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THE SOCIAL MOVEMENT OF PEOPLE WITH PSYCHOSOCIAL DISABILITIES IN JAPAN

Strategies for taking the struggle to academia

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Origin and nature of movements

The first aim here is to set out the histories of social movements of people with psychosocial disabilities in Japan. These movements originated in the 1960s and gradually became more active. A national organization was first established in the 1970s.

A key reason why the movements became active was the existence of student movements developed by students in medical departments. Especially in western Japan, after medical students declared their support for anti-psychiatry and called for the reformation of psychiatry obtained their doctor’s license and were subsequently assigned to a mental hospital, they organized self-governing groups of patients and supported patients’ discharge. The Japanese government had promoted a policy to increase the number of beds in mental hospitals after World War II. Subsequently, long-term hospitalization and abuses in institutions became serious problems in the second half of the 1960s. The government, however, did not take any measures to address this and, finally, after 2000, budgetary measures for the reduction of the number of beds and community transition began to be taken. Thus, the discharge of long-term inpatients in western Japan from around 1969 continued uncertainly, without a systematic basis.

In Japan, over 90% of residences are located in the private market, and the custom is that renters’ family members need to cosign lease contracts. However, most people with psychosocial disabilities who have no relatives are unlikely to have a cosigner. People who could not rent these residences because of such circumstances have had no other choice but to live in areas where residences do not have strict conditions for renting. Many people with psychosocial disabilities settled in these areas after their hospital discharge and naturally interacted with one another. For example, they visited one another’s homes. Around 1969, people with psychosocial disabilities had very few social resources in their community. When they were
not feeling well, peers living nearby offered them lodging and cared for them. In this way, communities of persons with psychosocial disabilities helping one another were gradually created in these areas.

In one such area, a learning group for citizens called *Osaka kibo no kai* (group for hope in Osaka) was established mainly by student movements. Persons with psychosocial disabilities were influenced by the learning group and started their own unique activities. Shiro Nishiyama, who lived in the area, established an organization of people with psychosocial disabilities, called *Tomoshibi kai* (Group of Lamplight), based on his painful inpatient experiences. He also joined *Osaka kibo no kai*. He then rented an apartment in 1973 and started to host *Shabette tomaru kai* (Group to Talk and Stay Together) where people with psychosocial disabilities from eastern and western Japan could be together at weekends (Nishiyama, 1995).

Around this time, mental hospital inpatients started other unique activities that were different from the activities in communities. In 1970, some mental hospital inpatients who worked at companies out of the hospitals in rehabilitation schemes in daytime and slept in the hospitals at night, demanded wage increases for outside working, seeing it as a labor or employment issue. Reformist psychiatrists developed cooperative relationships with the labor unions of nurses and other mental hospital staff members. The labor union eventually came into contact with inpatients who demanded wage increases for outside working. Subsequently, people with psychosocial disabilities decided to set up their own organization to represent inpatients. The first self-governed group of inpatients in Japan was established in 1972. This group began to express opinions on the improvement of mental hospitals and legislation (Editorial Committee on the Histories of Iwakura Hospital, 1974). Such activities in and out of hospitals were also initiated in other areas of Japan and spread widely.

The Japanese government introduced an amendment to the Penal Code in May 1974. This included security measures that aimed to prevent crime among people with ‘mental illness’ who were recognized as not having criminal responsibility. It was the first government action to systemize the legislation of security measures, and it was met with an outcry from people with psychosocial disabilities, psychiatrists, lawyers, and labor unions. In 1973, shortly before the drafting of this bill was completed, an open letter titled “Let persons with psychosocial disabilities get together to protest against security measures” written by a person with psychosocial disabilities was published by a major newspaper company. People got together as a response to this call and established the *Tomo no kai* (Group of Friends) in the same year (Yamada, 1974). Since then, people with psychosocial disabilities have sought to form a national organization and develop a movement against such security measures. Finally, *Zenkoku ‘seishin-byo’ sha shudan* (Japan National Group of Mentally Disabled People (JNGMDP), was established as the first national organization of people with psychosocial disabilities in May 1974 (Higashikawa, 1974). I write as a member of this organization.

