

* This English manuscript is a translation of a paper originally published in the *Psychiatria et Neurologia Japonica*, Vol.125, No.4 p. 283-290 which was translated by the Japanese Society of Psychiatry and Neurology and published with the author's confirmation and permission. If you wish to cite this paper, please use the original paper as the reference.

Special Feature Article

A Policy of Peer Supports on an Achieve Advocate Service in Psychiatric Hospitalization

Naoyuki KIRIHARA

1 Japan National Group of Mentally Disabled People

2 Research Fellow of the Japan Society for the Promotion of Science

3 Doshisha University

Psychiatria et Neurologia Japonica 125: 283-290, 2023

Abstract

This paper outlines the overall system of patient advocates for persons admitted to psychiatric hospitals and other facilities, who are external parties responsible for visiting facilities and protecting the rights of admitted patients. It also aims to clarify the role of peer supporters within that system. Patient advocates have taken on multiple different lineages, and have therefore come to be interpreted differently by different proponents. This paper details both the lineage of legal models based on the principles for the protection of persons with mental disorders and the improvement of mental healthcare, as well as the lineage of social models that follow from the Convention on the Rights of Persons with Disabilities. It points out that in Japan, since patient advocates have come to be accepted based on the legal model perspective, discussion based on the social model perspective has been scarce. This is followed by a description of the governmental review process in respect of the introduction of a formal patient advocate system. The issues raised in the report of the working group on the future of mental healthcare and welfare (February 2017) are effectively being reconsidered, and it has been made clear that the patient advocate system is being transitioned to one based on the defense of rights. Moreover, the author proposes an overall vision of the introduction of a patient

advocate system that details its functions, roles, targets, actors, implementation framework, funding, and similar. Finally, with respect to the utilization of peer support, the paper points out several gaps that cannot be overlooked between the image of peer supporters imagined by governmental policy on national peer support professional skills evaluation and the lineage of peer supporters who work at Centers for Mental Health and Human Rights. Peer supporters who work at Centers for Mental Health and Human Rights make up a large majority of those affiliated with a peer supporter group. Through the above, this paper allows the overall picture of the patient advocate system and the role of peer supporters within that system to be clarified.

Keywords: advocate, advocacy, peer supports, Convention on the Rights of Persons with Disabilities, social model

Introduction

The purpose of this paper is to provide an overview of the entire system of rights advocacy activities, hereafter referred to as the “patient advocate,” conducted through external visits to individuals hospitalized in psychiatric institutions, and clarify the role of peer supporters within this framework. In this context, “patient advocate” refers to a series of remedial activities aimed at supporting the rights of psychiatric inpatients through interventions from outside the hospital. This term is used in a broad sense, regardless of differences in ideological background or institutional lineage.

The structure of this paper is as follows. Section I discusses two distinct traditional views of the patient advocate and examines how the concept has been

received in Japan, in order to establish a conceptual foundation. Section II elucidates the process by which a patient advocate system has been explored and considered for institutionalization in psychiatric hospitals. Section III offers detailed proposals for the realization of such a system, including its functions and organizational structure. Section IV outlines future prospects for the use of peer support. The final section, entitled ‘Conclusion,’ summarizes the main arguments of this paper.

I. Historical development of the Patient Advocate System

1. Issues arising from the increasing complexity of the patient advocate system

Currently, the patient advocate system involves multiple, distinct traditions, resulting in an overly abstract and vague explanation of the system. If institutionalization proceeds forcefully based on a consensus among experts while these differing interpretations remain unresolved, there is a risk that the coherence of the system will eventually collapse, leading to confusion in practice. Therefore, it is essential to clarify the functions and roles of the advocacy system before institutionalization. In this section, the image of the patient advocate system will be examined through the lens of two distinct traditions.

