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PSYCHIATRIC COMMITMENT IN JAPAN: INTERNATIONAL CONCERN AND DOMESTIC REFORM

Pamela Schwartz Cohen†

I. INTRODUCTION

A. OVERVIEW

Psychiatric commitment is one of the most sensitive and complex policy issues confronting any government. Legislating or adjudicating in this area is like juggling on a tightrope; the acrobat must balance the interests and realities of law, psychiatry, politics, and culture, while walking a precarious line between protecting human rights and safeguarding against the potentially devastating effects of mental illness. The manner in which this balancing act is accomplished will depend on the characteristics of the juggler and the nature of the issues being juggled. A successful performance in one setting may be unpopular or unworkable in another.

In promulgating the Mental Health Act of 1987 ("1987 Act"),¹ the Japanese government overhauled its approach toward the balancing act of psychiatric commitment. The 1987 Act provided for the first time in Japan's history a legislative scheme for

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1. English translations of provisions of the 1987 Act and regulations promulgated thereunder (including the Psychiatric Review Board Manual) are from the unofficial translation published by the Mental Health Division of the Health Service Bureau of the Ministry of Health and Welfare of Japan (1988).

protecting the legal rights of psychiatric patients.² Among other reforms, the 1987 Act instituted the Psychiatric Review Board ("P.R.B.") system of tribunals to monitor psychiatric patients' hospitalization and to hear patients' requests for discharge and complaints about their treatment.

In April 1992, the International Commission of Jurists sent the last of three missions to Japan (the "1992 [I.C.J.] mission") to evaluate that country's protection of the legal rights of psychiatric patients. This author was a member of the 1992 mission,³ which studied the P.R.B. system among other aspects of Japanese mental health law. This Article draws upon the findings of that mission, as well as the author's independent research,⁴ to describe the P.R.B. system and to evaluate it in its own cultural context as well as in relation to international standards of human rights.

B. HISTORICAL CONTEXT: JAPANESE MENTAL HEALTH LAW AND PSYCHIATRIC TREATMENT PRIOR TO 1987

Japanese mental health law prior to 1987 is best characterized in the negative. There were virtually no substantive laws protecting psychiatric patients' rights or procedures by which patients or prospective patients could challenge their commitment or their treatment.⁵

2. For a comprehensive discussion of the 1987 Act and its protection of psychiatric patients' rights, see Stephan M. Salzberg, *Japan's New Mental Health Law: More Light Shed on Dark Places?*, 14 INT'L J.L. & PSYCHIATRY 137 (1991).

3. The first two I.C.J. missions took place in 1985 and 1988 and are discussed *infra* notes 27-32, 42-44, and accompanying text. The other members of the 1992 mission, with whom it was my pleasure and privilege to work, were: Dr. Timothy W. Harding, Head of the Division of Legal Psychiatry at the University Institute of Legal Medicine, Geneva; Niall MacDermot, Q.C., formerly Secretary-General of the International Commission of Jurists, Geneva; and Dr. Harold M. Visotsky, Professor and Chairman, Department of Psychiatry and Behavioral Sciences, Northwestern University Medical School, Chicago, Illinois. The 1992 mission's conclusions and recommendations are set forth in its report, INTERNATIONAL COMMISSION OF JURISTS, HUMAN RIGHTS OF PSYCHIATRIC PATIENTS IN JAPAN: MISSION RECOMMENDATIONS (1992) (on file with the PAC. BASIN L.J.) [hereinafter 1992 I.C.J. REPORT].

4. Except where the 1992 I.C.J. mission or its recommendations are directly cited, the opinions contained herein are the author's own and do not necessarily reflect the views of the other members of the mission or the International Commission of Jurists. Facts reported herein, when not attributed to other sources, are drawn from the author's own research both as a member of the 1992 I.C.J. mission and as Visiting Scholar at Sophia University.

5. For detailed discussions of the historical development of mental health care, law and policy in Japan, see Salzberg, *supra* note 2, at 144-49; Timothy W. Harding, *Ethical Issues in the Delivery of Mental Health Services: Abuses in Japan*, in PSYCHIATRIC ETHICS, 474-78 (Sidney Bloch & Paul Chodoff eds., 2d ed. 1991); E. Totsuka, *The History of Japanese Psychiatry and the Rights of Mental Patients*, 14 PSYCHIATRIC BULL. 193 (1990); TIMOTHY W. HARDING ET AL., HUMAN RIGHTS AND MENTAL PATIENTS IN JAPAN 8-14 (1985) [hereinafter "1985 I.C.J. REPORT"].

Psychiatric patients in Japan have historically been viewed as "outsiders" (*yosomono*), ostracized by their families and isolated from their communities.⁶ In the pre-World War II era, people with mental disabilities were treated more as pariahs than as individuals or patients:

Mental illness was regarded as genetic, incurable, impossible to understand and dangerous, namely one of the worst diseases. As a result, the mentally ill were thought to be a disgrace to the family. The Japanese did not want to talk about them, did not want to see them, to hear about them, to get married to them, and did not want to employ them. Japanese families hid these mentally ill relatives in a cell at home or in a mental hospital. Even conscientious doctors and families thought mental patients would be happier in remote asylums rather than in the community. Thus, concern about public safety took precedence over patients' rights.⁷

The Mental Hygiene Act of 1950 ("The 1950 Act"),⁸ the precursor to the 1987 Act, replaced the prevailing practice of private incarceration with custodial institutional care. Psychiatric care in Japan has been characterized by long stays on mostly locked wards in overcrowded facilities, with little opportunity for therapeutic treatment.⁹ The legacy of Japan's historical treatment of mental disabilities lives on,¹⁰ with stays in psychiatric hospitals still averaging among the longest in the world.¹¹

The isolation and institutionalization of individuals with mental illness in Japan has created a "race of hospital people" who are stigmatized and discriminated against by the rest of soci-

6. Tsunetsugu Munakata, *Sociocultural Background of the Mental Health System in Japan*, in 10 *CULTURE, MED. & PSYCHIATRY* 351, 352-61 (1986). For historical overviews of mental health care in Japan, see also K. Koizumi & P. Harris, *Mental Health Care in Japan*, 43 *HOSP. & COMMUNITY PSYCHIATRY* 1100 (1992); 1985 I.C.J. Report, *supra* note 5, at 10; Salzberg, *supra* note 2, at 145. The ostracism of the mentally ill from their families is particularly isolating in a society like Japan's, where individuals are largely defined by their membership in groups, and families provide a critical social network. Totsuka, *supra* note 5, at 363.

7. Totsuka, *supra* note 5, at 194.

8. For a detailed discussion of the 1950 Mental Hygiene Act, see Salzberg, *supra* note 2.

9. For discussions of conditions in Japanese psychiatric hospitals prior to the 1987 Act, see Munakata, *supra* note 6; Salzberg, *supra* note 2, at 139-42; Harding, *supra* note 5, at 474-84; Totsuka, *supra* note 5, at 195; LAWRENCE GOSTIN, *HUMAN RIGHTS IN MENTAL HEALTH: JAPAN* 13-15 (1987).

10. See, e.g., Totsuka, *supra* note 5, at 194.

11. See Munakata, *supra* note 6, at 352-57; Koizumi & Harris, *supra* note 6, at 1101-02. The long average length of stay has been explained by cultural expectations that psychiatric patients will sever ties with their communities and regard the hospital as their home, as well as by the profit motive of private hospitals. Munakata, *supra* note 6, at 357-64.

ety.¹² The virtual invisibility of patients once they are committed, combined with a lack of incentive on the part of private hospitals and the government to improve conditions and provide adequate treatment, has perpetuated an "effective absence of public responsibility for the welfare of the mentally ill."¹³ This, in turn, has increased the risk of abuse against patients.¹⁴

Mental health legislation prior to 1987 did little to protect people with mental disabilities from abuse and neglect. The 1950 Act eliminated the longstanding practice of incarceration at home and gave psychiatric hospitals the full responsibility of caring for people with mental disabilities.¹⁵ However, the law made no attempt to regulate or provide mechanisms for monitoring the conditions of patients' hospitalization or treatment.¹⁶ Furthermore, the 1950 Act provided no means by which patients or prospective patients could challenge their commitment or initiate discharge proceedings on their own.¹⁷ Other legal avenues such as habeas corpus, civil litigation, and administrative procedures also failed to provide effective procedural opportunities for individuals to initiate review of their own commitment.¹⁸

The powder keg of unchecked institutionalization finally exploded in March 1984, when staff members brutally beat to death two inpatients at Hotokukai Utsonomiya Psychiatric Hospital outside of Tokyo.¹⁹ Investigations by local authorities uncovered inhumane living conditions, chronic and severe understaffing, regular interference with patients' mail and meetings with visitors, as well as serious forms of corruption and abuse at the hospital.²⁰ These investigations also revealed that 222 deaths had occurred at the hospital in the years 1981 through 1984—only 27 of which could be accounted for by death certificates and police records.²¹

12. Munakata, *supra* note 6, at 362. See also Salzberg, *supra* note 2, at 153. There are still over 400 national, prefectural and local laws and regulations which discriminate against those with mental illness. Harding, *supra* note 5, at 487. See also 1992 I.C.J. REPORT, *supra* note 3, at 12; GOSTIN, *supra* note 9, at 15-17.

13. Salzberg, *supra* note 2, at 144.

14. *Id.* at 139-40.

15. *Id.* at 148.

16. *Id.* at 148, 157-59.

17. Salzberg, *supra* note 2, at 158. See also Kazuo Itoh, *On Publication of the "Citizens' Human Rights Reports"*, 20 L. JAPAN 29, 44 (1987). Under the 1950 Act, only the prefectural governor could initiate an external review of the necessity of a patient's commitment, and only pursuant to the procedures specified in the statute. Salzberg, *supra* note 2, at 158.

18. Itoh, *supra* note 17, at 44-47. See also Salzberg, *supra* note 2, at 143; GOSTIN, *supra* note 9, at 8; 1985 I.C.J. Report, *supra* note 5, at 77-78.

19. For details of the "Utsonomiya incident," see Salzberg, *supra* note 2, at 141.

20. See *id.*; 1985 I.C.J. Report, *supra* note 5, at 18.

21. 1985 I.C.J. Report, *supra* note 5, at 16.

Although isolated incidents of abuse against psychiatric patients had surfaced in previous years,²² the Utsonomiya incident was the first to draw widespread media attention and public concern.²³ Despite the disturbing findings of local investigations, the national government took no action beyond issuing an administrative circular urging prefectural governors to supervise psychiatric hospitals more closely.²⁴ When the issue of conditions in psychiatric hospitals arose before the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, the Japanese government denied that widespread abuses had taken place.²⁵ In the face of this evasiveness, the Japanese Fund for Mental Health and Human Rights, a group of patients' rights advocates, invited the International Commission of Jurists to send a mission to Japan to investigate the human rights of psychiatric patients and to report their findings and recommendations to the government.²⁶

C. THE I.C.J. MISSIONS AND THE GENESIS OF THE 1987 ACT AND THE P.R.B. SYSTEM

In May 1985, the I.C.J., in connection with the International Commission of Health Professionals, sent its first mission to study the human rights of psychiatric patients in Japan.²⁷ After extensive meetings, hospital visits, and interviews,²⁸ the 1985 mission concluded that the Japanese mental health system was "seriously inadequate in terms of the human rights of mentally disordered persons and of their treatment."²⁹ The mission suggested that "a complete overhaul of legislative provisions taking into account the rights of mentally disordered persons and new techniques of psychiatric treatment should be carried out."³⁰ It also recommended that an independent, multidisciplinary tribu-

22. See Salzberg, *supra* note 2, at 141; Harding, *supra* note 5, at 478; 1985 I.C.J. Report, *supra* note 5, at 15.

23. Salzberg, *supra* note 2, at 141; 1985 I.C.J. Report, *supra* note 5, at 15.

24. Salzberg, *supra* note 2, at 141-43. See also 1985 I.C.J. Report, *supra* note 5, at 16-19.

25. Salzberg, *supra* note 2, at 143.

26. 1985 I.C.J. Report, *supra* note 5, at 21; Salzberg, *supra* note 2, at 143. For detailed discussions of the international response to allegations of human rights abuses against psychiatric patients in Japan, see Salzberg, *supra* note 2, at 142-44; Harding, *supra* note 6, at 479-81; 1985 I.C.J. Report, *supra* note 5, at 21-22.

27. The members of the 1985 I.C.J. mission to Japan were Dr. Timothy W. Harding and Dr. Harold M. Visotsky, who also participated in the 1992 I.C.J. mission and the Honorable Joseph Schneider, formerly Presiding Judge, County Division, Circuit Court of Cook County, Illinois.

28. The methods of the 1985 I.C.J. mission are described in 1985 I.C.J. Report, *supra* note 5, at 23-25.

29. *Id.* at 80.

30. *Id.* at 82.

nal system be implemented at the prefectural level to respond to appeals from patients and to carry out automatic reviews of all cases of involuntary hospitalization.³¹ The mission considered that substantive reform for protecting patients' rights could not be realized without an effective procedural mechanism for monitoring and enforcing those rights.³²

Largely as a result of the 1985 I.C.J. mission's recommendations and the surrounding domestic and international scrutiny of Japan's mental health system, the Ministry of Health and Welfare announced in August 1985 that it would undertake a substantial revision of the 1950 Act. The Mental Health Act of 1987 was passed in September 1987 and took effect on July 1, 1988. The 1987 Act and the regulations promulgated thereunder significantly improved the status of patients' rights³³ by (1) allowing patients to admit themselves to psychiatric hospitals voluntarily;³⁴ (2) recognizing the importance of community treatment and rehabilitation;³⁵ (3) limiting the use of seclusion, physical restraints, and other restrictions;³⁶ and (4) establishing patients' right to free communication with the outside world.³⁷ The 1987 Act also mandates that each prefecture establish a Psychiatric Review Board ("P.R.B.")³⁸ to address patients' requests for discharge and improved treatment,³⁹ as well as to review the hospitalization of all involuntarily committed patients.⁴⁰

Each P.R.B. is regulated both by the 1987 Act and by local regulations. These regulations take the form of local P.R.B. "manuals," which are based on, and in most cases virtually identical to, a model issued by the Ministry of Health and Welfare in

31. *Id.* at 84.