Since its foundation, JNGMDP has argued against security measures, called for the abolition of the Mental Health Act, and protesting against damage from psychiatric practice. JNGMDP was less interested in making accusations against medical malpractices in individual hospitals, than in criticizing psychiatry itself. This objective is reflected in the name of JNGMDP, in which “seishin-byo (mental illness)” is enclosed in quotation marks to represent doubt in the very idea of “mental illness.” The organization called for the participation of people who had histories of mental hospital admission based on the diagnosis of mental illness, without questioning whether the person actually had mental illness. In addition, the members of JNGMDP, who had had experiences of being excluded due to deviance from the regulated norms of organizations, thought that their group of people with psychosocial disabilities should not exclude others based on such organizational principles. Therefore, JNGMDP adopted a form of group that
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was different from both traditional communal societies and organizations; it did not have an instruction system, and did not establish bylaws nor elect representatives. The decision-making of JNGMDP as a group was not made by majority voting of the executive, but basically by mutual consent of members who gathered at the group’s office. JNGMDP, however, was active not as an aggregation of individuals but as a group. JNGMDP intended to avoid the risk of their complaints being medicalized. This was because when concrete harm is experienced in mental health systems, allegations from individuals with psychosocial disabilities are often regarded as delusionary and dismissed as meaningless.

From its establishment, JNGMDP has been managed solely by people with psychosocial disabilities. To provide such mutual help, JNGMDP has relied on public assistance for individual members and the wages of leaders as their main financial resource. This has meant that they have had a vulnerable, but stable, financial basis because the amount of public assistance in Japan has been comparatively larger than that in other countries. Actually, many members had jobs. Therefore, the cost of mutual help could not be judged as fully covered only by public assistance in a wholesale manner. Members could cover at least their daily costs using public assistance and did not have to request financial assistance from patient groups. Their main activities included providing mutual help, in which people with psychosocial disabilities invited their peers to their own house and cared for them. Subsequently, some members found it necessary to have a place for getting together, and they would call for donations and get such places.

Thus, the groups of persons with psychosocial disabilities in Japan were not forced to demand financial assistance from the government and did not have to introduce relationships as providers and clients among members. Moreover, their activities were variable, without fixed service menus. Most of the activities were independent and voluntary and did not need to develop a well-organized service system.

Claims-making on security measures and the Mental Health Act

The government’s plan to set up security measures in the Penal Code was decided on May 29, 1974. The provisional draft of the bill for revising the Penal Code, opened in April 1940, provided four types of security measures: labor measures to correct the work behavior of vagrants and people who were seen as averse to work, preventive measures to detain people who had committed serious crimes, custodial measures for people diagnosed with mental illness and with hearing and speech impairment, and corrective measures for people with addiction to alcohol and anesthetic drugs. In the discussion on the bill, some security measures had to be deleted or changed, and finally, only security measures to prevent recidivism among “persons who had caused serious cases under the condition of insanity” were adopted. Mass movements against the security measures were staged by well-known intellectuals, labor unions, and citizens. The Criminal Affairs Bureau of the Ministry of Justice summarized the movements as criticisms against the growth of state power (Criminal Affairs Bureau of the Ministry of Justice, 1974).

The Japanese Society of Psychiatry and Neurology, an organization of psychiatrists, argued that the security measures provided in the bill of the Penal Code were inapplicable to psychiatry, because it was impossible for health care to foresee offence and for treatment to prevent repeat offences. The Society also argued that health care exists for the benefit of patients, and giving priority to the public while excluding patients under medical treatment is contrary to the main principles of medicine (Japanese Society of Psychiatry and Neurology, 1972, 1974a, 1974b). The Japan Federation of Bar Associations, an organization of lawyers, argued that the establishment of the security measures represented the expansion of punishment rights by destroying the principle of no punishment without law, and that discussions were not enough, noting
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the lack of national participation despite the Bill’s profound influence on the entire nation. In addition, the Federation stated that mental impairment is the reason for the repeat offences of specific persons with mental illness, and argued that enrichment of psychiatry was needed more than revision of the law because repeat offences could be prevented by the treatment of mental illness. They further argued that the enrichment of psychiatry would prevent the first offence, while revision of the Penal Code would only be able to prevent repeated offences. Based on these arguments, the Federation demanded that the Ministry of Health and Welfare revise the Mental Health Act (Japan Federation of Bar Associations, 1974, 1981a, 1981b, 1982).