2. The historical development of patient advocate systems as due process within the legal model

The movement toward institutionalizing the patient advocate system gained momentum around 1987, when the revision of the Mental Health and Welfare Law introduced procedural safeguards. This revision was prompted by two key factors: the need to establish a welfare-based legal framework, and the demand for procedural safeguards in response to the Utsunomiya Hospital incident. The latter was particularly influenced by international developments. At the time, the United Nations Sub-Commission on Prevention of Discrimination and Protection of

Minorities was deliberating formulation of the Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care (hereafter, the United Nations Principles). During these discussions, a conflict emerged between the International Law Commission and World Psychiatric Association. The former advocated for the introduction of procedural safeguards to prevent arbitrary practices by medical professionals and serve the interests of patients. In contrast, the latter argued that state interventions in medical practice through legal mechanisms, such as security measures (hoan shobun), violated patients' rights, and that it was in patients' best interests to respect the discretion of medical professionals to the greatest extent possible. Following this debate, the former approach came to be known as the "legal model," while the latter became known as the "medical model."

As a result of this conflict, the United Nations Principles were adopted in 1991 as a compromise between both positions. The principles included procedural safeguards for the appointment of patient advocates from the perspective of the legal model (Principle 18). Since then, the demand for such safeguards in the appointment of advocates has gradually gained traction in Japan as well.

3. The historical development of advocacy systems aligned with the social model of the Convention on the Rights of Persons with Disabilities

On December 13, 2006, at the 60th session of the United Nations General Assembly, the Convention on the Rights of Persons with Disabilities (hereafter “CRPD” or “the convention”) was adopted. The convention does not grant new rights to persons with disabilities; rather, considering the current reality that they are not able to fully exercise human rights equally with others, it aims to realize a society in which they can enjoy these rights on an equal basis. The Japanese government signed the Convention on September 28, 2007. Following legal preparations for ratification, the Diet unanimously ratified it in January 2014.

The convention is based on the social model. This model rejects the “individual model,” which attributes disability-related problems to the individual, and instead takes the position that society as a whole is responsible for overcoming these issues and aims to shift toward a framework dedicated to their resolution. From the perspective of the social model, the practice of attributing the challenges faced by psychiatric inpatients solely to their medical condition, and the tendency to place responsibility for

problems within psychiatric hospitals solely on those institutions while civil society refuses to engage, must be fundamentally reformed. Moreover, psychiatric inpatients must be guaranteed the right to receive medical care of a quality equivalent to that offered in general medical departments.

Considering the convention’s principles, a patient advocate system must encompass several elements: support to be able to exercise legal capacity (Article 12, Paragraph 3); measures to prevent abuse (Article 16); progressive steps to promote the transition from institutional care to community living (Article 19); and support for informed consent in medical care (Article 25). In addition, the institutionalization of such a system must ensure the participation of persons with disabilities in policymaking processes through organizations representing them (Article 4, Paragraph 3), as well as their involvement in the implementation and monitoring of the convention (Article 33, Paragraph 3). The participation of persons with disabilities is thus essential.

4. Acceptance of the patient advocate system in Japan

To introduce patient advocates in Japan, the activities of Protection and Advocacy, Incorporated (PAI), a public

rights protection agency in the state of California, USA, have often been cited as a case example. PAI has adopted a system in which, for every person with a mental disability who is involuntarily hospitalized, a patient advocate, referred to as a public guardian and advocate for rights, is individually assigned. In addition, when an incident occurs in a psychiatric hospital, PAI has the authority to conduct independent investigations, and the findings are made public.²⁾ Since the introduction of PAI's example, Japan has seen increasing discussion about the need to establish a system in which each involuntarily hospitalized patient is assigned an individual advocate, similar to the model in California.¹⁾ At that time, the patient advocate system in Japan was primarily understood through the lens of the legal model.

Furthermore, during the process of legal reform undertaken to prepare for Japan's ratification of CRPD, the patient advocate system was also considered. However, much of this consideration was driven by expectations that the system would serve as a tool to promote deinstitutionalization, without sufficient attention to alignment with the core principles of the convention. As a result, the concept of a patient advocate based on CRPD and the social model has rarely been discussed.

Moving forward, it is essential to develop a coherent patient advocate system grounded in the values of the convention and social model.