32. *Id.* at 84. See also Timothy W. Harding, *Realism in Mental Health Law Reform: the 1987 Amendments to the Japanese Mental Health Law*, 40 INT'L DIG. HEALTH LEGIS. 254, 257-60 (1989).

33. For a complete discussion of the passage of the 1987 Mental Health Act and the changes in Japanese mental health law pursuant thereto, see Salzberg, *supra* note 2.

34. 1987 Mental Health Act art. 22-2. See also discussion *infra* notes 60-65 and accompanying text.

35. See 1987 Mental Health Act arts. 1, 2, 7, 9, 10.

36. 1987 Mental Health Act art. 36-3; Ministry of Health and Welfare Notification Nos. 129, 130 (Apr. 8, 1988) [hereinafter M.O.H.W. Notification]; Mental Health Law Enforcement Regulations, Ministry of Health and Welfare Ordinance No. 29, art. 18 (Apr. 8, 1988) [hereinafter Enforcement Regulations]. See also discussion of seclusion, *infra* note 225; Salzberg, *supra* note 2, at 163-64.

37. 1987 Mental Health Act art. 36-2; M.O.H.W. Notification, *supra* note 36, No. 128.

38. 1987 Mental Health Act art. 17-2.

39. *Id.* art. 38-5.

40. *Id.* art. 38-3.

1988 ("the [P.R.B.] Manual").⁴¹ This Article refers to the Ministry's Manual in discussing regulations which have been adopted by all or virtually all prefectures.

In April 1988, after the new Act was passed but before it was implemented and before the P.R.B. Manual was released, the I.C.J. sent a second mission to Japan to follow up on its original recommendations.⁴² The 1988 I.C.J. mission expressed "guarded optimism" about improvements in Japanese mental health law under the 1987 Act but noted little change in hospital conditions to that date.⁴³ The mission also specified concerns about the P.R.B. system, which it hoped would be addressed by the forthcoming regulations.⁴⁴

The third I.C.J. mission spent two weeks in Japan in April 1992. It conducted interviews with a wide range of individuals who represented various perspectives on the Japanese mental health system, visited hospitals, and attended seminars in anticipation of the government's statutorily-mandated⁴⁵ revision of the Mental Health Act in 1993. The 1992 mission issued a twelve-page report outlining its conclusions and recommendations, in which it noted certain areas of improvement under the new Act and suggested further changes in other areas.⁴⁶ Although the mission submitted its report to the Ministry of Health and Welfare, the Ministry's revision of the Mental Health Act in 1993 contained only nominal reforms, none significantly affecting the P.R.B. system.

41. Although most prefectures' regulations concerning the Psychiatric Review Board ("P.R.B.") system have been adopted directly from the Ministry's model manual, it is important to note that prefectures are free to change their own manuals as long as they do not conflict with the 1987 Act or other national or local laws. Furthermore, the existence of the model Manual does not result in uniformity among P.R.B.s; there is wide variation among prefectures in the many aspects of P.R.B. practice which are addressed loosely or not at all by the 1987 Act and the Manual. See Nobuko Kobayashi, *Toddling Advocacy in Japan*, in *INNOVATIONS IN JAPANESE MENTAL HEALTH SERVICES* 67, 73 (James M. Mandiberg ed., 1993).

42. The members of the 1988 I.C.J. mission were Dr. Timothy W. Harding, the Honorable Joseph Schneider, Dr. Harold M. Visotsky, and Niall MacDermot, Q.C., all of whom also took part in either or both the 1985 and 1992 missions, see *supra* notes 3, 28.

43. Timothy W. Harding, et al., *International Commission of Jurists' Mission to Japan, April 1988: Preliminary Report and Recommendations*, 37 I.C.J. NEWSL. 32 (April/June 1988) [hereinafter *1988 I.C.J. Report*].

44. *Id.* Among the concerns that the 1988 mission expressed were the tribunals' lack of independence, the lack of provision for representation of patients, and the lack of budgetary provisions for support staff. *Id.* at 36. The 1988 mission made several specific recommendations to ensure that "the basic principles of due process" were observed in the P.R.B. process. *Id.* at 40.

45. 1987 Mental Health Act, Supplementary Provision Art. 9 requires that the government reevaluate the Act five years after its enactment.

46. 1992 I.C.J. REPORT, *supra* note 3.

D. TOOLS FOR ANALYSIS: U.N. PRINCIPLES FOR THE PROTECTION OF PERSONS WITH MENTAL ILLNESS AND THE IMPROVEMENT OF HEALTH CARE

The experience of the I.C.J. missions reflects that both law and psychiatric practice are culture-specific. Each mission had to face a threshold question: By what standards should members of an international body assess an institution such as the P.R.B. which is the product of a culture entirely different from those of its evaluators? On one hand, Japanese mental health law exists in a unique historical, political, social and cultural context. It may not be meaningful or fair to measure the P.R.B. system against standards of "human rights," "personal autonomy," or "medical appropriateness" as they are defined in the West. On the other hand, a completely value-free and objective analysis is not within the realm of human possibility, and might in fact be counter-productive. As Dr. Harding, a member of all three I.C.J. missions to Japan, has written: "Arguments based on cultural relativism are dangerous for the protection of human rights and the promotion of ethical standards. . . [since] certain values and human rights transcend cultural barriers."⁴⁷

In December 1991, the United Nations attempted to universalize minimal standards for the protection of persons with mental disabilities by promulgating its Principles for the Protection of Persons with Mental Illness and the Improvement of Health Care ("the U.N. Principles").⁴⁸ Like most statements of

47. Harding, *supra* note 5, at 481.

48. After the Utsonomiya incident in 1984, Japanese psychiatrists and politicians led an effort to develop international standards of human rights specifically for psychiatric patients. The United Nations focused attention on the issue by declaring the years 1983 to 1992 the "Decade for Disabled Persons" and producing the first two international reports about the conditions of people with mental disabilities. U.N. ESCOR, *Human Rights and Disability*, U.N. Doc. E/CN.4/Sub.2/13 (1991) ("the Despouy Report"); U.N. ESCOR, *Principles, Guidelines, and Guarantees for the Protection of Persons Detained on Grounds of Mental Illness or Suffering from Mental Disorder*, U.N. Doc. E/CN.4/Sub.2/17 (1983) ("the Daes Report"). See also E. Rosenthal and L. Rubenstein, *International Human Rights Advocacy under the "Principles for the Protection of Persons with Mental Illness"*, 16 INT'L J.L. & PSYCHIATRY 257, 257-59 (1993); Timothy W. Harding, *Japan's Search for International Guidelines on Rights of Mental Patients*, LANCET, March 21, 1987, at 676-77.

Although the 1991 U.N. Principles were the first to deal specifically with psychiatric patients, other more generally-applicable standards of human rights have been invoked on behalf of people with mental disabilities. U.N. Principle 1(5) states that "[e]very person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the rights of Disabled Persons and the Body of Principles for the Protection of all Persons under Any Form of Detention or Imprisonment". *Principles for the Protection of Persons with Mental Illness and for*

human rights, the U.N. Principles "come from an individualistic, libertarian perspective that emphasizes restrictions on what the state can do to a person with mental illness."⁴⁹ To the extent that this perspective is not universal and that change cannot be effected without careful attention to culture-specific norms and practices,⁵⁰ international principles have a limited role in influencing legal reform in any country.⁵¹ However, United Nations General Assembly Resolutions such as the U.N. Principles, while not directly binding on states, are legally significant for their moral persuasiveness as well as their impact on the application of treaty-based rights and their contribution to the development of international customary law.⁵² Moreover, they serve as useful analytical tools by providing a vocabulary and set of standards for evaluating and comparing institutions across different cultural contexts.

The U.N. Principles establish minimal standards both for the substantive rights of persons with mental disabilities and for the procedural mechanisms by which those rights are enforced.⁵³ In terms of procedural rights, the Principles require that each state establish a "judicial or other independent and impartial [review] body" to hear patients' requests for discharge or change to voluntary status,⁵⁴ as well as "review the cases of involuntary patients at reasonable intervals as specified by domestic law."⁵⁵ The U.N. Principles also set standards for the operations of these

the Improvement of Mental Health Care (1991) U.N.Y.B. G.A. Res. 46/119. In addition, the European Convention on Human Rights contains directives for review bodies such as the P.R.B.s which are relevant, although not directly applicable, to countries outside Europe. These directives are interpreted by the European Commission for Human Rights and the European Court of Human Rights.

49. Rosenthal & Rubenstein, *supra* note 48, at 260.

50. U.N. Principle 7(3) recognizes the importance of culture-specific psychiatric treatment by requiring that every patient "shall have the right to treatment suited to his or her cultural background."

51. See Timothy W. Harding, *The Application of the European Convention of Human Rights to the Field of Psychiatry*, 12 INT'L J.L. & PSYCHIATRY 245 (1989).

52. Rosenthal and Rubenstein, *supra* note 48, at 268.

53. Rosenthal and Rubenstein describe the procedural mechanisms required by the U.N. Principles as compensation for the Principles' deferential standards for psychiatric commitment. "As though to ameliorate the impact of the loose standards for involuntary treatment and the concomitant assault on personal autonomy, the Principles surround the use of coercion with elaborate procedural safeguards". Rosenthal & Rubenstein, *supra* note 48, at 265-66.

54. U.N. Principles 17(1), 17(3). See also Principle 21, "[e]very patient and former patient shall have the right to make a complaint through procedures as specified by domestic law" and Principle 22 "[s]tates shall ensure that appropriate mechanisms are in force to promote compliance with the present Principles, . . . for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient").

55. U.N. Principle 17(4).

tribunals.⁵⁶ Although some of the "judicial-like procedures [imposed by the U.N. Principles] are likely to be an unfamiliar accoutrement of civil commitment in much of the world"⁵⁷ (including Japan), they are important to ensuring the protection of psychiatric patients' substantive rights.

E. THE ADMISSION SCHEME OF THE 1987 ACT

In order to appreciate how the P.R.B. system affects psychiatric commitment, it is necessary to understand the admission scheme for psychiatric hospitals under Japanese law.⁵⁸ The following is a brief overview of the primary forms of admission under the 1987 Act: voluntary admission, involuntary admission on grounds of dangerousness, and involuntary admission effected by the "consent" of a type of guardian known as a *hogo-sha*.⁵⁹

1. Voluntary Admission

Before 1987, no legal provision allowed a psychiatric hospital to admit a patient on the patient's own consent. Although a small number of patients were admitted informally outside the regulatory scheme of the 1950 Act,⁶⁰ a person with mental illness could officially receive inpatient treatment only after commitment by the state pursuant to its police powers,⁶¹ or commitment by a family member pursuant to the doctrine of "substitute consent."⁶² The 1987 Act introduced voluntary admission (*nin'i*

56. U.N. Principles 17, 18.

57. Rosenthal & Rubenstein, *supra* note 48, at 266.

58. The 1987 Act's definition of a "mentally disordered person" is quite broad and imprecise, including "those who are psychotic due to intoxication," people with mental retardation, psychopaths and people with psychoses. Article 33. In addition, Article 51 extends the scope of the Act to persons who have been "chronic stimulant addicts". This Article uses the term "mental disabilities" to refer collectively to all of these diagnoses. However, the issue of commitment to psychiatric hospitals applies mostly to people who have mental illnesses. Therefore this population is the focus of this Article and the I.C.J. missions' reports.

59. The name *hogo-sha* was changed from *hogo gimu-sha* by 1993 amendments to the 1987 Act. Law No. 74 (1993).

The 1987 Act also includes other less-utilized forms of admission: two forms of emergency admission under Articles 29-2 and 33-4, and temporary admission under Article 34. For a more complete discussion of the admission scheme under the 1987 Act its precursor, see Salzberg, *supra* note 2, at 149-57. For demographic data regarding psychiatric patients and service providers, and an discussion of how mental health services are administered in Japan, see Kunihiro Asai, *Mental Health Services in Japan*, 18 J. SOC. & SOC. WELFARE, June 1991, at 141.

60. Such informal voluntary admission, termed *jiyū nyūin* ("free hospitalization"), accounted for about 5% of total inpatient admissions prior to 1987. Salzberg, *supra* note 2 at n.96 and accompanying text.

61. See discussion *infra* notes 66-69 and accompanying text.

62. See discussion *infra* notes 70-81 and accompanying text.

nyūin) to Japanese mental health law⁶³ and required that hospital superintendents "endeavor to admit" people with mental illness based on their own consent.⁶⁴ This policy has apparently been utilized frequently; by fiscal year 1991, voluntary admission accounted for 57% of all psychiatric patients hospitalized in Japan.⁶⁵

2. Commitment on Governor's Order

Under Article 29 of the 1987 Act, an individual may be involuntarily committed to a psychiatric hospital on a finding by at least two Designated Mental Health Physicians ("Designated Physicians") that he is "mentally disordered" and, as a result, liable to injure himself or others unless hospitalized.⁶⁶ This type of hospitalization is known as *sochi nyūin* (hereinafter "commitment on governor's order"). A Designated Physician (*shitei'i*) is an experienced and specially-trained psychiatrist certified as such by the Ministry of Health and Welfare.⁶⁷ Anyone "who has discovered a person who has been mentally disordered, or is suspected to be mentally disordered" may apply to the governor for

63. 1987 Act Art. 22-2. Despite the new legal provision for voluntary admission, a very small number of psychiatrists continue to admit some voluntary patients "informally" as *jiyū nyūin*. The legal status of such admissions under the 1987 Act is unclear. In order to incorporate all admission within the scope of the Act, the 1992 I.C.J. mission has recommended that a statutory procedure for informal admission be instituted. 1992 I.C.J. REPORT, *supra* note 3, at 7-8.

64. 1987 Act Art. 22-2. A voluntary patient's status may be changed to admission on the substitute consent of the patient's *hogo-sha*, see discussion *infra* notes 70-81 and accompanying text, on 72 hours' notice. Article 22-3.

65. Department of Mental Health, Japanese Ministry of Health and Welfare, BUS. REP. HEALTH SERVICES ADMIN. (1991) [hereinafter M.O.H.W. Statistics].