In contrast, JNGMDP opposed the security measures and the Mental Health Act, on the grounds that they were discriminatory. They referred to their own humiliating experience of forced hospitalization under the Mental Health Act, and judged the security measures as having the same problem as the Mental Health Act in terms of the possibility of detention on the basis of “mental disorder.” They also argued that the security measures were founded on discriminatory beliefs that looked upon people with mental disorders as people with criminal predispositions. Discriminatory belief is thus a belief that links mental disorders to offences, considers persons with mental disorders as offenders and other people as victims, and alienates persons with mental disorders, in spite of the possibility of any person becoming an offender and having mental impairment in the future. Such a belief undermines people’s ability to consider the security measures as something that could affect them. People with psychosocial disabilities believed that each citizen could be persuaded that the security measures were their concern too by sharing their experiences of forced hospitalization under the existing Mental Health Act as a precedent for the security measures. They warned that anyone could become a person with mental disorder and be detained as a result (JNGMDP, 1977, 1981). In summary, the JNGMDP believed that perceptions of affinity and exclusion that draw boundaries between persons with mental disorders and other people privileged the security measures in the Penal Code and forced hospitalization in the Mental Health Act. Thus, they opposed both security measures in the Penal Code and forced hospitalization in the Mental Health Act because they saw these as promoting discrimination and exclusion.

Pioneer of international activities

Deliberations in the Japanese parliament, the Diet on the Bill on security measures in the Penal Code drafted by the government in 1974 were postponed because of opposition by psychiatrists, lawyers, labor unions, lawyers, and people with psychosocial disabilities. Discussions to legislate security measures restarted in 1980, triggered by a case of arson by a person who had a history of being hospitalized in a mental hospital. The main point of the discussion was the conflict between the Ministry of Justice, which sought to revise the Penal Code and establish security measures, and the Japan Federation of Bar Associations, which aimed to prevent persons with mental disorders from committing crimes by revising the Mental Health Act and enriching psychiatry. The Japan Federation of Bar Associations prepared a report of their visits to the United Kingdom, which has a system of high-security psychiatric hospitals in their Mental Health Act, and a suggestion to revise the Mental Health Act in Japan (Special Committee for Revision of the Penal Code and Committee for Protection of Human Rights of the Daini Tokyo Bar Association, 1982).

Discussions between the Ministry of Justice and Japan Federation of Bar Associations continued with an additional focus on whether legalization of the security measures should be achieved by the revision of the Penal Code, revision of the Mental Health Act, or establishment of independent law on social welfare. Suddenly, the discussions were halted in March 1984
after the incident known as the Utsunomiya Hospital Scandal became public. Reports revealed
that nurses at Utsunomiya Hospital brutally beat and caused the death of two mental hospital
inpatients. The scandal attracted wide attention as an issue of human rights in mental hospitals,
later influencing the revision of the Mental Health Act (Yasui, 1984, 1986).

Meanwhile, political abuse in relation to psychiatry in the former Soviet Union was revealed
as problematic by the World Psychiatric Association from the second half of the 1970s to 1983,
when the Soviet Psychiatric Association withdrew from the World Psychiatric Association
in a tumultuous manner. This incident shed light on the problems with human rights in
psychiatric practice, not only in the former Soviet Union, but worldwide. Subsequently,
the momentum to establish international principles on mental health increased. The Sub-
Commission on the Prevention of Discrimination and Protection of Minorities within the
UN Human Rights Committee nominated Erica-Irene Daes as special rapporteur. Principles
in relation to mental health began to be drafted on September 10, 1980. The Principles,
Guidelines and Guarantees for the Protection of Persons Detained on Grounds of Mental
Ill-health or Suffering from Mental Disorder (UN Doc. E/CN.4/Sub.2/1983/17), drafted
by the Sub-Commission and known as the Daes draft, were published on August 31, 1982.
The Daes draft was designed to eliminate arbitrary decisions in psychiatry via due process
and fair judgment. The International Commission of Jurists, an international organization of
lawyers, was involved in drafting the Daes draft and took the initiative in promoting its legal
model. The World Psychiatric Association, however, pointed out that the Daes draft would
make it possible for the state to control the relationships between patients and medical staff
by introducing due process, and criticized the Daes draft for opening a door to potential political
abuses of psychiatry by the state. They recommended a medical model that gave discretion to
medical professionals.

In response to the Utsunomiya Hospital Scandal, the International Commission of Jurists
sent a letter to the Prime Minister of Japan in May 1984 to request that the government estab-
ish an independent committee to examine the treatment of persons with mental disorders and
related legislation. The Japanese government did not reply to this letter. Then in September
1984, the International Commission of Jurists dispatched a joint investigation team to Japan,
in cooperation with the World Health Professions Alliance. This team interviewed some
organizations related to the hospital scandal, including the JNGMDP. The investigations
were summarized in a report and published by the Sub-Commission on the Prevention of
Discrimination and Protection of Minorities. The “Conclusion and recommendation” of
the report included a request to revise the Mental Health Act immediately, stipulating the
processes of hospitalization, and providing legal and judicial protections to inpatients. Hidesuke
Kobayashi, chief of the Mental Health Division of the Ministry of Health and Welfare, in
attending the 38th conference of the Sub-Commission on the Prevention of Discrimination
and Protection of Minorities in Geneva on August 21, 1985, promised revision of the Mental
Health Act by saying “We will revise the Mental Health Act with the aim of protecting the
of the International Commission of Jurists was carefully prepared by them to impress the legit-
imacy of the legal model in the drafting of the principles of mental health.