II. Background

1. Preceding developments

On October 8, 2021, the Ministry of Health, Labour and Welfare established a review committee to begin discussions on the institutionalization of a patient advocate system within psychiatric hospitals. This section outlines the process of consideration leading up to the present. In Japan, two representative institutional efforts have been made to protect the rights of psychiatric inpatients: the Therapeutic Environment Supporter Program implemented by Osaka Prefecture, and the Mental Health Duty Attorney System established by bar associations.

The Therapeutic Environment Supporter Program originated from advocacy efforts by the Osaka Center for Psychiatric Patient Rights (founded in 1985) and from the Yamatogawa Hospital Incident in 1993. In 1996, the Osaka Prefectural Mental Health and Welfare Council issued a report declaring that: "social hospitalization constitutes a human rights violation." In response, the Osaka Mental Health and Human Rights Center launched the "Burari Visit" Program as an initiative aimed at improving the closed nature of

psychiatric hospitals. In 2003, Osaka Prefecture inaugurated the Psychiatric Care Ombudsman Program, thereby institutionalizing the “Burari Visit” Program as a public initiative. Today, it continues in the form of the Therapeutic Environment Supporter Program.

The Mental Health Duty Attorney System was first institutionalized in Japan by the Fukuoka Bar Association in 1993. Under this system, attorneys visit psychiatric hospitals to offer patients a free, one-time legal consultation. Since then, the number of bar associations implementing this system has increased nationwide. However, under the Comprehensive Legal Support Act, legal aid does not cover discharge requests or petitions for better treatment, leading to calls for a stronger public legal foundation for the system.

2. Legal reforms toward ratification of the “Convention on the Rights of Persons with Disabilities”

The Japanese government began its consideration of institutionalizing a patient advocate system in the context of legal reforms aimed at ratifying the Convention on the Rights of Persons with Disabilities (CRPD). On June 29, 2010, the cabinet adopted the “Basic Policy on the Promotion of Reform of Systems for Persons with Disabilities,” which stated the government’s intent to

“promote intensive reforms of systems concerning persons with disabilities in Japan, including the development of domestic legislation necessary for ratifying CRPD.” In the area of healthcare, the policy declared that “a conclusion should be reached by the end of 2012 regarding the system for involuntary hospitalization of and forced medical intervention for persons with mental disabilities, including a review of the “guardianship system in psychiatric care.”⁴⁾ In response, the Ministry of Health, Labour and Welfare established the “Study Team for the Development of a New Community-Based Mental Health and Medical Care System” in June 2012, and in October of the same year, full-scale discussions began regarding the guardianship system in psychiatric care and inpatient system.

During these discussions, a major issue that emerged was who would assume the role of providing consent in cases of involuntary hospitalization with the consent of a guardian, following abolition of the guardianship system in psychiatric care. Initially, this role was referred to as that of a “proxy,” envisioned as someone responsible for rights advocacy. However, after extended discussions, the role of the proxy was redefined as part of a system to support an inpatient’s decision-making and expression of intent. As a

result of the review, a key concern was formally recognized in relation to revision of the system for involuntary hospitalization with the consent of a guardian: “Whether adequate rights protection is ensured for patients who are hospitalized without their own consent.”¹⁾

In the 2013 revision of the Act on Mental Health and Welfare for the Mentally Disabled, Supplementary Provision Article 8¹²⁾ included the following clause: “The government shall, within three years of the enforcement of this act, taking into account the status of enforcement and changes in the environment surrounding mental health and welfare for persons with mental disabilities, conduct a review of the transportation and admission procedures under involuntary hospitalization with the consent of a guardian, measures to promote transition to community life through discharge from such hospitalization, and the support system for decision-making and expression of intent by persons with mental disabilities regarding treatment and discharge during hospitalization in psychiatric hospitals. If deemed necessary, the government shall take appropriate measures based on the results of this review.” Thus, the institutionalization of systems supporting the decision-making and expression of intent by

persons with mental disabilities was deferred to a future legal amendment.