66. This substantive standard for involuntary commitment under Japanese law, a discussion of which is beyond the scope of this article, is in some ways broader and in some ways narrower than the U.N. Principles. U.N. Principle 16(1) states:

A person may (a) be admitted involuntarily to a mental facility as a patient; or (b) having already been admitted voluntarily as a patient, be retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorized by law for that purpose determines . . . that the person has a mental illness and considers: (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or (b) That in the care of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

For a discussion of the commitment standard under the U.N. Principles, see Rosenthal & Rubenstein, *supra* note 48, at 265.

67. 1987 Mental Health Act Art. 18. The 1992 I.C.J. mission has recommended that Article 29 be amended to provide that only one of the two admitting psychiatrists may be attached to the admitting hospital. 1992 I.C.J. REPORT, *supra* note 3, at 8.

commitment under Article 29.⁶⁸ The percentage of patients committed on governor's order has fallen in recent years, from 30.2% in 1970, to 6.4% in 1987, and to 2.8% in 1991.⁶⁹ While this trend and the increase in voluntary admissions are positive developments, the harsh reality is that almost half of all patients are still being committed involuntarily by the form of commitment described below.

3. *Commitment on Substitute Consent*

Before the 1987 Act, psychiatric patients who were not committed on governor's order were generally committed on the consent of a family member serving as a type of guardian known as a *hogo-sha*.⁷⁰ The *hogo-sha* system is a far-reaching and increasingly controversial form of guardianship whereby a family member is appointed according to a statutory list of prioritized relationships⁷¹ to represent a person with a mental disability. The 1987 Act obligates the *hogo-sha* to "ensure that the mentally disordered person receives medical care, . . . supervise him so as not to injure himself or others . . . , protect his interests of a proprietary nature, . . . cooperate with a physician so that a medical examination can be properly carried out," and follow the instructions of treating physicians. The *hogo-sha* is also obligated to receive the ward upon discharge from a psychiatric hospital.⁷²

The 1987 Act left undisturbed one of the most significant aspects of the *hogo-sha* system: the authority of the *hogo-sha* to substitute his or her own consent to psychiatric hospitalization for the consent of the patient. Under Article 33 of the 1987 Act, a *hogo-sha* may commit⁷³ an individual to a psychiatric hospital if

68. 1987 Mental Health Act Art. 23. Article 54 imposes penalties for false applications.

69. Salzberg, *supra* note 2, at 150; M.O.H.W. Statistics, *supra* note 65.

70. See 1950 Act art. 33.

71. 1987 Mental Health Act Art. 20. The Ministry of Health and Welfare's translation of *hogo-sha* is a "person responsible for custody". Due to the absence of a comparable concept in the English language (the word "guardian" vastly understates the level of responsibility and authority involved), the Japanese word is used in this article without translation. The 1993 amendments to the 1987 Mental Health Act change the name from *hogo gimu-sha* to *hogo-sha*, but the meaning remains the same. See *supra* note 59.

72. 1987 Mental Health Act arts. 22, 41. The 1987 Mental Health Act contains no penalties for the failure of a *hogo-sha* to comply with his or her duties under these Articles.

73. Because of the *hogo-sha's* "substitute" consent, some Japanese psychiatrists consider Article 33 admission "voluntary admission" rather than "involuntary commitment". However, U.N. Principle 15 categorizes voluntary patients as those who "have the right to leave the mental health facility at any time". In accordance with this Principle, as well as Principle 9(4) which emphasizes preserving and enhancing the patient's personal autonomy, the label "voluntary" should be reserved for patients who are admitted on their *own* consent.

one Designated Physician certifies that the individual is mentally disordered and in need of hospitalization. In contrast to commitment on governor's order, no showing of dangerousness or a concurring physician's opinion is required for admission under Article 33 (*iryōhogo nyūin*; hereinafter "commitment on substitute consent").

If an individual does not have a *hogo-sha*, Article 33(2) allows the hospital superintendent to admit him without his own consent for a period of up to four weeks until a *hogo-sha* is appointed.⁷⁴ The mayor of the individual's city, town, or village may also act as a substitute *hogo-sha* when necessary.⁷⁵ In fiscal year 1991, commitment on substitute consent accounted for 36.5% of all psychiatric hospitalizations in Japan.⁷⁶

Commitment on substitute consent is one of the most controversial aspects of the 1987 Act.⁷⁷ The powerful role of the *hogo-sha* is in keeping with the centrality of the family and the group in Japanese culture. Substitute consent for psychiatric admission is "consonant with a world view where autonomy, to a lesser or greater extent, yields to the nurturance and security provided by one's group, and especially one's family."⁷⁸ On the other hand, as the 1992 I.C.J. mission concluded, commitment on substitute consent amounts to involuntary hospitalization without the procedural safeguards required for commitment on governor's order.

The availability of commitment on substitute consent places family members as well as people with mental illness in an untenable position. A regrettable conflict of interest arises when family members who might otherwise support an individual in need of help are legally responsible for locking her up against her will.⁷⁹ Because of the coercive nature of commitment on substitute consent and the unreasonable burdens that it places on fam-

74. Approximately one-third of all patients committed on substitute consent fiscal year 1991 were committed under Article 33-2 pending the selection and appointment of a *hogo-sha*. M.O.H.W. Statistics, *supra* note 65.

75. 1987 Mental Health Act art. 21. Professor Salzberg writes: "The notion that municipal officials, having jurisdiction over the person's residence or, when that is unknown, the person's location, can give 'consent' to involuntary hospitalization stretches the paternalistic family consent model to the limit, if not beyond." Salzberg, *supra* note 2, at 154 n.93.

76. M.O.H.W. Statistics, *supra* note 65.

77. For a discussion of the history and sociocultural context of the *hogo-sha* system and commitment on substitute consent, see Paul S. Appelbaum, *Mental Health Law and Ethics in Transition: A Report From Japan*, 45 HOSP. & COMMUNITY PSYCHIATRY 635 (1994); Salzberg, *supra* note 3, at 152-55.

78. Salzberg, *supra* note 2, at 153.

79. 1992 I.C.J. REPORT, *supra* note 3, at 8. For a discussion of the problems surrounding commitment on substitute consent, see also Salzberg, *supra* note 2, at 151-55.

ily members,⁸⁰ the 1992 I.C.J. mission recommended abolishing commitment on substitute consent entirely.⁸¹

II. THE PSYCHIATRIC REVIEW BOARD SYSTEM

The Psychiatric Review Boards, modeled largely on the Mental Health Review Tribunals of England and Wales,⁸² are multidisciplinary tribunals with two functions. They address psychiatric patients' requests for discharge or improved treatment, and also conduct periodic reviews of involuntary patients' treatment. This section describes how the P.R.B. system is designed and how it has been implemented. The following section analyzes the system in the context of international law and suggests areas for reform.

A. CURRENT PRACTICE

The P.R.B.s are responsible for conducting two types of reviews: reviews of patients' requests for discharge or improved treatment, and periodic reviews of the treatment of patients committed involuntarily, i.e. on governor's order or substitute consent. The first type of review is initiated by an "application" of the patient or the patient's representative. The latter is a procedure conducted at regular intervals set by law. Because P.R.B. panels view these reviews as two distinct tasks, they are discussed separately below.

1. *Composition of the P.R.B.s and Panels*

Each prefecture in Japan has one Psychiatric Review Board,⁸³ consisting of between five and fifteen members appointed and paid by the prefecture.⁸⁴ P.R.B. budgets are entirely the responsibility of prefectural governments. The national government allocates no funds to the system.

The 1987 Act limits the number of P.R.B. members to fifteen, regardless of the size of the prefecture's patient popula-

80. See Kobayashi, *supra* note 41, at 72.

81. In connection with abolishing commitment on substitute consent, the 1992 I.C.J. mission suggested that provision be made for individuals to be committable on governor's order on the basis of their need for treatment alone as well as on the basis of dangerousness. 1992 I.C.J. REPORT, *supra* note 3, at 8. See U.N. Principle 16, *supra* note 66. The 1992 I.C.J. mission also proposed replacing the entire *hogo-sha* system with a system of professional guardians when patients require this type of protection. 1992 I.C.J. REPORT, *supra* note 3, at 4.

82. See Kobayashi, *supra* note 41, at 73. For a comprehensive study of the British Mental Health Review Tribunals, see JILL PEAY, TRIBUNALS ON TRIAL (1989).

83. As required by the 1987 Mental Health Act art. 17-2.

84. *Id.* art. 17-3.

tion.⁸⁵ Consequently, panels in prefectures with greater numbers of psychiatric patients or fewer P.R.B. members are busier than panels in other prefectures.

Each P.R.B. functions in multi-disciplinary five-member panels (*gōgitai*, or “collegiate bodies”), consisting of three Designated Physicians, one person “of knowledge and experience in law” (usually either a practicing lawyer, a law professor, a public prosecutor, or a judge), and one *yūshiki-sha*, a person with knowledge and experience in another field.⁸⁶ There are no written criteria for serving as a *yūshiki-sha*, and standards used in practice do not require experience working with people who have mental disabilities. Although *yūshiki-sha* are sometimes social workers, they often work in unrelated fields. P.R.B. panels make decisions by majority vote,⁸⁷ with members expected to “perform their duties independently based on their knowledge and experience in their specialties.”⁸⁸

2. *Addressing Patients' Requests for Discharge and Improved Treatment*

a. The Application Process

In order for any adjudicatory system to be effective, the individuals whom it is designed to protect must understand the application process and know how to use it. Despite statutory notice provisions, psychiatric patients' knowledge and understanding of the P.R.B. system appears to be sketchy at best.

The 1987 Act requires that hospitals notify patients upon admission of procedures available for requesting discharge.⁸⁹ However, the notice that the Ministry of Health and Welfare has issued for this purpose does not mention the P.R.B. by name or explain the system in any way. Instead, it simply contains a space for the address and telephone number through which patients may contact the “local authorities”. To the extent that patients understand that this number and address may be used to request discharge or complain about treatment, they often operate under the reasonable misconception that they are contacting a governmental agency rather than an independent review body. These patients have little if any way of knowing to whom their communications are being directed or the procedures by which they are addressed.

85. *Id.*

86. 1987 Mental Health Act arts. 17-3, 17-4.

87. P.R.B. Manual § III.3.

88. *Id.* § I.

89. 1987 Mental Health Act arts. 22-3(1), 29-3, 29-2(4), 33-3, 34-2. *See also* Enforcement Regulations, *supra* note 36, arts. 5, 7, 15.

In fact, the P.R.B.s do function more as bureaucratic arms of the prefectural governments than as independent bodies. Pursuant to the P.R.B. Manual, the governor initially receives all P.R.B. applications, confirms basic facts and gathers certain information, and then forwards the applications to the P.R.B.⁹⁰ Accordingly, the workers who answer patients' telephone calls and letters and process their applications are under the control of the prefectural government rather than of the P.R.B. itself. These employees are accountable to the governor and have virtually no direct contact with P.R.B. members. Nevertheless, they enjoy a great deal of discretion in addressing patients' complaints and determining the fate of inquiries and applications before they reach the P.R.B.⁹¹ In fact, it remains unclear exactly how or by whom it is determined which communications from patients are treated as mere inquiries and which are treated as applications to be processed in accordance with the procedures discussed herein.

The 1987 Act and the P.R.B. Manual deal cursorily with the P.R.B. application process. No national standards for the processing of applications or for record-keeping are established. Although the Ministry of Health and Welfare has specified the information to be included in a patient's P.R.B. application,⁹² prefectures are free to establish their own application procedures.

Some of the prefectures' procedures for processing P.R.B. applications involve direct participation by representatives of the prefectural government. For example, the Tokyo government regularly sends Designated Physicians who are *not* members of the P.R.B. to hospitals in order to interview patients who file P.R.B. applications.⁹³ These psychiatrists are accompanied by a representative of the prefectural government, whose only appar-

90. P.R.B. Manual § IV.1(1)-(2). See *infra* note 103.

91. The prefectural employees who answer telephone calls and written applications from patients are generally clerical workers. A notable exception is in Kyoto prefecture, where patients' telephone calls and letters are answered by psychiatrists and other mental health professionals who are employed by the prefecture. Because these individuals are expected to exercise professional judgment, they enjoy a particularly great amount of discretion in channeling patients' complaints either toward or away from the P.R.B. process.

92. The following information is required in a P.R.B. application: the address; name and birth date of the patient or the other person making the request ("the requestor"); the requestor's relationship with the patient, if applicable; the name of the hospital; the "intent and the reason(s) for the request"; and the date of the request. Enforcement Regulations, *supra* note 36, art. 22.

93. In an unusual departure from the Ministry's model Manual, the Tokyo P.R.B. manual specifically authorizes this practice of screening interviews conducted by Designated Physicians who are not P.R.B. members. Tokyo P.R.B. Manual § IV.3.

ent function is to give the interview an official air.⁹⁴ The psychiatrists then issue a report to the P.R.B. panel stating their recommendations as to the appropriate disposition of the patient's application. In most cases, this interview effectively substitutes for the usual P.R.B. proceedings. Unless the patient is unusually persistent, the P.R.B. panel makes its final determination solely on the basis of the government physicians' report. However, if the patient persists and lodges three complaints before the P.R.B. has handed down its decision, a member or members of the P.R.B. will visit the patient to conduct an interview.

Some prefectures impose additional restrictions on P.R.B. applications which effectively restrict patients' access to the system. For example, although patients initiate contact with P.R.B.s by telephone far more often than by written letters, most P.R.B.s have policies which discourage oral applications.⁹⁵ In addition, it is standard practice in Tokyo for clerical staff to put patients' inquiries "on hold" until the patient has been hospitalized for at least one month.

b. The "Hearing" Process

Perhaps the most notable aspect of the P.R.B. system is that it does not provide patients with the opportunity to appear or present evidence before a full P.R.B. panel. The Manual specifies that patients who request P.R.B. review on their own behalf do not have the right to make oral presentations before the tribunal.⁹⁶ Instead, one or more members of the panel may interview the patient in the hospital, as long as one of the interviewers is a

94. The Tokyo P.R.B. Manual requires that when such interviews take place, the interviewing psychiatrists must be accompanied by a representative of the prefectural government. Tokyo P.R.B. Manual § IV.3. The Tokyo Manual justifies this practice as an exercise of the Governor's independent powers of inspection under Article 38-6 of the Mental Health Act. *Id.* See discussion *infra* note 143.