JNGMDP expressed their rejection of the principles through the Disabled People’s
International, established in 1981, at the Sub-Commission on the Prevention of Discrimination
and Protection of Minorities. As there was no international organization of persons with psy-
chosocial disabilities at the time, Disabled People’s International was a suitable organization
to express opinions internationally from the position of people with disabilities. JNGMDP
expressed their opinions from the viewpoint of people with disabilities themselves and criticized
adversely the way forced hospitalizations were made possible by due process or the judgment of a doctor. This report of the JNGMDP to the International Commission of Jurists attracted attention as the world’s first opinion from persons with psychosocial disabilities themselves (JNGMDP, 1990). However, such opinions had little influence on the drafting of the principles because the conflicts between the International Commission of Jurists’ legal model and the medical model of the World Psychiatric Association dominated the discourse.

A statement of Principles and Guarantees for the Protection of Mentally Ill Persons (UN Doc. E/CN.4/Sub.2/1984/19), known as the Palley draft, was submitted to the Sub-Commission on the Prevention of Discrimination and Protection of Minorities on September 2, 1988. The Palley draft put more emphasis on medical paternalism compared with the Daes draft. Subsequently, discussions were held and the draft was continually revised. The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (UN Doc. A/Res/46/119) were adopted at the UN General Assembly in December 1991. The adopted principles included some conditions that justified involuntary admission on the basis of mental disorders.

The World Federation of Psychiatric Users was established in 1991, and so the first international organization of people with psychosocial disabilities was born (World Federation of Psychiatric Users, 1991). The WFPU became a member of the monitoring committee of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (UN Doc. A/Res/48/96), and was then involved in the establishment of the International Disability Alliance. It changed its name to the World Network of Users and Survivors of Psychiatry (World Network of Users and Survivors of Psychiatry, no date), and subsequently played a large role in drafting the Convention on the Rights of Persons with Disabilities from the viewpoint of a social/human rights model. The Convention on the Rights of Persons with Disabilities (UN Doc. A/Res/61/106) recommends state parties to take measures to prohibit the deprivation of liberty and restriction of legal capacity on the basis of disability.

**Blocking the revision of the Mental Health Act**

In July 2016, a former staff member at an institution for persons with disabilities in Sagamihara City, Kanagawa Prefecture, killed 19 residents. The suspect, now a death-row inmate, was later revealed to have carried out the murder because of his belief that “the life of persons with disabilities has no use.” The mass media, however, focused on his history of forced hospitalization in a mental hospital and consecutively aired many sensational reports.

I believe that the incident occurred because of policies that gathered and isolated people with disabilities in institutions and that the problems of institutions are similar to problems of forced hospitalization. Institutions make society one without persons with disabilities by placing people with disabilities in separate designated places. As a result, many people lose the chance to meet people with disabilities and tend to internalize the prejudice that people with disabilities are powerless. Likewise, forced hospitalization deprives people of the chance to meet persons with psychosocial disabilities and aggravates the prejudice that persons with psychosocial disabilities are dangerous. Such a chain of exclusion reinforces false beliefs about such offenders (see the incident in Sagamihara City). Strengthening forced hospitalization is only likely to prevent true resolution. However, revision of the forced hospitalization policy was strongly promoted, according to the intentions of the government. Subsequently, the government submitted a Bill for the amendment of the Mental Health Act, which included provisions to monitor persons with psychosocial disabilities by police after discharge from forced hospitalization (Kirihara, 2017).
When JNGMDP started its movement to oppose this Bill, no one had been protesting against it. Nonetheless, we in JNGMDP, decided to treat this situation as a good opportunity to showcase the power of persons with psychosocial disabilities, especially if such movements of people with psychosocial disabilities could lead to obstructing the passage of the Bill to revise the Mental Health Act. We carefully prepared and formulated detailed strategies. First, JNGMDP requested that the message, “Do not replace the issues relating to the incident with matters directed at forced hospitalization” was explicit in resolutions and programmes of events relating to the incident in Sagamihara City, undertaken in cooperation with organizations of people with disabilities. Second, JNGMDP continued to voice opinions to the Ministry of Health, Labor and Welfare, request action from organizations of mental health professionals and lawyers and, lobby against the Bill in the Diet. After the Bill was put on the agenda, JNGMDP was involved in activities in the Diet that aimed to make the position of opposition parties against the Bill at the examinations of bills at Policy Research Councils, send people with psychosocial disabilities as witnesses to the committee for the deliberation on the Bill, and demand circumspect deliberation while preparing to submit a supplementary resolution. We concentrated our biggest efforts on developing theories to oppose the Bill. Consequently, most opposition parties took positions against the Bill, and JNGMDP succeeded in sending their member to the Diet as a witness. Deliberations on the Bill to revise the Mental Health Act were confusing, took a long time, carried over to the next session, and finally the Bill was abolished. The government intended to put out a Bill to revise the Mental Health Act again in the next session without changing the contents of the previous bill. JNGMDP, however, lobbied the ruling parties intensively against the Bill on a daily basis. As a result, the government gave up putting the Bill on the agenda. The Bill fell into a situation where it could not be put on the agenda without having its contents changed, though the situation was called a deferral state (Kirihara, 2020).

