that he might have a fracture of a cervical vertebra. He was transferred to a general hospital by an ambulance in that late morning. An orthopedic surgeon of the general hospital he was transferred diagnosed that his cervical vertebra had been fractured and he was dying. He was treated in Intense Care Unite.

On January fourth he went into cardiopulmonary arrest. He fortunately recovered however he needed a tracheotomy to use a tracheal cannula and a tube feeding afterward.

He had weighed more than 70 kg. but was getting thin down to less than 30 kg. and growing weak.

On April 28th in 2014 he died at the age of 36 after he had gone into cardiopulmonary arrest again. He had never been able to move even on his bed after this incident.

He and his family filed a law suit against the psychiatric hospital on in 2013. The defendant excuses that the nurse just put his foot on the patient's head to stop his strong struggle. The defendant argues that the plaintiff can demand neither compensation for loss of earnings, since the patient would have never been able to work because of his grave schizophrenia nor compensation for future hospital fee, because the patient would have never been able to leave a hospital because of his grave schizophrenia, even if he had not been injured.

The court that deals with this case hesitates to hold an open court. The police once questioned the nurse but the police investigation has hardly proceeded. The competent authorities have not tried to investigate this case.

The video by an observation camera inside the seclusion room took the situation that the nurse kicked and stamped down the patient on the head. See Picture 1-2. And the two nurse tied to wipe up blood on the patient's face just after kicking and stamping down.

Two orthopedic surgeons, one was an orthopedic surgeon who treated the patient and another was a professor of orthopedics of a medical university, analyzed the same that the patient's cervical vertebra had been fractured by kick and stamp by the nurse and any other causes could not be found from January first to third inside the seclusion room, watching the video in that window.

There have been lots of incidents involving personal Injury and abuse in psychiatric hospitals in Japan. International Committee of Jurist visited Japan to recommend the government to take an effective action to protect and promote human rights for persons with psycho-social disabilities in late 1980s and 1990s. However numbers of incidents involving personal injury and abuse in psychiatric hospitals has not decreased so far.¹⁰

¹⁰See attached pictures how nurses kicked him and his injured face. The first three pictures from the record by the video camera in the seclusion room

2. Overview of Incidents involving Personal Injury and Abuse in Psychiatric Hospitals (Those incidents below picked up from newspapers, there could be huge numbers of incidents that did not report and come into light.)

1954 January; 6 inpatients died in the fire.

1955 June; 18 inpatients died in the fire.

1957 March; Niigata University operated a human experimentation on infection of Japanese river fever using 149 inpatients.

1968 March; sexual assault of female inpatients

December; 13 inpatients were hit by a bat and 1 died.

1969 February; A hospital got inpatients go to a building construction site to work to hide overcrowded situation of its rooms before an inspection by the authority.

June; 34 inpatients run away from a hospital and one of them committed a suicide and one of them died of illness.

July; A hospital offered a bribe to the authority to gather patients from slum areas.

August; 3 nurses hit an inpatient by a bat to die.

November; 6 inpatients died in the fire.

1970 May; A hospital forced inpatients work after mid night.

June; 17 inpatients died in the fire.

June; Half of inpatients, 52 inpatients, of a hospital cannot be found necessity of hospitalization by an inspection by the authority.

1971 February; 6 inpatients died in the fire.

1972 May; Some inpatients ran away from a hospital to evade involuntary ECT and forced labor.

A hospital ignored a request from an inpatient to let him leave a hospital and continued long term hospitalization.

An inpatient who committed a suicide had been bruised all over.

1973 April; involuntary lobotomy surgery

1975 July; A hospital forced inpatients work and exploited inpatients' disability pension.

1977 February; 3 inpatients died in the fire.

1980 January; A nurse injured an inpatient resulting to death.

September; A hospital exploited wages of ipatients.

1982 June; Two inpatients committed a suicide after they had been taken back from their escape.

1984 March; An inpatient were tortured to die. Abuses by a superintendent, Forced labor, an illegal dissection of a dead inpatient

So called "Utsunomiya Hospital Case", ICJ decided to inspect situation in Japan.