95. These policies are supported by section IV.1(2) of the Manual, which states that requests for discharge "shall be in writing, in principle. However, in cases where there are circumstances preventing the presentation of a written request, a verbal request shall be allowed."

Other factors may also discourage applications by telephone. Most hospitals have complied with Ministry of Health and Welfare regulations requiring the installation of public telephones "in places to which patients have free access" and in locked wards. M.O.H.W. Notification No. 130, *supra* note 36, item 3. However, it is not uncommon for hospital staff to discourage patients' use of telephones by, for example, refusing to distribute telephone cards or coins. Furthermore, many patients in rural hospitals are reluctant to incur the long-distance charges of calling the telephone number assigned to the nearest P.R.B. These patients will often call the local police instead, who are likely to refer their complaints back to the hospital administration.

96. P.R.B. Manual § IV.3(2)(b).

psychiatrist.⁹⁷ Patients have no legal right to be present before the full tribunal, and in practice an interview with one or two panel members invariably substitutes for an actual hearing.⁹⁸

The 1992 I.C.J. mission discovered that P.R.B. members' interviews of patients are cursory and one-sided affairs. Although patients are sometimes accompanied by family members, they are usually alone. The interview consists of a series of questions from the psychiatrist to the patient, with little opportunity for the patient to make statements or ask questions of her own.

After the interview, the participating P.R.B. member(s) present their conclusions to the rest of the panel in a closed-door session. The patient has no access to any of the documents used or generated by the P.R.B., except for a cursory written decision.⁹⁹

The P.R.B.'s evidentiary rules and practices reinforce the unilateral nature of the process. The 1987 Act leaves the selection of evidence for evaluating a patient's application almost entirely to the discretion of the P.R.B. The Act requires only that each panel hear the opinions of the applicant and the hospital superintendent, unless it deems either of these "unnecessary".¹⁰⁰ The Manual adds only the following provisions: (1) the hospital superintendent, the applicant if it is a third party acting on behalf of the patient (which is rarely the case), and "others whom the [panel] deems appropriate" have the right to make oral presentations to the panel as a whole;¹⁰¹ (2) at least one P.R.B. member must interview the hospital superintendent, the patient's *hogo-sha* if he has one, and the applicant if it is a third party;¹⁰² and (3) the governor, upon receipt of an application, must collect certain documents regarding the patient's hospitalization and forward them to the P.R.B. for its review.¹⁰³

97. *Id.* § IV.3(1).

98. The Manual also allows interviews of patients to be replaced by written statements in cases in which "interviews are likely to delay the overall handling of the requests considerably." *Id.* § IV.6. However, this provision has been invoked rarely if ever.

99. Section IV.3(2)(c) of the Manual states that "materials used by the [panel] shall not be disclosed".

100. 1987 Mental Health Act art. 38-5(3).

101. P.R.B. Manual § IV.3(2).

102. *Id.* § IV.3(1).

103. The following are documents which the governor must compile and send to the P.R.B. panel: a report of the patient's medical examination at the time of admission; notification from the hospital superintendent to the governor that the patient has been admitted, which includes confirmation of the *hogo-sha*'s consent (in cases where patients are committed on substitute consent); the patient's periodic reports from the hospital to the governor (for review by the P.R.B., *see infra* notes 131-43 and accompanying text); and "materials concerning requests for discharge, etc." P.R.B. Manual § IV.2(2). The governor must also "facilitate the review by checking

In practice, the panel members who visit the hospital to interview the patient usually interview the patient's family members, the treating psychiatrist, and other hospital staff as well. The panel as a whole hears only the interviewers' conclusions. The patient has no way of knowing about or responding to any of the testimony or evidence upon which the panel bases its decision, and has no right of access to documents relied on or generated by the panel.

The law is silent as to the issue of legal representation in P.R.B. proceedings,¹⁰⁴ and in practice attorneys are rarely involved. The few lawyers who have represented patients in P.R.B. proceedings have found the experience frustrating and essentially futile. According to the practice of all P.R.B.s, the attorney's role is limited to accompanying the patient during the hospital interview. To date, no attorney has appeared before a full P.R.B. panel on a patient's behalf. Since the patient's lawyer has no better access to relevant information than does the patient himself, she is able to do little more than provide moral support and guard against flagrant misconduct. Consequently, few attorneys are interested in representing patients in P.R.B. proceedings, and no money has been allocated by the national or local legislatures for legal or lay representation.¹⁰⁵

c. P.R.B. Decisions

P.R.B. panels have the authority to make two types of recommendations in addition to maintaining the status quo: that the patient be discharged, or "necessary measures [be taken] for the improvement of his treatment."¹⁰⁶ The P.R.B. Manual specifies that the P.R.B. should recommend changes in treatment whenever warranted, even if the patient's application requested discharge alone.¹⁰⁷

i. Substantive Criteria: Requests for Discharge

The standard that P.R.B. members use to determine whether a patient should be retained involuntarily is the same as

procedural matters in advance" such as whether the *hogo-sha's* consent was properly obtained, and must consolidate multiple P.R.B. requests and otherwise prepare a "well-organized file". *Id.*

104. The only legal provision which mentions attorneys in connection with P.R.B.'s is P.R.B. Manual § IV.1(1), which states that, except for certain family members (as specified in Article 38-4 of the 1987 Mental Health Act), only a lawyer may file an application for P.R.B. review on behalf of a patient. This is ironic, since lawyers are virtually excluded from the P.R.B. process itself.

105. 1988 I.C.J. REPORT, *supra* note 43, at 36.

106. 1987 Mental Health Act art. 38-4.

107. P.R.B. Manual § IV.5(5).

is used for initial commitment.¹⁰⁸ Accordingly, a patient committed on governor's order will be retained if he continues to be "mentally disordered and liable to injure himself or others."¹⁰⁹ The Ministry of Health and Welfare has issued a "Notification" which describes in medical language the symptoms and behaviors to be considered in applying this standard.¹¹⁰ Similarly, a patient committed on substitute consent will be retained if he continues to be "mentally disordered, and thus in need of admission to a hospital for medical care and custody."¹¹¹ The medical nature of these criteria lends particular weight to the opinions of the psychiatric members of the panels.¹¹²

Notwithstanding the Act's medical criteria for commitment and retention, practical considerations often prevail. Like most countries, Japan suffers from a shortage of community-based facilities and services for individuals with mental disabilities who could be treated in environments less restrictive than hospitals.¹¹³ In 1983 the Japanese Ministry of Health and Welfare estimated that more than 30% of all psychiatric patients hospitalized in Japan could be discharged if adequate and appropriate facilities existed to care for them in the community.¹¹⁴ Although the Japanese government has stated a commitment to improving and expanding community-based mental health and housing services,¹¹⁵ such services remain vastly underfunded and in critically short supply.¹¹⁶

108. This is the accepted practice; the 1987 Mental Health Act and the P.R.B. Manual are silent on the standard that P.R.B.'s should apply to retention as opposed to initial commitment.

109. 1987 Mental Health Act art. 28-2.

110. M.O.H.W. Notification No. 125, *supra* note 36.

111. 1987 Mental Health Act art. 33(1). This "standard" is so vague as to be virtually meaningless.

112. See *infra* notes 162-65 and accompanying text.

113. See Yukio Sukegawa, *Community Support System for Mentally Disabled People: Public Health and Mental Health Centers in Kanagawa Prefecture*, in INNOVATIONS IN JAPANESE MENTAL HEALTH SERVICES, *supra* note 41, at 45-56; Teruo Yanaka, *The Village of the Hermit Crab*, in INNOVATIONS IN JAPANESE MENTAL HEALTH SERVICES, *supra* note 41, at 57-66; Asai, *supra* note 59; Salzberg, *supra* note 3, at 166-67.

114. 1992 I.C.J. REPORT, *supra* note 3, at 3. In the same survey, sixty percent of the families responded that they would be unable to care for their mentally ill relatives upon discharge from the hospital. See Asai, *supra* note 59, at 147.

115. Articles 1, 2, and 7-10 of the 1987 Mental Health Act encourage the development of, and authorize funding by the national and prefectural governments for "mental health centers" and "social rehabilitation facilities". See also 1992 I.C.J. REPORT, *supra* note 3, at 2 (noting the "widespread acceptance" in both the public and private sectors "of the need to move progressively toward more community-based care and to provide sufficient resources for such developments."); Salzberg, *supra* note 2, at 166-67 (discussing the 1987 Act as well as other Ministry of Health and Welfare publications concerning community services).

116. See 1992 I.C.J. REPORT, *supra* note 3, at 3; James M. Mandiberg, *Between a*

Faced with a shortage of appropriate placements for individuals with mental disabilities who do not require hospitalization or who do not meet legal criteria for commitment, review tribunals in any country will be forced to choose between two evils: institutionalizing a person against his will and in violation of legal standards, or discharging him into a setting where his needs will not be met.¹¹⁷ The choice will be influenced by the relative weights that the society places upon individual rights as opposed to individuals' "best interests" and the needs of the society as a whole. The Japanese emphasis on group dynamics and responsibilities over individual rights and freedoms¹¹⁸ lends itself to a cautious approach toward discharge. In order to prevent the creation of an underserved or homeless population of deinstitutionalized psychiatric patients, P.R.B. panels often decline to discharge patients who fail to meet the legal standard for commitment in the absence of appropriate housing, employment, or medical services in the community.¹¹⁹

ii. Substantive Criteria: Requests for Improved Treatment

On its face, the 1987 Act grants *all* patients the right to file a request with the P.R.B. for improved treatment.¹²⁰ However, to date, only patients committed on governor's order or substitute consent have taken advantage of this right; no voluntary patients have applied to a P.R.B. for changes in their treatment.

Rock and a Hard Place: The Mental Health System in Japan, in INNOVATIONS IN JAPANESE MENTAL HEALTH SERVICES, *supra* note 41, at 9-10; Kobayashi, *supra* note 41, at 74; Asai, *supra* note 59, at 146-48. The recent increase in voluntary patients as compared to involuntary patients has resulted in a substantial financial savings for the national government, which pays for involuntary commitment but not voluntary admission. However, none of the savings have been cycled back into the system in the form of community-based care. Mandiberg, *supra* at 11.

117. A complete discussion of this dilemma is beyond the scope of this article. For a discussion of one controversial approach which reflects the complexity of the issue, see U. Aviram & S. Smoyak, *Discharged Pending Placement: How Courts Created A New Intermediate Legal Status for Confining Mentally Ill Persons*, 17 INT'L J.L. & PSYCHIATRY 139 (1994).

118. See discussion *infra* notes 170-76 and accompanying text.

119. Kobayashi, *supra* note 41, at 74. A shortage of community-based services will also influence the decisions of individuals with mental disabilities and their *hogo-sha* to consent to hospitalization. See Asai, *supra* note 59, at 152 ("Many chronic patients hesitate to leave the hospital and live in the community because of the lower cost of admission (to the hospital) and lack of rehabilitation facilities."); Salzberg, *supra* note 2, at 154-55 ("It is clear that a determination as to the necessity for [commitment on substitute consent] is as much a function of the family and surrounding community's ability to accommodate the person concerned as of that person's symptoms, viewed in isolation.").

120. 1987 Mental Health Act art. 38-4 ("A person admitted to a mental hospital or a person responsible for his custody . . . may [through the P.R.B. process] request a Prefectural Governor to . . . direct the superintendent of the mental hospital to discharge him or take necessary measures for the improvement of his treatment.").

The 1987 Act and the regulations promulgated thereunder do not define what type of "improved treatment" a patient may request through a P.R.B. proceeding. In practice, however, the permissible scope of such requests is understood to be dictated by a Ministry of Health and Welfare regulation granting psychiatric inpatients certain substantive rights during their hospitalization.¹²¹ This regulation prohibits hospital staff from unnecessarily interfering with patients' communication with the outside world and sets standards for the use of isolation and physical restraints.¹²² Complaints about other matters, including those related to patients' medical treatment, are effectively excluded from P.R.B. review under the current practice.

iii. The Decision-Making Process

On average, P.R.B. panels meet for approximately four hours each month to conduct periodic reviews and discuss requests for discharge and improved treatment. Given the small number of requests from patients,¹²³ the bulk of these meetings is devoted to periodic reviews. Since the panels usually meet only once each month, it often takes two or three months from the time a patient makes an application to the time the panel reaches a decision.

The panel notifies the prefectural governor when it reaches a decision on a patient's application.¹²⁴ Although in theory the P.R.B.'s decision is only a recommendation, the governor virtually always rubber-stamps it and puts it into effect. If the P.R.B. recommends that discharge be granted, the governor must "confirm the measures taken by the hospital superintendent within approximately one month after the review has been completed."¹²⁵ The Manual also requires that the governor "make his best efforts to inform the [applicant] of the result of the review within approximately one month after he has received the request, or within approximately three months at the longest . . ."¹²⁶ However, the written "decision" that the governor sends

121. M.O.H.W. Notification No. 130, *supra* note 36. See also 1987 Mental Health Act art. 37-1 (granting authority for this regulation).

122. With regard to regulation of seclusion, see *infra* note 225.

123. See discussion *infra* notes 128-29 and accompanying text.

124. P.R.B. Manual § IV.3(3).

125. P.R.B. Manual § IV.4(3). Article 52-2 of the 1987 Act imposes penalties on hospital superintendents who fail to discharge patients pursuant to a governor's order.

126. P.R.B. Manual § IV.5(3).

to the applicant is simply a cursory statement of the panel's conclusion and does not include reasons for the decision.¹²⁷

iv. Statistics and Outcomes

Since its implementation, few patients have taken advantage of the P.R.B. system by filing applications for review. In fiscal year 1991, only 825 of the 349,190 hospitalized psychiatric patients in Japan, or about .2%, filed P.R.B. applications.¹²⁸ Of these, 784 were requests for discharge and 41 were requests for improved treatment. Of the 766 requests for discharge that were heard to a final decision in that year, 11, or approximately 1.4%, resulted in recommendations for discharge.

Of the total number of P.R.B. applications filed in fiscal year 1991, approximately 5% were requests for improved treatment. Of these 41 cases, only 5, or approximately 12%, resulted in recommendations to change the patient's "therapeutic milieu."