Joint, tense relations and conflicts between research and movements

In July 2017, the Japanese government released “Guidelines to ensure the provision of high-quality and appropriate medical care to persons with mental disorders” and formally institutionalized the role of peer supporters of persons with psychosocial disabilities. The preamble of the guidelines states as follows:

The government promotes peer support, such as mutual supports by exchanges among persons with mental disorders, promotes developing independent relationships of persons with mental disorders and their families by supporting the families, who closely support persons with mental disorders, and pushes forward activities to prevent isolation from society.

(Ministry of Health, Labour and Welfare, 2014)

I believe that the government’s systemization of peer support has overall been positive, but the definition of peer support was changed after the systemization. Currently, peer supporters described by the government refer to persons with psychosocial disabilities who are employed by mental health and welfare offices. Therefore, mutual help in social movements of persons with psychosocial disabilities is being stripped from the meaning of peer support. The belief that only persons with psychosocial disabilities who are employed by mental health and welfare offices are accepted as peer supporters is problematic because it precludes as peer supporters those organizations of persons with psychosocial disabilities, which are involved in the domestic
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Implementation of the Convention on the Rights of Persons with Disabilities and lobbying against the revision of the Mental Health Act. In addition, “recovery” is described as the adjustment of people to society, through treatment and rehabilitation and the goal of care in the field of care management.

There is no doubt that peer support and recovery were innovations that had their origins in the social movements of people with psychosocial disabilities. In Japan, however, the meanings of peer support and recovery have been increasingly undermined. They have been deconstructed to become concepts shaped by the medical models of medical professionals, as in many other countries. Meanwhile, movements of people with psychosocial disabilities have tended to explain abstractly the concepts of peer support and recovery. For example, recovery has been explained in terms of “self-definition,” “having hopes,” and “beliefs different from psychiatry.” These explanations are unfortunately problematic as they leave room for arbitrary interpretation and distortion. Movements of people with psychosocial disabilities cannot progress with only passion. It is necessary to prove our uniqueness by putting into clear words the differences between our definitions and those of mental health professionals. Without such clarification and verbalization, we cannot differentiate our ideas from others’, and the ideas will remain vulnerable to becoming distorted by professionals. I believe that the academics should help to put the ideas of movements into words and play a part in preventing the movement of persons with psychosocial disabilities from being distorted by professionals.

Ways forward

Movements of persons with psychosocial disabilities in Japan tend to be critical of academia. The criticism comes from misgivings that when they cooperate in research, it is the contribution and influence of researchers that increases, whereas their own circumstances do not improve. Such criticisms are often too passive for activists, because the main actors to change society should be social movements. Societal change should not be left to researchers. Activists need to have their own code on how they use academia and realize the desires of their movements. In particular, movements of people with psychosocial disabilities should pay the most careful attention to research to create evidence for national policy and this is a field where activists and academics should work together. Activists need to use academia effectively.

Activism and the academia are separate things. However, they are not necessarily caught in dualism, because the latter should involve the former in tackling issues of disability within its structures. Some academics promote a social/human rights model against the prevailing traditions of academia, in which the medical model is dominant and are involved in social movements to change academic society. Moreover, many academics who are involved in such social movements are persons with disabilities themselves.

I am involved in both social movements and research and comply with the criteria of the social/human rights model in both fields. Activities must be pushed forward, based on the achievements of histories of movements of persons with disabilities and in accordance with the social/human rights model.

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