3. Advocate guidelines

In January 2016, the “Study Meeting on How the Future of Mental Healthcare and Welfare should be” (hereinafter “Study Meeting on Future Directions”) was established as a forum for deliberation based on Supplementary Article 8 of the Act on Mental Health and Welfare for the Mentally Disabled. At the Study Meeting on Future Directions,³⁾ deliberations were once again held on supporting the decision-making and expression of intent of persons with mental disabilities, pursuant to Supplementary Article 8. As a result, it was confirmed that support service offices would take on this role in practice, targeting medical institutions conducting involuntary hospitalization with the consent of a guardian, and that this service would be positioned as a Community Life Support Project. Four main functions were outlined: (i) staying close to the patient, helping them understand the content of treatment, drawing out their will to support decision-making, and communicating their will to the medical institution if the patient consents; (ii) supporting decision-making toward discharge and facilitating discharge; (iii) supporting inpatients to exercise

their own rights, such as requests for discharge; and (iv) determining the necessity of hospitalization and whether appropriate medical care is being provided. In parallel, several research projects were conducted as part of initiatives funded by the Health and Labour Sciences Research Grant under the Comprehensive Welfare Promotion Project for Persons with Disabilities: FY2013, “On the Training and Implementation of Personnel to Provide Decision-Making Support and Advice for Persons with Mental Disabilities” (Study Group on Establishing Support Triads for Persons with Mental Disabilities, chaired by Professor Hiromi Shiraishi of Toyo University); FY2014, “Model Project on Decision-Making and Expression of Intent by Hospitalized Persons with Mental Disabilities” (same study group); FY2015, “Model Project on Decision-Making and Expression of Intent of Persons with Mental Disabilities Regarding Hospitalization” (Japan Psychiatric Hospitals Association). Based on these results, a framework called the “Advocate Guidelines,” aimed at systematization, was proposed.⁸⁾ The content of the guidelines specified that support for decision-making and expression of intent for hospitalized persons with mental disabilities should be carried out by a team based at a support service office, consisting of one

support coordinator and two peer supporters. The basic approach to support emphasized attentive listening, with minimal direct intervention.

Furthermore, in the FY2018 national budget, a training program was included for those involved in the support of decision-making, etc. (hereinafter, “FY2018 Budget Project”). In this program, based on the Advocate Guidelines, human resource training is to be conducted with the goal that support coordinators (advocates) affiliated with support service offices will visit hospitals that accept involuntarily admitted patients, and support decision-making toward discharge as well as the exercising of rights, such as requests for discharge.”⁵⁾

4. Transition to the advocate system

In response to government actions, the Osaka Center for Psychiatric Patient Rights issued a statement in December 2017, entitled: “Opinion, Demanding the Establishment of a Rights Advocacy System for People Hospitalized in Psychiatric Hospitals, Opposing the Advocate Guidelines by the Japan Psychiatric Hospitals Association,” clearly expressing opposition to the Advocate Guidelines.¹⁰⁾ These guidelines included: (i) provisions prohibiting advocates from providing information to hospitalized patients; (ii) provisions

requiring advocates to unilaterally report the content of conversations with patients to medical institutions; and (iii) provisions stating that advocates should promote patients' understanding of their treatment. The Osaka Center for Psychiatric Patient Rights argued that if advocates do not provide information to patients, unilaterally report conversations to medical institutions, and act solely to ensure treatment is administered, then this cannot be called "rights advocacy." Furthermore, in February 2018, a joint meeting was held by several organizations, including the Osaka Center for Psychiatric Patient Rights, Disabled Peoples' International Japan, the Japan Council on Disability (JD), the Japan National Group of Mentally Disabled People, the National Federation of Associations of Mental Health Service Users in Community Life (AMI), and the Japanese Association of Psychiatric Social Workers, to assert that the guidelines were inappropriate as a rights advocacy system.

The Japan National Group of Mentally Disabled People pointed out that, although the role of advocates was defined as "those who support individuals to receive psychiatric care autonomously in a supplementary manner" in the 2015 Comprehensive Welfare Promotion Project for Persons with Disabilities "Model Project on

Decision-Making and Expression of Intent by Hospitalized Persons with Mental Disabilities,"⁹⁾ the report of the Study Meeting on Future Directions positioned the advocates' purpose as "promoting understanding of treatment and eliciting the patient's will," revealing a marked inconsistency that necessitated reconsideration. They also demanded a review of the rationality of delegating functions that hospital staff should otherwise perform to advocates outside medical institutions, from the perspective of principles of public health insurance. Due to these opposing views, the 2018 budget project was not implemented.