The P.R.B. Manual requires that panels make recommendations for improved treatment whenever they believe it is warranted, even if the original request was for discharge alone.¹²⁹ However, statistics for fiscal years 1990 and 1991 reflect no recommendations for improved treatment in cases in which the patient filed a request for discharge. Conversations with P.R.B. members reflect that many are reluctant to recommend changes in treatment, regardless of the type of application filed, because they feel powerless to monitor and enforce such recommendations on a day-to-day basis.

d. Appeals

The 1987 Act and the Manual are silent as to the appealability of P.R.B. decisions. However, the Ministry of Health and Welfare has taken the position that a hospital may appeal a P.R.B. judgment to a court, but a patient may not.¹³⁰ To date, no appeals from P.R.B. decisions have been taken.

3. *Periodic Reviews of Involuntary Patients' Treatment*

The second function of the P.R.B. system is to periodically review the hospitalization of all involuntarily committed psychi-

127. Section IV.3(3) of the P.R.B. Manual requires that the P.R.B. include an "outline" of its reasons in its recommendation to the governor. However, these reasons are not forwarded to the patient.

128. All of the statistic cited in this section are from M.O.H.W. Statistics, *supra* note 65.

129. P.R.B. Manual § IV.5(5).

130. SEISHIN HOKENHO SHOKAI [ANNOTATED MENTAL HEALTH LAW] 200 (Seishin hokenhō kenkyūkai [Commission to Study Provisions of the Mental Health Law] eds., 1990).

atric patients (i.e. those committed under governor's order or substitute consent). Hospital superintendents must report regularly to the governor each involuntary patient's "symptoms and other matters specified by a Health and Welfare Ministerial Ordinance."¹³¹ The P.R.B. must then "review the necessity of the admission" based on these reports and make a recommendation to the governor.¹³²

In contrast to decisions on a patient's application, the only recommendations available to a P.R.B. panel conducting a periodic review are discharge, change in admission category, or maintaining the status quo.¹³³ Recommendations based on changes in treatment are not within the panel's official authority. The governor must arrange for the patient to be discharged if he concludes that this is appropriate based on the P.R.B.'s recommendation.¹³⁴

The P.R.B. reviews the periodic reports of patients committed on governor's order every six months, and patients committed on substitute consent annually.¹³⁵ The first of these reviews takes place the month after the patient is hospitalized.¹³⁶

The information to be contained in hospitals' periodic reports to the governor and the governor's subsequent reports to the P.R.B. includes: (1) names, addresses, and dates relevant to the patient, his physician, and his *hogo-sha*; (2) diagnostic information including the name of the illness and an "outline" of the patient's symptoms and condition for the past twelve months (for patients committed on governor's order) or six months (for patients committed on substitute consent); (3) the patient's "life history" and the history of his illness; and (4) a projected treat-

131. 1987 Mental Health Act art. 38-2.

132. 1987 Mental Health Act art. 38-3. In addition to mandating periodic P.R.B. reports, the 1987 Act requires hospitals to notify the prefectural governor of the following with regard to all patients committed on substitute consent within ten days of the date of hospitalization: the name and address of the admitting hospital; the address, name, gender and birthdate of the patient; the date of hospitalization; the diagnosis; the background of the patient and the history of the illness; the name of the examining Designated Physician; the address, name and gender of the *hogo-sha* and his or her relationship to the patient; and the date of the *hogo-sha*'s appointment by the Family Court, if applicable. Enforcement Regulations, *supra* note 36; 1987 Mental Health Act art. 33-4. As with periodic reports, a P.R.B. panel reviews these reports and makes a recommendation to the governor. 1987 Mental Health Act art. 38-3. No such initial reports or reviews are required for patients committed under governor's order.

133. P.R.B. Manual § IV.2(4).

134. 1987 Mental Health Act art. 38-3. Article 52-1 imposes penalties on hospital superintendents who do not comply with a governor's order to discharge a patient pursuant to an Article 38-3 review.

135. Enforcement Regulations, *supra* note 36, arts. 19(3), 20(3).

136. *Id.*

ment plan.¹³⁷ Notably, "matters related to the [patient's physical] treatment" must be included for patients committed on governor's order but not for those patients committed on substitute consent.¹³⁸

On their face, these regulations appear to require a fairly comprehensive report of the patient's medical condition and treatment. However, this information is presented to the governor, and forwarded to the P.R.B., on a standard two-page form issued by the Ministry of Health and Welfare. This form is completed by the patient's treating physician and contains only enough space for very brief or multiple choice responses.

P.R.B. panels conduct periodic reviews in the same monthly sessions in which they address requests for discharge and requests for improved treatment. The treating physician's form is usually the only document that P.R.B. members consult in the course of a review; it is very uncommon for a member to read any portion of the patient's actual hospital record.

To supplement the review of a treating physician's report, the Act provides that when a P.R.B. panel deems it "necessary" (or "especially necessary" under a parallel provision in the Manual),¹³⁹ it may hear the opinions of the patient, the superintendent, or others.¹⁴⁰ In marked contrast, the Manual *requires* that the P.R.B. hear the opinion of the hospital superintendent if it determines that the patient should be discharged.¹⁴¹ In a few prefectures, notably Kyoto, P.R.B. members periodically interview patients in connection with periodic reviews. In most prefectures and in most cases, however, the review ends with the treating physician's report.

Conversations with P.R.B. members reflect a widespread reluctance to act decisively based upon the results of periodic reviews. Many members hesitate to order discharge on the basis of the sketchy information provided by the treating psychiatrist, but lack the time and resources (and in some cases, the initiative) to conduct more complete investigations. Accordingly, if a P.R.B. member is concerned about something that he reads on a patient's report (which rarely happens, since the form is completed by the treating physician), he usually goes no further than bringing up the matter with the patient's psychiatrist and asking for a follow-up statement in the next regularly-scheduled report.

137. *Id.* arts. 6, 19, 20, 21.

138. *Id.* art. 19(5).

139. P.R.B. Manual § V.2(3).

140. 1987 Mental Health Act art. 38-3(3).

141. P.R.B. Manual § V.2(3).

In fiscal year 1991, P.R.B. panels throughout Japan conducted a total of 182,972 periodic reviews (including initial reviews of patients committed on substitute consent).¹⁴² This breaks down to a range of 690 to 12,749 reviews per prefecture, with panels in prefectures with larger patient populations often feeling overburdened by the task. Of the 182,690 periodic reviews that were completed during 1991, only approximately .1% resulted in recommendations that the patient be discharged (3 cases), or that the patient's admission status be changed (160 cases). Statistics do not reflect any recommendations for changes in treatment resulting from periodic reviews.¹⁴³

B. ANALYSIS AND I.C.J. RECOMMENDATIONS

1. Introduction

The goals of the 1992 I.C.J. mission were three-fold: (1) to study the status of psychiatric patients' rights in Japan under the 1987 Act; (2) to identify ways in which Japanese mental health law, including the implementation of the P.R.B. system, measures up to the international legal standards embodied in the U.N. Principles; and (3) to recommend changes to help bring Japan into compliance with international law. The previous sections of this Article described the factual realities of the P.R.B. system and the legal structure upon which the system is built. The following sections evaluate the P.R.B. system in light of standards embodied in the U.N. Principles.

The 1992 I.C.J. mission studied the P.R.B. system from the perspective of the U.N. Principles, but not in a cultural vacuum.

142. See *supra* note 132. All of the statistics cited in this section are from M.O.H.W. statistics, *supra* note 65.

143. In addition to P.R.B. reviews, the 1987 Mental Health Act allows the prefectural governor or the Minister of Health and Welfare to conduct their own reviews of psychiatric patients' hospitalization and treatment. Article 38-6 allows the minister or the governor to conduct investigations by gathering information from the hospital, ordering medical examinations, and questioning relevant individuals if he "deems it necessary." If the minister or the governor finds a violation of the Mental Health Act, or finds that the patient's treatment is otherwise "extremely inappropriate," he may order either discharge or a change in the patient's treatment. Mental Health Act art. 38-7(1).

Similarly, the Minister of Health and Welfare or the prefectural governor may order two or more Designated Physicians to examine a voluntary patient who is being held for 72 hours pending discharge, a patient committed on substitute consent, or a patient admitted temporarily for further observation. The minister or governor must order the patient's discharge if, as a result of the examination, the two physicians do not agree that the patient should be hospitalized. *Id.* art. 38-7(2).

Although Articles 38-6 and 38-7 are potentially powerful tools for protecting patients' rights, they are exercised solely at the discretion of the governors and the Minister of Health and Welfare. Statistics are not available, but it appears that investigations pursuant to this authority are few and far between.

The members of the mission understood that it is not sufficient for an institution to conform to international law; it must also function effectively in its own domestic context. Therefore, complex but unavoidable considerations such as sociocultural norms in the areas of law and medicine, political feasibility, and the need for consistency among prefectures played important roles in the mission's analyses. At each juncture, the mission struggled to balance domestic realities with idealistic legal standards to arrive at recommendations that were at once feasible and theoretically sound.

Three main themes emerge from the I.C.J. mission's conclusions and recommendations with regard to the P.R.B. system. These themes run throughout the following discussion and analysis of the mission's report.¹⁴⁴ The first theme is the importance of adequate, appropriate, and accessible community-based placements and support services for hospital patients subject to discharge through the P.R.B. process. As discussed above, P.R.B. panels are reluctant to discharge patients who have no other place to go. It is unrealistic (and perhaps irresponsible) to expect P.R.B. procedures to be changed and implemented in a way that results in additional discharges in the absence of concurrent changes in the mental health system resulting in more and better alternatives to institutional care.

The second theme running throughout the I.C.J. mission's report is that P.R.B.s must be independent and fair. Many of the recommended procedural reforms are designed to ensure that panels and P.R.B. proceedings are even-handed, impartial, and accountable to patients as well as to the public. Related to this theme is the need for P.R.B. proceedings to be truly bilateral, with greater input from and responsiveness to patients and their representatives.

The third theme is not stated in the mission's report, but is implied. None of the mission's recommendations stand a chance of being adopted or effective unless they can be implemented in a way that makes sense in Japan. The recommendations are designed as a broad outline of the changes that would be necessary to bring the P.R.B. system into compliance with international law. The outline must be filled in by people within Japan who can devise specific reforms and implementation strategies that are culturally appropriate and domestically feasible as well as internationally acceptable.

144. This article is not a comprehensive description of the conclusions and recommendations of the 1992 I.C.J. mission. Instead, it discusses what the author considers the most significant aspects of that report in relation to the P.R.B. system. For the full text of the mission's report, see 1992 I.C.J. REPORT, *supra* note 3.

As part of this effort, the P.R.B. system must be adequately funded, preferably at the national level. The national government's failure to financially support the system exacerbates inconsistencies among prefectures and betrays a lack of commitment to the system itself.¹⁴⁵

2. *The Least Restrictive Alternative*

a. Establishing a Climate for Discharge Recommendations: Ensuring Alternatives to Hospitalization

U.N. Principle 9(1) states that "[e]very patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others."¹⁴⁶ The doctrine of the least restrictive alternative encompasses not only treatment by the least restrictive means, but also treatment in the "least restrictive environment."¹⁴⁷ The U.N. Principles "seek an infusion of resources for [community-based] facilities, staffing, and training, together with the construction of systems of services that will enable the preference for community-based care to become a reality."¹⁴⁸

As discussed above, P.R.B. panels frequently take advantage of loose and ambiguous commitment standards to retain involuntarily patients who would otherwise be in danger of falling through the cracks of the mental health system.¹⁴⁹ These cracks

145. See Kobayashi, *supra* note 41, at 73.

146. See also U.N. Principle 16(1)(b) (stating that one condition for committing or retaining a person with severe mental illness and impaired judgment is that failure to do so will be "likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the *least restrictive alternative*") (Emphasis added).

147. *Id.* See also 1992 I.C.J. REPORT, *supra* note 3, at 4 (The principle of the least restrictive alternative "requires that patients be moved to a more supportive form of community care unless hospitalization is absolutely necessary.") In addition to treatment in the community whenever possible, the doctrine of the least restrictive alternative requires that patients be "treated in open wards unless their condition specifically requires measures of security [and that treatment] during particularly serious phases of illness under secure conditions should be available in units integrated into existing hospitals." 1992 I.C.J. REPORT, *supra* note 3, at 4.

148. Rosenthal & Rubenstein, *supra* note 49, at 289. See U.N. Principles 3, 7, 9(1), 13(2).

149. The 1988 I.C.J. mission foresaw this situation when it wrote:

Careful attention should be paid to the potential risk of discharging patients when community support is lacking. Japan should not, as in other countries, reduce the number of hospitalized patients by creating a large homeless population of the mentally ill. This risk should not be used to justify continued long term care, but means that adequate community resources must be made available.

1988 I.C.J. REPORT, *supra* note 43, at 43.

are substantial, widened by the shame, stigma, and ambivalence toward people with mental disabilities that have marked Japanese laws, medical practices, and attitudes through the ages.

If those who participate in the P.R.B. system are to take seriously their responsibility to evaluate impartially a patient's need for hospitalization, then Japan must establish adequate, appropriate, accessible, and coordinated mental health, housing, employment, and income support services to support individuals with mental disabilities in the community.¹⁵⁰ As long as attitudes, laws, practices, and funding mechanisms ensure that hospitalization is the only alternative to homelessness or inadequate care, the discharge of persons without medical need for hospitalization will never be seen as an appropriate goal. As long as this persists, the P.R.B. system will never be used as a means to enforce the doctrine of the least restrictive alternative as required by international law.¹⁵¹

b. Expanding the Scope of P.R.B. Decisions to Issues Involving Treatment

The 1992 I.C.J. mission has recommended that P.R.B. panels treat every request for discharge which is not granted as a request for improved treatment, including transfer to a more appropriate treatment facility.¹⁵² This is, in effect, a restatement of the current rule that P.R.B. panels should make recommendations for improved treatment even when presented with applications for discharge—a rule honored exclusively in the breach.¹⁵³ Because of the reluctance of P.R.B. panels to issue recommendations about patients' treatment, as well as the scarcity of applications for improved treatment¹⁵⁴ and the narrow scope of such applications,¹⁵⁵ matters involving treatment are virtually excluded in practice from P.R.B. review. In order to fully evaluate

150. See 1992 I.C.J. REPORT, *supra* note 3, at 5-7; 1988 I.C.J. REPORT, *supra* note 43, at 41-42; 1985 I.C.J. REPORT, *supra* note 5, at 44-50, 85. See also, e.g., Kobayashi, *supra* note 41, at 74; Salzberg, *supra* note 2, at 166-67; Asai, *supra* note 59, at 153-4; Japanese Society of Psychiatry and Neurology, Proposals Regarding the Resumption of Social Activities of Mentally Handicapped Individuals (Sept. 7, 1991) (unpublished manuscript on file with author).