October; 8 inpatients died in the fire.

1985 April; A nurse hit an inpatient and fractured his skull.
July; An inpatients suddenly died unnaturally.
October; A superintendent exploited inpatients income and assets and hospitalize patients unnecessarily.

1986 May; Forced labor and illegal restraints
October; A hospital hided a inpatient's suicide.

1989 February; A nurse embezzled money from 57 inpatients.
May; An illegal hospitalization and restraint. A nurse operated ECT.

1992 June; Two inpatients died from ECT under illegal involuntary hospitalization.

1993 February; An inpatient died after a bodily injury.
September; An inpatient was bodily injured.

1994 April; Inpatients were randomly shot by an air gun. Illegal restraint
December; An inpatient died of carbon monoxide poisoning.

1995 November; A nurse embezzled money from inpatients.
December; An inpatient choke to death during restraint.

1996 November; A superintendent embezzled money from inpatients. Abuse

1997 February; Two nurses hit an inpatient's head against a wall. She died.

1998 July; Ex-staff embezzled money from inpatients.
September; An inpatient choke to death during illegal restraint.
November; An inpatient was bound to a tree in a hospital garden.
December; Two inpatients were secluded in a seclusion room and one of them died from bodily injury.

1999 February; 19 inpatients were died of influenza in overcrowded hospital rooms. Forced labor
November; A hospital made an inpatient to withdraw his application to request his discharge to the Psychiatric Review Board.

2000 May; An inpatient died from malpractice of a transfusion.
A nurse embezzled money from inpatients.
August; A nurse embezzled money from inpatients.
September; A nurse had sexual relationship with an inpatients.
A psychiatric social worker embezzled money from inpatients.

November; A psychiatrist unnecessarily operated intraventricular hemorrhage, IVH, on inpatients who could eat from their mouth. A doctor operated not in a operating room but in a patient's room. Illegal restraints

December; 12 inpatients were committed involuntarily without substantial necessity of hospital treatment.

2001 January; A patient choked to death during her involuntary conveyance to a hospital.
February; A nurse hit a inpatient by a golf club.
March; A staff embezzled money from inpatients.
August; Overcrowd situation of a hospital, illegal restraint, illegal restriction of an exit permit and communication with outside
December; An inpatient choked to death during seclusion and restraint.
A hospital did not tell a inpatient's family that she had died of unknown cause and their rejected request to meet her.

2002 January; An inpatient was strangled by somebody. Illegal work in a hospital
April; Seclusion without permission by a qualified psychiatrist
July; A nurse beat an inpatient to death.
August; 123 inpatients were infected O 157 and 9 inpatients died.
October; More than two inpatients were secluded in a seclusion room. Illegal restriction of communication with outside.
December; Illegal rejection against a request to leave a hospital from an inpatient

2003 April; Illegal rejection against a request to leave a hospital from an inpatient, illegal restriction of communication with outside, illegal restraint
May; A psychiatrist operated ECT to an inpatient who had cardiovascular disease. He died.
August; Illegal restraint, Overcrowd, Exploitation of inpatient's work
December; Exploitation of inpatients' work

2004 January; An inpatient went out from a hospital and froze to death.
February; 8 inpatients were infected tuberculosis.
June; A nurse embezzled money from 8 inpatients.
October; Staff who were not a psychiatrist prescribed medicine.
November; 4 inpatients had died from economy-class syndrome during a restraint.
December; 6 inpatients were infected tuberculosis.
November; An inpatient choked to death. Sexual assault by nurse

2005 February; A nurse injured an inpatient.
April; Sexual assault by a superintendent of a hospital
June; 6 inpatients were infected tuberculosis.
July; Two nurse hit a ten-year-old inpatient.
November; A nurse had sexual relationship with an ex-inpatient.
December; A psychiatric social worker embezzled money from an inpatient.
89 inpatients were infected norovirus.