Subsequently, in April 2019, under the Ministry of Health, Labour and Welfare administrative promotion research project subsidies, a sub-team, entitled: "Research on Supporting Decision-Making and Expression of Intent for Individuals with Mental Disabilities," was launched as part of "Policy Research to Promote the Strengthening of Community-Based Mental Health, Medical, and Welfare Systems" (Principal Investigator: Chiyo Fujii).⁶⁾ This sub-team aimed to continue addressing remaining issues regarding decision-making and expression of intent support for hospitalized persons with mental disabilities, effectively becoming a venue for reconsidering the advocate

system from a rights advocacy perspective. The sub-team adopted the policy of no longer using the term “advocate” but instead using “patient advocate.”

III. Proposal for the Patient Advocate System

1. The role of the advocate system in rights advocacy

This section provides detailed proposals outlining the overall framework for institutionalizing the advocate system in psychiatric hospitals. Fundamentally, rights advocacy is not confined to the advocate system, but should be regarded as a more expansive field of activity. Therefore, to clarify the role of the advocate system, it is first necessary to consider how this system should be positioned within the broader context of rights advocacy. Beyond the functions of the advocate system, rights advocacy activities include initiatives within hospitals, requests for discharge or improvements in treatment conditions, judicial solutions provided by legal professionals, administrative guidance and supervision of hospitals, reporting of detected abuse, daily life-independence support projects, and community-based services such as visiting care for persons with marked disabilities.

An important function that the advocate system should fulfill is

connecting hospitalized patients to external rights advocacy bodies, such as legal professionals. Safeguards against involuntary hospitalization, namely, rights advocacy functioning to provide monitoring and solution mechanisms, should be the responsibility of legal professionals, carried out through Mental Health Review Boards or judicial procedures.

2. Purpose of the advocate system

The purpose of introducing the advocate system can be summarized in two main points: (i) to bring an external perspective into psychiatric hospitals, thereby fostering an environment where transparency and open dialogue are ensured, contributing to the appropriate provision of medical care; and (ii) to assign advocates who support and represent the expressed will of hospitalized individuals. The “external perspective” in (i) overlaps with the role mentioned in the previous section of connecting hospitalized individuals to external rights advocacy bodies. By linking patients with people outside the hospital, they can regain the ability to exercise their inherent rights, which also leads to empowerment. Additionally, for hospitals, the introduction of an external perspective is expected to improve the closed internal culture and create a foundation

for delegating support to external parties.

Regarding (ii), conflicts of opinion may arise between hospitalized individuals and medical staff or family members regarding the necessity of hospitalization. In practice, the “appropriateness of hospitalization” is often overly emphasized, while consideration for the patient’s will and autonomy tends to be insufficient, often resulting in patient isolation. The advocate system plays a role in preventing such isolation by supporting and backing the patient’s expressed will.

3. Target population and perspective on rights violations

The system of involuntary hospitalization under the Act on Mental Health and Welfare for the Mentally Disabled constitutes a restriction of personal liberty based on the presence of a mental disability, and it has been criticized as violating the spirit of Article 14 of the Convention on the Rights of Persons with Disabilities (CRPD). Based on Article 39 of CRPD, the Japanese government is highly likely to face strong recommendations from the United Nations. To respond to such recommendations, it will be necessary to revise or abolish the current hospitalization system under this law and transition the entire framework to one aligned with that of

general medical care. It becomes clear that involuntary hospitalization results in a rights violation under international human rights treaties. Therefore, before discussing rights advocacy, the priority should be to eliminate such violations. Otherwise, the situation becomes self-contradictory: violating rights through involuntary hospitalization while simultaneously claiming to advocate for those rights.