151. See Salzberg, *supra* note 2, at 167 ("Even the most vigilant system of procedural and substantive safeguards cannot vouchsafe effective treatment and social rehabilitation of the mentally ill when there is not a fully functioning system of intermediate care facilities.")

152. 1992 I.C.J. REPORT, *supra* note 3, at 10. In addition, the permissible scope of requests for improved treatment should be expanded to include all complaints regarding medical, psychological or physical mistreatment, abuse or inadequate care.

153. See discussion *supra* note 129 and accompanying text.

154. See discussion *supra* note 128 and accompanying text.

155. See discussion *supra* notes 120-22 and accompanying text.

patients' treatment and enforce the doctrine of the least restrictive alternative, the P.R.B. must concern itself with the conditions of patients' treatment and confinement in addition to the appropriateness of the commitment itself.

Expanding the effective scope of P.R.B. decisions beyond the issue of commitment would not require any changes in the law. The 1987 Act and the P.R.B. Manual already encourage P.R.B. panels to make recommendations with regard to patients' treatment,¹⁵⁶ and the limited scope of requests for improved treatment is a matter of practice only.¹⁵⁷ On the other hand, such a change would require a fundamental trust in the P.R.B. system—a trust which is currently lacking among physicians, patients, and P.R.B. members themselves.

The P.R.B. will be able to enforce the doctrine of the least restrictive alternative only if it is considered an appropriate and effective mechanism for reviewing and making recommendations on treatment decisions. Reforms such as the ones discussed in this Article that increase the fairness and efficiency of the P.R.B. process should also increase public and professional confidence in the system. However, compliance with international law and adherence to recommendations from outside Japan will not alone overcome the current skepticism and distrust of the P.R.B. system. It is critical that within the parameters of human rights reflected in the U.N. Principles, the form and function of the P.R.B. system be defined from inside Japan in accordance with that country's unique cultural, historical, and political realities.

3. *Structure of Psychiatric Review Boards*

a. P.R.B. Secretariat

One critical shortcoming of the P.R.B. system as it is presently implemented is its lack of independence from the prefectural government. The U.N. principles require that review bodies be "independent and impartial,"¹⁵⁸ and the Manual states that P.R.B. members "shall perform their duties independently."¹⁵⁹ Some connection between the P.R.B. system and the government is acceptable in the form of oversight. The process should, however, be as isolated as possible from the political fray in order to ensure that the P.R.B. is not simply another arm of

156. See discussion *supra* note 107 and accompanying text.

157. See discussion *supra* notes 121-22 and accompanying text.

158. U.N. Principle 17(1).

159. P.R.B. Manual § I.

the same bureaucracy that authorized the commitment and treatment decisions in the first place.¹⁶⁰

The P.R.B. system cannot be independent as long as the application process is in the hands of individuals who are accountable to the government rather than to the P.R.B. itself. A patient's initial contact with the P.R.B. system is crucial; it not only determines whether and when the formal process will begin, but also dictates the applicant's impression of the system as a whole. In order to enhance the P.R.B.'s independence, both in fact and as perceived by patients and others involved in the system, applications should be handled by staff of the P.R.B. itself instead of by agents of the local government.

Toward this end, the I.C.J. mission has proposed that each P.R.B. have its own secretariat.¹⁶¹ This secretariat would consist of mental health professionals supported by clerical and professional staff. Although members of the secretariat (like P.R.B. members themselves) would be paid by the prefecture, they would be under the direction of the P.R.B. chairman who would receive a part-time salary for this purpose.

The P.R.B. secretariat would have two main functions: processing applications and keeping records. Patients' telephone calls and letters to the P.R.B. would be directed to the secretariat, which would process all applications. The secretariat would also keep complete records of P.R.B. proceedings, including relevant statistics. To increase the system's accountability, each P.R.B. would be required to file an annual report containing statistics and details of all P.R.B. activities, which would rely on pooled data (rather than confidential information), and would be available to the public.

b. Membership of P.R.B. Panels

The psychiatric members, who outnumber the other members of P.R.B. panels by three to two, tend to play a dominant role in virtually all aspects of the P.R.B.'s work. This is partially due to the psychiatrists' majority voting block on each panel.¹⁶²

160. The line between acceptable governmental oversight and unacceptable interference is a fine one. It should be drawn based on the way the system functions, rather than its form alone. For example, the P.R.B. system may be able to function independently if the Ministry of Health appoints designated physicians and the prefectural governments select and pay P.R.B. members, as long as other controls are in place to limit the influence of the state.

161. For the 1992 I.C.J. mission's recommendations regarding the P.R.B. secretariat, see 1992 I.C.J. REPORT, *supra* note 3, at 8-9.

162. See Kobayashi, *supra* note 41, at 73, (noting the potential conflict of interest in psychiatrists who are affiliated with private psychiatric hospitals serving as members of P.R.B. panels).

The other panel members tend to exacerbate this discrepancy by showing great deference to the psychiatrists' expertise and professional judgment, undermining their own role in the decision-making process.

Although psychiatrists' knowledge and perspective are crucial to the P.R.B.s' operations, and required under the U.N. Principles,¹⁶³ no one group's voice should predominate the proceedings. Psychiatrists are trained to identify and treat mental illness, not to evaluate medical needs in the context of individual rights or societal resources.¹⁶⁴ A truly multi-disciplinary and impartial panel requires all members to participate on a more or less equal basis.

The non-medical members of the P.R.B. bring their own important perspectives to the process. The *yūshiki-sha*, if actually experienced in a relevant field, should provide valuable insight into the patient's potential ability to function in the community given available resources. The role of the legal member is important in ensuring that all rules and standards are applied properly and fairly. The legal member's perspective carries additional importance in cases involving dangerous patients, which may actually or potentially involve the criminal law system as well as civil commitment.

In order to achieve a more even balance in the composition of P.R.B. panels, the 1992 I.C.J. mission has recommended that the number of panel members be reduced from five to three: one psychiatrist, one lawyer, and one *yūshiki-sha*. The *yūshiki-sha* should be a mental health professional with actual experience working with people with mental disabilities (e.g. a psychiatric social worker, a psychologist, or a mental health rehabilitation specialist).¹⁶⁵ The mission's other recommendations for improving the P.R.B.s' efficiency, discussed below, would enable each panel to function more effectively with fewer members.

163. U.N. Principle 17(1) states that review bodies shall "have the assistance of one or more qualified and independent mental health practitioners and take their advice into account."

164. One author has gone so far as to argue that psychiatrists' professional focus on mental disorders raises a "substantial doubt that [they] can function as neutral and detached hearing officers" at all. S. Lynne Klein, *Mental Health Professionals as Civil Commitment Hearing Officers: Procedural Due Process Problems*, 17 U.C. DAVIS L. REV. 653, 682 (1984).

165. 1992 I.C.J. REPORT, *supra* note 3, at 9. To reduce the disparity among the workloads of various P.R.B.s, the I.C.J. mission has recommended that the number of P.R.B. members be proportional to the number of psychiatric beds in each prefecture, with at least one three-member panel for every 3,000 beds and a minimum of five panels in each prefecture. *Id.*

4. Patients' Counselors

a. Socio-Cultural Factors Influencing Psychiatric Commitment and the P.R.B. System

Individuals with mental disabilities, like other people, vary widely in their ability to exercise their autonomy in the course of medical treatment. As the U.N. Principles recognize, psychiatric patients sometimes require the assistance of family members or others in order to fully appreciate and implement their legal rights.¹⁶⁶ Depending on the nature of their illness and the socio-cultural climate, these patients may not have the informational, emotional, or practical resources to gauge whether or not their treatment meets legal standards or to take appropriate steps to identify and address problems.

The role of the patient in medical treatment and the P.R.B. process must be assessed from a cultural perspective. A comprehensive discussion of socio-cultural influences on the psychiatric commitment process in Japan is beyond the scope of this Article. However, two important factors warrant some elaboration: the paternalistic nature of the relationship between physicians and patients, and the limited role of lawyers and litigation in dispute resolution in Japan.

Japanese society is, in many respects, strictly hierarchical. Interpersonal relationships are defined on the basis of a "parent-child" model of reciprocal obligations and deference to authority.¹⁶⁷ This results in a paternalistic model of medicine in which patients (the "children") are expected to defer to the judgment of physicians (the "parents") in virtually all matters of medical treatment. This atmosphere is not conducive to psychiatric patients' ability to identify or voice concerns about their commitment or treatment, or to their effective use of the P.R.B. system to address these concerns.¹⁶⁸

166. See, e.g., U.N. Principles 12(2) ("If and for so long as a patient is unable to understand [information concerning his or her rights], the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient's interests and willing to do so."); 12(3) ("A patient who has the necessary capacity has the right to nominate a person who should be informed [of the patient's rights] on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility.").

167. See, e.g., Chin Kim & Craig M. Lawson, *The Law of the Subtle Mind: The Traditional Japanese Conception of Law*, 28 INT'L AND COMP. L. Q. 491, 499 (1979); S. N. Eisenstadt & Eyal Ben-Ari, *Japanese Models of Conflict Resolution* 214 (1990). See generally JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 100-03 (1984).

168. Gaps in communication and authority exist between doctors and patients all over the world. See generally KATZ, *supra* note 168 (United States); PEAY, *supra* note 82, at 38 - 41 (Great Britain). However, these gaps are particularly wide in Japan, where, despite the gradual encroachment of western ideas of individual au-

The role of law in Japan also has a significant impact on the P.R.B system. Law in Japan has been compared to "an heirloom samurai sword: it is to be treasured but not used."¹⁶⁹ The main objectives of the legal system are to minimize conflict and to preserve group harmony, rather than to protect individual rights.¹⁷⁰ Laws are seen more as guiding principles than as strict mandates,¹⁷¹ with flexibility maintained through a strong reliance on customary norms,¹⁷² "administrative guidance",¹⁷³ and extralegal sanctions.¹⁷⁴

In accordance with the concept of a flexible "living law,"¹⁷⁵ the Japanese legal system has historically relied more on informal methods of dispute resolution such as negotiation and mediation than on litigation.¹⁷⁶ When litigation is employed, trials tend to

tonomy, patients still have little input in their treatment and the doctrine of informed consent is a foreign concept with only a limited academic following. See, e.g., Appelbaum, *supra* note 77; Stephan M. Salzberg, *The Social Model of Mental Health Care and Law in Comparative Context in Proceedings, 1993 World Congress, World Federation of Mental Health* 303-319; Mandiberg, *supra* note 42, at 5; Yasuo Iwata, *The Mental Health Consumers' Self-Help Movement in Japan*, in Mandiberg, *supra* at 85; Norio Higuchi, *The Patient's Right to Know of a Cancer Diagnosis: A Comparison of Japanese Paternalism and American Self-Determination*, 31 WASHBURN L. J. 455 (1992); Hiroyuki Hattori et al., *The Patient's Right to Information in Japan - Legal Rules and Doctor's Opinions*, 32 SOC. SCI. & MED. 1007 (1991).

169. John O. Haley, *Sheathing the Sword of Justice in Japan: An Essay on Law Without Sanctions*, 8 J. JAPANESE STUD. 265, 265 (1982).

170. See generally THE JAPANESE LEGAL SYSTEM (Hideo Tanaka & Malcolm Smith eds., 1976) 254-330; Kim & Lawson, *supra* note 167, at 503. This is a general categorization. For a more subtle analysis, see KYOKO INOUE, MACARTHUR'S JAPANESE CONSTITUTION: LINGUISTIC AND CULTURAL STUDY OF ITS MAKING 51-55 (1991); Tetsuya Obuchi, *Role of the Court in the Process of Informal Dispute Resolution in Japan: Traditional and Modern Aspects, with Special Emphasis on In-Court Compromise*, 20 L. IN JAPAN 74, 78-79 (1987).

171. See John O. Haley, *Introduction: Legal vs. Social Controls*, 17 L. IN JAPAN 1, 5-6 (1984).

172. See Haley, *supra* note 169.

173. "Administrative guidance" refers to the process by which government agencies enforce the law through the elicitation of "voluntary" compliance. See *id* at 279; THE JAPANESE LEGAL SYSTEM, *supra* note 170, at 353-404.

174. Japanese law is enforced largely through social controls in the absence of effective legal sanctions. See Haley, *supra* note 169.

175. *Id.*

176. See generally Eisenstadt & Ben-Ari, *supra* note 167. See also Kim & Lawson, *supra* note 167, at 503:

[R]esort to law carries the shameful implication that the plaintiff thinks his opponent is an unworthy or an abnormal person with whom mutual understanding cannot be reached through ordinary discussion. The shame that accompanies litigation may be one of the most important elements of the Japanese aversion to the legal process.

Id.

The issue of why the Japanese legal system has tended away from litigation has been the subject of much discussion and debate. See generally John O. Haley, *The Myth of the Reluctant Litigant*, 4 J. JAPANESE STUD. 359 (1978); Nobutoshi Yamanouchi & Samuel J. Cohen, *Understanding the Incidence of Litigation in Japan:*

be less adversarial than in the common law tradition, with judges retaining more control over the proceedings relative to the litigants and their attorneys.¹⁷⁷

The role of lawyers in Japan is consistent with the role of law. Before World War II in Japan:

Given the peculiar bent in the Japanese people's "law consciousness," practicing attorneys were looked upon as intruders, meddling uninvited in disputes which otherwise could have been resolved in the "traditional spirit of harmony" The people held such a jaundiced view of the lawyer that his social standing stood little chance of improvement.¹⁷⁸

Although the societal view of lawyers has improved gradually, "it must be said that the legal profession as a group still has a long way to go in order to gain general social acceptance of the social status it claims and of the role it plays."¹⁷⁹

b. Recommendation for Patients' Counselors

One of the I.C.J. mission's most important recommendations was that "patients' counselors" be available in all psychiatric hospitals to assist patients with P.R.B. proceedings and related matters.¹⁸⁰ These counselors would serve as intermediaries between patients and hospital staff in the ordinary course of hospitalization, and between patients and P.R.B. members in the context of P.R.B. proceedings. This type of intermediary plays an important role in any situation involving conflict or potential conflict between individuals with different degrees of authority, knowledge, and power. However, it is particularly critical in Japan where the paternalistic nature of the doctor-patient relationship and the traditional skepticism toward judicial proceedings combine to make authority figures (physicians as well as P.R.B. members) and the P.R.B. system as a whole particularly inaccessible to the patients whom they are intended to serve.¹⁸¹

Under the I.C.J. recommendations, patients' counselors would hold regular office hours on the premises of each hospital

A Structural Analysis, 25 INT'L LAW. 443 (1991); Obuchi, *supra* note 171. As Japan has become more exposed to western influences, there is evidence that litigation is becoming a more acceptable form of dispute resolution. See generally FRANK K. UPHAM, LAW AND SOCIAL CHANGE IN POSTWAR JAPAN (1987); THE JAPANESE LEGAL SYSTEM, *supra* note 170, at 405-43.