2006 January; 47 inpatients were infected norovirus.
Forced labor, Recommendation on too long hospitalization with poor care by the

Local Bar Association

April; A psychiatrist raped an ex-inpatient using a soporific

June; An inpatient in a locked ward died in the fire.

A staff embezzled money from a inpatient.

July; A nurse injured an inpatient.

August; A nurse embezzled money from inpatients.

An inpatient choked to death.

September; A missing inpatient was found in a ward after four years but the body had reduced to bones.

A nurse stole an inpatient's bank card and withdrew money from his bank account.

October; A secluded inpatient died in the fire and four secluded inpatients suffered serious burns in the fire. Staffs of the ward did not open locks of seclusion rooms during the fire.

A staff embezzled money from inpatients.

A nurse embezzled money from eight inpatients.

November; A psychiatrist beat an inpatient with PTSD.

A case that a municipality involuntarily transferred a patient without any legal basis had been decided illegal by the District Court, but the Higher Court approved this transfer.

December; 112 inpatients were infected norovirus.

2007 January; 24 inpatients were infected norovirus.

A superintendent of a hospital hit an inpatient's head to a wall to injure when she asked him to perform informed consent.

February; A board and care institution that was not officially qualified put handcuffs on some inpatients and put others into cages.

A nurse injured an inpatient.

30 inpatients were infected norovirus.

April; 76 inpatients were infected norovirus. Two inpatients died. One of them choked to death under restrained condition.

May; A nurse embezzled money from two inpatients.

June; An inpatient stabbed another inpatient in the same room to death.

July; A nurse embezzled money from 13 inpatients.

November; An inpatient was found to be strangled on her bed.

An inpatient went into cardiopulmonary arrest after an injection of a sedative drug during conveyance. He died after a year.

December; 53 inpatients were infected norovirus.

A nurse hit an inpatient on the head to death.

2008 February; An inpatient hit another inpatient in the same room to death.

April; 64 inpatients were infected pneumococci and four of them died.

June; A secluded inpatient died from poisonous smoke in the fire. Staffs of the ward did not open the lock during the fire.

August; A nurse beat an inpatient on the face.

November; A nurse twisted an inpatient's arm to be broken.

December; A superintendent of a hospital was stalking an ex-inpatient and sent blackmails.

He was arrested.

An inpatient who had been restrained illegally went into gravely physically ill. He died after he had been transferred to a general hospital.

A nurse injured an inpatient.

18 inpatients were infected norovirus.

2009 March; An inpatient died from a traumatic enterorrhexis.

VIEWER

KDB Viewer



02
2012/01/01-16:14:12-211

TOA

2012/1/24
17:09:28

年 : 2012
月 : 01

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22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

時 : 16
分 : 14

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カメラ 1																								
カメラ 2																								
カメラ 3																								
カメラ 4																								

スキップ

スピード



Kicking on the head
Recorded by the video
camera in the seclusion
room

VIEWER

KDB Viewer



2012/1/24
17:04:06

年 : 2012 ▲▼
月 : 01 ▲▼

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29	30	31	1	2	3	4
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時 : 16 ▲▼
分 : 14 ▲▼

Stamping on the head

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カメラ 1	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
カメラ 2																								
カメラ 3																								
カメラ 4																								

Control panel with various icons for camera management, including zoom, pan, and speed controls.

スキップ (Skip) ▲▼
スピード (Speed) ▲▼

Navigation buttons: Home, Previous, Play, Next, Stop, Full Screen, Power.

VIEWER

KDB Viewer



2013/09/11
09:58:23

年 : 2012
月 : 01

日	月	火	水	木	金	土
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22	23	24	25	26	27	28
29	30	31	1	2	3	4
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時 : 16
分 : 16

Wiping up blood on the face

00 01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23

カメラ	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23
カメラ 1																								
カメラ 2																								
カメラ 3																								
カメラ 4																								

Navigation and control panel with various icons for zoom, pan, and playback.

スキップ スピード



injured face