The United Nations Principles recommend, from a due process standpoint, that advocates be assigned to individuals subject to involuntary hospitalization. However, the author takes a cautious view of this procedural argument. The concern is that this logic risks framing the advocate as an “essential component” of the involuntary hospitalization system itself. A common misunderstanding follows this reasoning: “Medical care should fundamentally be based on consent, but in some cases, non-consensual treatment may be necessary. Since non-consensual treatment can infringe on human rights, if involuntary hospitalization is to be permitted, then a rights advocacy system must accompany it.” However, rather than accepting involuntary hospitalization as a given and building rights advocacy around it, legal norms that result in rights violations must be reviewed, while simultaneously ensuring that

individuals receive the rights advocacy they need.

Additionally, the issue of consent or non-consent in medical care is conceptually distinct from that of whether a human rights violation or need for rights advocacy exists. There are cases where non-consensual treatment does not amount to a rights violation, and cases where treatment with consent may still constitute a violation. For example, failing to provide necessary treatment due to lack of consent can itself be a rights violation, while forcing treatment despite a clear refusal also constitutes a violation. Thus, while medical providers should operate under the principle that invasive procedures without consent are unlawful, rights advocates should not overemphasize consent as a singular criterion. The target population for the advocate system should include all hospitalized individuals who require rights advocacy, regardless of whether their hospitalization is voluntary or involuntary.

4. Roles and responsibilities of patient advocates

The patient advocate seeks to enhance transparency in psychiatric hospitals through external visits and contribute to the appropriate delivery of medical care. Therefore, it is a prerequisite in system design that the

advocate belongs to an “external” entity relative to the psychiatric hospital. Then, what does “external” mean? It should be determined based on whether the individual is in a position free from the influence of the hospital administrator, attending physician, and other hospital staff. The following individuals are considered to lack such externality and are thus not suitable to serve as advocates: (i) family members who have consented to involuntary hospitalization for medical protection, (ii) family members who filed the report related to the compulsory hospitalization, (iii) physicians who issued the referral letter to the admitting hospital, (iv) staff of the admitting medical institution, (v) staff of another medical institution operated by the same corporation, (vi) the assigned consultation support specialist and care manager, and (vii) lawyers under contract with the hospital, such as legal advisors.

Two main activities are proposed for patient advocates: regular scheduled (and preferably unannounced) rounds at psychiatric hospitals, and individual visits in response to requests from inpatients. During both types of visits, the advocate listens to the patient and engages in discussions with other involved parties, supporting the patient’s expressed will in these settings. Although direct support is not

envisioned as a core duty, the advocate's involvement does not preclude the patient from independently requesting or contracting such services. A two-person team is recommended as the standard format for visits, although solo visits are not categorically excluded. It is important to note that patient advocates are not tasked with decision-making support. Under Articles 42 and 51-22 of the Comprehensive Support Act for Persons with Disabilities, service providers are obligated to consider providing decision-making support. However, under current guidelines, such support is based on a "best interests of the person" principle, which partially conflicts with the objectives of this advocate system. Patient advocates are permitted to provide information to inpatients. While information provision should generally be based on patient requests, a strict interpretation that no information can be shared unless requested contradicts the intent of the system. Therefore, discussions are needed to clarify the conditions and standards under which information can be offered without a direct request from the patient. The author believes that it would be preferable to make information on social resources, such as relevant institutions, chlorpromazine-equivalent dosages, the 630 Survey, Mental Health Review Boards, and patient organizations,

available even without a specific request from the patient.

5. Implementation structure

The implementing bodies of the advocate system shall be prefectures and ordinance-designated cities. The operation of the system shall, in principle, be carried out as a commissioned project, and its financial resources should be positioned as a "mandatory service" under the Community Life Support Projects based on the Act on the Comprehensive Support for the Daily and Social Life of Persons with Disabilities. To ensure smooth initiation and dissemination of the system, the introduction of a subsidy scheme by the national government is desirable. The implementing body shall establish a center, tentatively named, and a forum for discussion to support the implementation framework. This center shall function as a consultation contact point and be responsible for the dispatch of patient advocates. Considering the differences in roles between related systems such as the supervision system and Act on the Prevention of Abuse, collaboration with a competent administrative authority is desirable. Serious abuse cases should be brought up as agenda items for the Prefectural Mental Health and Welfare Review Councils. A forum for discussion

should be established as an important channel through which the hospital and patient advocate can exchange opinions and work to resolve issues.