177. See THE JAPANESE LEGAL SYSTEM, *supra* note 170, at 506-40 (discussing the gradual and partial shift of control from the judge to litigants and their attorneys from the prewar to the postwar era); Yamanouchi & Cohen, *supra* note 176, at 444-47 (discussing the limited role of discovery in litigation).

178. THE JAPANESE LEGAL SYSTEM, *supra* note 170, at 265.

179. *Id.* For a discussion of role of the legal profession in Japan, see *id.* at 263-68.

180. The 1992 I.C.J. mission's recommendations regarding patients' counselors, as described in this section, are set forth in 1992 I.C.J. REPORT, *supra* note 3, at 9.

181. See Kobayashi, *supra* note 42, at 73-74.

but would be paid by the prefectural government and function independently. They would be recruited from three main sources. An obvious group of candidates would be the Mental Health Center counselors who are already mandated by the 1987 Act.¹⁸² Patients' counselors would also include appropriately trained volunteers from families and mental health support groups, as well as other mental health professionals.¹⁸³

The role of patients' counselors would be threefold. First, the counselors would facilitate communication between patients and hospital personnel, thereby helping to solve problems before they become P.R.B. complaints. Second, when an application to the P.R.B. is warranted, counselors would be available to help guide patients through the process.¹⁸⁴ Finally, patients' counselors would play an important role in educating patients about their legal rights and how to exercise them.¹⁸⁵

5. Applications

As a result of inadequate regulation of the P.R.B. application process at the national level, many patients are effectively denied access to the system. Additional procedural safeguards

182. 1987 Mental Health Act arts. 42, 43.

183. The use of patients' counselors in Japan is not unprecedented. The Japanese legal system has relied on the use of intermediaries as a way of avoiding conflict in other contexts. See Eisenstadt & Ben-Ari, *supra* note 167 at 215-16. In the mental health context, several psychiatric hospitals make use of *kazokukai*, family volunteers with offices on hospital grounds. These groups of volunteers, most of whom are family members of patients, provide information to patients and facilitate communication between patients and hospital staff. Telephone Interview with Stephan M. Salzberg (June 30, 1994). These groups are linked together via a national support organization called ZENKAREN. See Takehisa Takizawa, *Patients and Their Families in Japanese Mental Health*,

Nonprofit advocacy groups are also beginning to make their mark in Japan. For example, the Tokyo Center for Mental Health and Human Rights has done a great deal on a small budget to empower psychiatric patients and inform them about the P.R.B. system. See Kobayashi, *supra* note 42. In addition, family and consumer groups have worked to change the dependant and helpless image of people with mental disabilities. See Iwao Oshima & Kazuyo Nakai, *The Japanese Mental Health System and Family Movement: History, Present Status, and Research Findings*, in INNOVATIONS IN JAPANESE MENTAL HEALTH SERVICES 13-23 (James M. Mandiberg, ed., 1993); Takizawa, *supra*; Iwata, *supra* note 168.

184. Under this proposal, the P.R.B. Manual would be amended to allow patients' counselors (as well as family members and attorneys) to file P.R.B. applications on patients' behalf. See Manual § IV.1(1).

185. The U.N. Principles place a great deal of emphasis on effectively notifying patients of their rights. See Principle 12(1) ("A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.") See also, Principles 12(2) and 12(3), *supra* note 167.

are required to ensure consistent and realistic accessibility to patients across Japan.

Toward this end, the I.C.J. mission has recommended that all P.R.B.s be required to accept both oral and written applications, without regard to length of hospitalization.¹⁸⁶ In accordance with U.N. Principle 17(4) which states that patients should be allowed to apply to the review body at "reasonable intervals", subsequent applications should be allowed after thirty days from receipt of the previous application.¹⁸⁷ To maximize accountability and efficiency, each P.R.B. should be required to keep records and statistics with regard to all communications with patients.¹⁸⁸

The 1987 Act is silent as to whether a voluntary patient may file an application to a P.R.B. requesting improved treatment, and to date no voluntary patient has made such a request. However, voluntary patients are not immune to problems that would be suitable for P.R.B. review. For example, at present almost half of all voluntary psychiatric patients in Japan are held on locked wards.¹⁸⁹ Therefore, the I.C.J. mission has recommended that the Mental Health Act specify that voluntary as well as involuntary patients have the right to make P.R.B. applications for improved treatment.¹⁹⁰

6. *Hearings Instead of Interviews*

a. Introduction

Under the U.N. Principles, the review bodies which address psychiatric patients' complaints need not operate full-fledged trials with formal rules of evidence. There is an acceptable spectrum of formality. For example, commitment hearings in the United States contain almost as many procedural protections as criminal trials,¹⁹¹ while Britain's Mental Health Review Tribunals operate more informally.¹⁹² Each country is left to develop appropriate procedures which are flexible and informal enough to promote efficient decision-making, while strict enough to protect patients' rights and enhance their autonomy.¹⁹³

186. 1992 I.C.J. REPORT, *supra* note 3, at 9.

187. *Id.* at 11. In addition, reprisals against patients for bringing complaints before the P.R.B. should be specifically prohibited.

188. *Id.* at 8.

189. *Id.* at 6. The 1992 I.C.J. mission has recommended that this practice be monitored, and completely phased out within five years. *Id.*

190. *Id.* at 9.

191. *See, e.g.,* Klein, *supra* note 164.

192. *See, e.g.,* PEAY *supra* note 82.

193. *See* Principle 9(4) ("The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.").

The 1992 I.C.J. mission has recommended that the present P.R.B. interview system be modified to a hearing system in closest possible compliance with the U.N. Principles. The mission has borne in mind that some procedural safeguards required by the U.N. Principles may not be readily accepted in a society accustomed to informal dispute resolution and medical paternalism, as discussed above. Accordingly, the mission has made some proposals which fall short of full compliance with the U.N. Principles in the hope that presenting realistic goals at the present time will ultimately promote long-term reforms.

b. Requirement of a Hearing

Although the U.N. Principles leave room for procedural variation, the key to fairness in a P.R.B.-type proceeding is that patients be given a hearing as opposed to merely an interview. Under the U.N. Principles, a hearing must provide the patient with an opportunity for face-to-face interaction with at least some members of the review body,¹⁹⁴ as well as a minimal level of evidentiary rights.¹⁹⁵ The Japanese system as it presently exists, with its very low level of patient participation, cannot be considered a "hearing" in any sense of the word.

The I.C.J. mission has recommended that the existing practice whereby P.R.B. members visit patients in the hospital be maintained, but that procedural protections be implemented to transform this interview process into a hearing. Whereas currently only one or two of the five panel members actually meet with the patient, the mission has recommended that at least two members of the newly-constituted three-member panel, including the psychiatrist, conduct the hearing.¹⁹⁶

Requiring that the patient have access to at least two-thirds of the panel, instead of one-fifth as is now the case, would ensure that most of the P.R.B. process takes place in the presence of the patient rather than behind the patient's back. It would also encourage greater communication among panel members, the majority of whom would have met the patient and would therefore have a meaningful basis for contributing to the discussion and the final decision. The elimination of the psychiatrists' majority block on each panel would further encourage more active participation from the other members of the panel.

194. See U.N. Principle 18(5) ("The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing."); Principle 18(6) (allowing the attendance at the hearing of any person chosen by the patient or his representative unless this poses a threat to the patient's health or the safety of others).

195. See discussion *infra* note 198 and accompanying text.

196. 1992 I.C.J. REPORT, *supra* note 3, at 10.

c. Hospital Reports

One of the most glaring deficiencies in the P.R.B. system is its failure to provide patients with any evidentiary rights. U.N. Principle 18(3) allows the patient or his attorney to "request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible." The 1992 I.C.J. mission has recommended that patients, either directly or through a representative, have the opportunity to make statements to P.R.B. members.¹⁹⁷

The 1992 I.C.J. mission has also addressed the evidentiary deficiencies in the P.R.B. system through the requirement of "hospital reports".¹⁹⁸ Under this proposal, immediately upon receipt of an application the P.R.B. secretariat would be required to request a report from the hospital containing: (1) a description of the patient's condition, emphasizing symptoms and functions rather than specific diagnoses; (2) an individual treatment plan, including beneficial responses to medications and possible side effects, a prognosis, and the expected length of hospitalization; and (3) a psychosocial assessment, including an evaluation of prospects for rehabilitation and community care (including a discussion of both levels of care needed and resources available).

The hospital would be required to provide the hospital report to the P.R.B. within one week of its request. The P.R.B. must then send a copy to the patient unless the treating psychiatrist has justified to the P.R.B.'s satisfaction that all or part of the information contained therein would be likely to be harmful to the patient's mental state or ongoing treatment. If the P.R.B. decides to withhold the report from the patient, the panel could, at its discretion, share all or some of the information contained therein with the patient during the hearing. The proposed requirement that patients be given the opportunity to make statements during the hearing specifically includes the right to comment on information contained in the hospital report.

The requirement of a hospital report serves several purposes. First, it provides the P.R.B. panel with important information on which to base its decision. Second, it grants patients at least a limited right to see and respond to this information in the

197. 1992 I.C.J. REPORT, *supra* note 3, at 10.

198. The 1992 I.C.J. mission's recommendations with regard to hospital reports, as described in this section, are set forth at 1992 I.C.J. REPORT, *supra* note 3, at 9-10.

Under the I.C.J. mission's recommendations, the hospital report is designed to be the primary source of information and evidence for all parties involved, *i.e.* the patient, the hospital, and the P.R.B. panel members. The mission has also recommended that in preparation for a hearing, panel members should have access to the patient's medical records and should be directed to interview anyone whom they deem necessary, such as treating psychiatrists and hospital staff.

context of P.R.B. proceedings. Third, hospital reports may play an important facilitative role in patients' day-to-day treatment.

Allowing P.R.B. members almost complete discretion in determining which evidence they will consider in reviewing a patient's application, as is presently the case, runs the risk that important information will be overlooked. Since P.R.B. members rarely extend their investigations to examinations of the patient's medical records, critical information about the patient's commitment and treatment is often overlooked. The proposed hospital report would ensure that such essential information is provided to P.R.B. members in an easily-accessible format.

The U.N. Principles require that patients have access to their medical records as well as to documents submitted to the reviewing tribunal, in the absence of extraordinary circumstances justifying limited disclosure.¹⁹⁹ Requiring that patients be sent a copy of the hospital record ensures their access to a significant portion of the information relied upon by the P.R.B. panel. This access to information is necessary for the patient to play an active role in the P.R.B. process as well as in the patient's own medical care.

As with information used in the P.R.B. process, patients in Japan have no legal right to access their own medical records. Furthermore, in accordance with the prevailing paternalistic model of medical care, Japanese physicians—especially psychiatrists—are often reluctant to provide patients with information regarding their condition and treatment.²⁰⁰ Allowing P.R.B. applicants access to their hospital reports might pave the way for increased openness and fuller disclosure in the context of everyday medical care.

Finally, the hospital report may serve a therapeutic function in addition to its role in P.R.B. proceedings. Although required by the U.N. Principles,²⁰¹ and critical to patient-centered care, individual treatment plans are not a universally-accepted part of Japanese psychiatric practice. The I.C.J. mission reluctantly con-

199. U.N. Principle 18(4) addresses patients' access to information in review proceedings. It requires: (1) that copies of the patient's records and any reports and documents to be submitted to the review body be given to the patient and his attorney unless this would cause serious harm to the patient's health or put at risk the safety of others; (2) that anyone withholding any part of a document inform the patient and his attorney of the reasons for the withholding, and provide the document to the patient's personal representative and counsel "when this can be done in confidence", and (3) that a determination that all or part of a document be withheld be subject to judicial review. Principle 19 grants patients overall access to their medical records, with identical exceptions and qualifications. U.N. Principle 19.

200. See discussion *supra* notes 167-68 and accompanying text.

201. U.N. Principle 9(2) ("The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.").

cluded that recommending that individual treatment plans be required for all patients would be both unrealistic and beyond the scope of the mission's mandate to report on the P.R.B. system. However, the mission's hope was that hospital reports would serve much the same function as individualized treatment plans for patients who are involved in the P.R.B. process, and might pave the way for the acceptance and widespread use of individualized treatment plans in the regular course of treatment.

d. Legal Representation

The U.N. Principles require that a patient be entitled to choose and appoint counsel to represent her in a review proceeding, and that "counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay."²⁰² In recognition of the importance of legal representation in P.R.B. proceedings,²⁰³ the 1992 I.C.J. mission has recommended that patients have the right to be accompanied during the hearing by any person or persons of their choice, including an attorney, and that patients be allowed to make statements at the hearing either directly or through a representative.²⁰⁴

In light of cultural factors surrounding the role of lawyers and the legal system in Japan,²⁰⁵ the mission stopped short of proposing that indigent patients be entitled to free legal representation in P.R.B. proceedings. In spite of this compromise,²⁰⁶ it was the mission's hope that a fairer and more efficient P.R.B. system will encourage the legal profession to develop feasible and appropriate methods of representing patients in P.R.B. proceedings. The use of patient's counselors as advocates should also help to empower patients in the exercise of their procedural and substantive rights in the P.R.B. process.

7. Notification and Timing of P.R.B. Decisions

The form in which the P.R.B. notifies patients of its decisions is inadequate under the U.N. Principles. Principle 18(8) provides in part that the "decision arising out of the hearing *and*

202. U.N. Principle 18(1).

203. For a discussion of the importance of legal representation in psychiatric commitment proceedings, see generally Virginia A. Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N. C. L. REV. 1027 (1982).

204. 1992 I.C.J. REPORT, *supra* note 3, at 10.

205. See discussion *supra* notes 169-79 and accompanying text.

206. This was indeed a compromise position, arrived at reluctantly in light of the importance of legal representation and the admonition of the 1988 I.C.J. mission that without the assistance of attorneys or non-lawyer patient advocates to assist patients, "the proceedings of the P.R.B.s may prove to be an illusion of due process, and the opportunity to serve many legal and social needs of patients will be denied." 1988 I.C.J. REPORT, *supra* note 43, at 36.

the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel." (Emphasis added.) Accordingly, the I.C.J. mission has proposed that the written decision which is sent to the patient and the hospital include detailed reasons for the panel's decision, including comments on the information contained in the hospital report.²⁰⁷

It is also important that P.R.B. decisions be made in a timely fashion and effectively carried out.²⁰⁸ The I.C.J. mission has proposed that P.R.B. panels be required to reach a decision within one month of receipt of a patient's application, and that the P.R.B. (rather than the governor) should be required to confirm the hospital's action within one week of the decision.²⁰⁹ The mission has also recommended that in the interests of both independence and efficiency, the P.R.B.'s decision should be directly binding on the hospital, without the need for rubber-stamping by the governor.²¹⁰

8. Appeals

The right of appeal is important to any type of adjudicative proceeding, both as a procedural protection for the non-prevailing party and as a means of improving the quality of judicial decision-making at the lower level.²¹¹ U.N. Principle 17(7) states that a patient, his representative, or any interested party must have the right to appeal the decision of a review body to a (higher) court.²¹² Accordingly, the 1992 I.C.J. mission has recommended that all interested parties have the right to appeal a P.R.B. decision to a court.²¹³ However, such an appeal should not stay the enforcement of a decision to discharge a patient except on an emergency petition to an appropriate court.²¹⁴

9. Periodic Reviews

The U.N. Principles mandate the "periodic review" function of the P.R.B.s as well as their "adjudicative" function. Principle 17 states that review bodies should "periodically review the cases

207. 1992 I.C.J. REPORT, *supra* note 3, at 10.

208. See European Convention on Human Rights Article 5 Paragraph 4 ("Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.").

209. 1992 I.C.J. REPORT, *supra* note 3, at 10.

210. *Id.*

211. See Hiday, *supra* note 203, at 1045 (commitment judges in the United States are often "sensitive to being reversed" by higher courts).

212. U.N. Principle 17(7).

213. 1992 I.C.J. REPORT, *supra* note 3, at 11.

214. *Id.*

of involuntary patients at reasonable intervals as specified by domestic law," and that patients should be discharged if the applicable commitment criteria are no longer met.²¹⁵

Although the cursory periodic reviews that P.R.B. panels perform may satisfy the letter of the U.N. Principles, they do not satisfy the spirit. It is virtually impossible for P.R.B. members to make an informed judgment on the necessity of a patient's continued commitment based exclusively on a skeletal report prepared by a treating psychiatrist. In order to determine whether a patient continues to meet the legal commitment standard, it is necessary to consult relevant portions of the patient's hospital record. In some cases it may also be necessary to interview the treating psychiatrist and other hospital staff.

In order to improve the quality of periodic reviews and allow P.R.B. members to devote more of their time to conducting fair and thorough hearings, the I.C.J. mission has recommended that P.R.B.s delegate periodic reviews to consulting Designated Physicians.²¹⁶ These Designated Physicians would work closely with the clerical and professional staff of the proposed P.R.B. secretariat and would refer cases requiring further attention to a P.R.B. panel.²¹⁷

The most often-heard justification for the fact that psychiatrists compose three-fifths of each P.R.B. panel is that their medical expertise is necessary for conducting periodic reviews. Delegating this function to other qualified psychiatrists would reduce the workload of P.R.B. panels and allow all members to focus their energies on a more comprehensive hearing process. This would facilitate the reduction of the P.R.B. panels from five members to three, and the corresponding elimination of the majority of medical members on each panel.

Although the 1992 I.C.J. mission did not specifically address this issue, the scope of the P.R.B.'s authority to make recommendations based on periodic reviews is too narrow to be effective. Under current law, the only recommendation available to a P.R.B. panel conducting a periodic review is discharge; panels are not authorized to recommend changes in treatment in this capacity.²¹⁸ Because P.R.B. panels tend to view recommendations for discharge as draconian measures, and because periodic reviews presumably uncover problems that may appropriately be addressed in the inpatient context, the usual response to a periodic review is informal communication with the treating physi-

215. U.N. Principle 17.

216. 1992 I.C.J. REPORT, *supra* note 3, at 11.

217. *Id.*

218. See *supra* note 133 and accompanying text.

cian.²¹⁹ In order to increase the effectiveness of periodic reviews and to ensure that recommendations and resulting actions are duly recorded, P.R.B. panels should be authorized and encouraged to recommend changes in treatment as well as discharge in response to periodic reviews.²²⁰

Finally, it is important to note that the P.R.B. periodic review process is designed to monitor only the treatment of individual patients; Japan has no national system to accredit or inspect psychiatric hospitals themselves. The U.N. Principles require that all mental health facilities "be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with [the] Principles."²²¹ Japan's lack of a mechanism for independent review of psychiatric hospitals has contributed to past abuses against patients, and jeopardizes future chances for mental health law reform.²²²

The 1992 I.C.J. mission has recommended that a body be created to set and enforce national standards for all mental health facilities (and ideally for non-psychiatric hospitals as well), and that all reimbursers be encouraged to limit coverage to accredited facilities.²²³ As an interim measure, the mission has recommended that a coalition of public and private psychiatric hospitals set national guidelines and standards for such institu-

219. See discussion *supra* note 143 and accompanying text.

220. The U.N. Principles also dictate the timing of periodic reviews. Principle 17(3) states that review bodies shall "periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law."

On the one hand, the intervals set forth by the Ministry of Health and Welfare (every sixth months for patients committed on governor's order and every year for patients committed on substitute consent) might meet this broad standard of "reasonableness" on their face. On the other hand, the law's distinction between the frequency of periodic reviews of patients committed on governor's order and patients committed on substitute consent might well be considered "unreasonable." Since there is no reason to believe that patients committed on substitute consent require less monitoring simply because they were admitted by their *hogo-sha* rather than by the governor, their records should be reviewed as often as those of patients committed on governor's order. The discrepancy in the information that must be provided to the P.R.B. for reviews of patients committed on substitute consent as opposed to patients committed on governor's order should also be eliminated. See *supra* note 138 and accompanying text.

221. U.N. Principle 14(2). See also Principle 22 (States "shall ensure that appropriate mechanisms are in force . . . for the inspection of mental health facilities. . .").

222. See Salzberg, *supra* note 2, at 158 ("It was precisely the lack of information and regular outside review regarding inpatients which allowed the inhumane and tragic abuses said to be endemic to the Japanese mental health care system to continue unobserved and unchecked for so long."); 1992 I.C.J. REPORT, *supra* note 3, at 6 ("Progressive systems of care require standards for quality, treatment, procedural guidelines, staffing patterns, and organizational structure.").

223. *Id.*

tions.²²⁴ Finally, the mission has recommended that P.R.B.s adopt two specific monitoring functions: supervising all cases of involuntary seclusion,²²⁵ and reviewing all cases in which patients are converted from voluntary to involuntary status.²²⁶

III. CONCLUSION

The task of the 1992 I.C.J. mission as it relates to psychiatric commitment was to study and comment upon Japan's implementation of the P.R.B. system. This Article has focused on the context of the mission's work and its recommendations to bring the P.R.B. system into closer compliance with international standards of human rights. Such an analysis begs a further question: Is the P.R.B. system—however modified—a potentially effective means of protecting the rights of people with mental disabilities in Japan, or are reform efforts wasted on a system that has proven itself unworkable?

It is clear that the P.R.B. system has not lived up to the expectations of patients' advocates either at the domestic or international level.²²⁷ The boards do not function independently of local governments, periodic reviews are cursory, and "hearings"

224. *Id.*

225. Historically, Japanese psychiatric hospitals have relied heavily on the use of seclusion isolation rooms for violent patients or those considered otherwise difficult. See Salzberg, *supra* note 2, at 163-4. In one of the most important of the recent mental health law reforms, the 1987 Act and corresponding regulations placed restrictions on hospitals' use of seclusion and physical restraints. 1987 Act Art. 36(3); M.O.H.W. Notification Nos. 129, 130, *supra* note 36; Enforcement Regulations, *supra* note 36, art. 18. U.N. Principle 11(11) prohibits the involuntary seclusion of psychiatric patients except when it is "the only means available to prevent immediate or imminent harm to the patient or others, and then only under certain conditions." In order to ensure that Japanese seclusion practices comply with both Japanese and international law, the 1992 I.C.J. mission has recommended that hospitals be required to keep seclusion registries documenting the duration of all instances of seclusion, and that all cases of seclusion over 72 hours of duration be reported to the P.R.B. 1992 I.C.J. Report, App. A *infra* at 11.

226. Under the U.N. Principles, the same commitment criteria and procedures should apply when a patient's status is changed from voluntary to involuntary as when a patient is initially admitted involuntarily. See U.N. Principle 15(3) ("Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right."). However, the conversion of patients from voluntary to involuntary status is a particularly sensitive issue because it takes place completely within the confines of the hospital. The change in status is difficult to monitor, and hospitalized individuals are especially vulnerable to institutional and outside pressures. To safeguard the rights of these patients, the I.C.J. mission has recommended that all instances of conversion from voluntary to involuntary status be required to be reported to the P.R.B. secretariat for review by the P.R.B. itself. 1992 I.C.J. Report, App. A *infra* at 11.

227. See, e.g., Kobayashi, *supra* note 41; Salzberg, *supra* note 2.

fail to provide even basic procedural protections. Furthermore, P.R.B. members, patients, and treating physicians alike feel alienated from the system.

What remains to be seen is whether the system as currently implemented is an important first step toward a more just and effective mechanism for protecting psychiatric patients' rights, or whether its only legacy will be its "prophylactic effect, opening a window on matters hitherto not subject to regular review."²²⁸ It is the author's opinion that the P.R.B. system has the potential to succeed by international and domestic standards if, and only if, both of the following occur: (1) modifications are made to both the mental health and P.R.B. systems in accordance with international standards reflected in the U.N. Principles; and (2) the P.R.B. system is fine-tuned from within Japan to fit smoothly into the Japanese culture.

It has been argued that the P.R.B. as an institution should be rejected as too adversarial and confrontational to survive in the context of the traditional Japanese approach toward conflict resolution.²²⁹ While it is true that many of the procedures required by the U.N. Principles are unfamiliar to the Japanese legal system, such procedures represent minimal standards necessary for the protection of patients' rights. Although it is important that review boards function in accordance with their unique cultural contexts, rules must be laid down to ensure the supremacy of fundamental human rights over cultural norms. While "law in practice" may have as significant an effect on commitment procedures as "law on the books,"²³⁰ the "content and the language of the law do make a difference by establishing the boundaries within which the other important variables regarding commitment may operate."²³¹

It is possible for the P.R.B. system to comply with international standards of human rights and still be effective from a domestic perspective. The use of patients' counselors as intermediaries between patients and treating physicians, greater emphasis on P.R.B. recommendations concerning patients' treatment and on periodic reviews, and other modifications such as those discussed in this Article would increase the P.R.B. system's accessibility to patients and give panel members more realistic

228. *Id.* at 162.

229. See Salzberg, *supra* note 168.

230. See U. Aviram, *Care or Convenience? On the Medical-Bureaucratic Model of Commitment of the Mentally Ill*, 13 INT'L J.L. & PSYCHIATRY 163, 165 (1990).

231. *Id.*; see also Rosenthal and Rubenstein, *supra* note 48, at 284-85 ("Unless states are pressured through international scrutiny and supervision to enact domestic laws reflecting international obligations . . . the rights promised in international instruments often remain empty and unfulfilled.").

and appropriate responsibilities. If these reforms were combined with an adequate system of community-based care providing a reasonable alternative to involuntary hospitalization, the P.R.B. system could evolve from a perceived obstacle to commitment into a useful tool for ensuring the least restrictive form of treatment.

These changes will not be made quickly or easily. In addition to political, economic, and socio-cultural realities surrounding both law and psychiatry, the P.R.B. system faces widespread antagonism as the product of foreign interference in Japanese life. The system itself was developed pursuant to international recommendations, under international pressure, based on a foreign model.²³² It may be compared to American laws which were imposed on Japan after World War II "like plants which have grown rapidly by means of forced cultivation. They bloomed before they put down roots. The blossoms might have appeared gorgeous, but have produced a meager yield of fruit."²³³

In order for the P.R.B. system to put down roots in Japan, there must be a commitment from within the country to make the system grow. The answer to the system's "meager yield of fruit" is not to discard the plant, but to cultivate it so that it can thrive in its own soil. With work from inside Japan, the international model of the P.R.B. system can "lead to a Japanese system—one that is appropriate for the culture and at the same time progressive for patients."²³⁴ The U.N. Principles do not require that states establish overly legalistic or adversarial forms of adjudication, but only that they ensure basic procedural protections for patients faced with involuntary hospitalization. Given perseverance, patience, and political will, Japan should be able to work within this framework to make the P.R.B. system its own.

232. The 1987 Act and the P.R.B. system evolved quickly in response to the first I.C.J. mission's recommendations and attention by the United Nations on the plight of Japan's institutionalized mentally ill. Salzberg, *supra* note 2, at 143-44. Accordingly, Japan's mental health system has been described as a "borrowed model, imposed on Japan without considering cultural, social and historical conditions." Kobayashi, *supra* note 41, at 5. "It is said that the P.R.B.s were modeled after Great Britain's Mental Health Review Tribunals. However, borrowing the concept did not make the system the same." Kobayashi, *supra* note 41, at 73.

233. M. Itō *quoted in* THE JAPANESE LEGAL SYSTEM, *supra* note 170, at 250.

234. Kobayashi, *supra* note 41, at 6.