To be registered as a patient advocate, completion of the designated training is required. Regarding the use of peer support, the basic principle shall be the participation of persons with actual experience who belong to user organizations, to move away from the traditional model of individual recruitment (i.e., handpicking) of peer supporters by service providers.

IV. Utilization of Peer Supporters

1. Regarding the utilization of peer supporters

The involvement of peer supporters had been anticipated from the time of the Advocate Guidelines, which was the conceptual stage of the advocate system. However, at that time, peer supporters were expected only to accompany consultation support professionals without disabilities, visit hospitals, and listen to inpatients; their role was quite limited. Notably, since April 2021, as part of the national policy to evaluate the expertise of peer supporters, additional compensation has been provided to those who complete training programs for peer supporters. In fact, there is a significant correlation between the image of peer supporters assumed here and their image as

patient advocates within this system. In this section, we aim to clarify the envisioned role of peer supporters in the advocate system by comparing it with their image based on the current system.

2. The position of persons with actual experience in the Center for Mental Health and Human Rights

The Center for Mental Health and Human Rights has engaged in repeated discussions involving participants from diverse backgrounds, such as persons with actual experience, families, medical professionals, legal experts, and social welfare workers, in regions including Osaka, Tokyo, Hyogo, Mie, Kyoto/Shiga, Saitama, and Kanagawa, carrying out activities such as hospital visits and telephone consultations. Under the national policy of “evaluation of the expertise of peer support,” certain achievements have been noted, such as the development of training materials for peer supporters, organization of peer supporters, and provision of remuneration. However, serious issues have also been pointed out, including the ambiguity and misunderstanding of the role of peer supporters, lack of continuity with traditional advocacy by persons with lived experience, overemphasis on individuals with mental disabilities employed by service providers, absence of peer support as an organized group, and lack of solidarity

with disability organizations. In contrast, the Center for Mental Health and Human Rights adopts a fundamentally different framework from the national policy: individuals with actual experience, as members of disability organizations (self-advocacy groups), participate with an emphasis on “differences in position” as a key principle.

3. Problems with the national peer support policy

The national peer support policy has been developed in isolation from organizations that have long been engaged in peer support activities, such as the Japan National Group of Mentally Disabled People. Under the current system, peer supporters are limited to persons with disabilities employed by service providers, and the diverse peer support activities conducted by staff of independent living centers or self-advocacy groups are not envisioned. Furthermore, the training materials for peer supporters recommended by the government do not include the history of activities carried out by organizations of persons with mental disabilities that have been active in Japan for many years.⁷⁾

The government positions the effectiveness of peer supporters as a form of “support based on experience,” in which individuals use their

experience of disability to empathize with users, articulate their situations, and act as a bridge to professionals who are non-disabled. However, the essential value of peer support is not in “experience,” but rather in “support based on a shared position.” That is, when individuals who face the same problems share and confront those problems together from a common standpoint, they gain confidence and empowerment by realizing that “this is not just my problem,” “this is a problem for all of us,” and “I am not alone.” Even a peer supporter without hospitalization experience can offer vital emotional support to an inpatient simply by being “another person with a mental disability providing support.” In this sense, the national peer support policy adopts a narrow interpretation of peer support.

For persons with mental disabilities to serve as patient advocates, it is essential to maintain the perspective of “support based on a shared position.”

Conclusion

Through the above, we have clarified the overall picture of the patient advocate system and specifically outlined the role of peer supporters within it.

Editorial Note

This special feature article is based on the symposium held at the 117th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Naoko Satake (Department of Psychiatry, Kohnodai Hospital, National Center for Global Health and Medicine) as the representative.

There are no conflicts of interest to disclose in relation to this article.

References

- 1) 新たな地域精神保健医療体制の構築に向けた検討チーム: 入院制度に関する議論の整理.
(<https://www.mhlw.go.jp/stf/shingi/2r9852000002e9rk-att/2r9852000002e9u6.pdf>) (参照 2023-03-14) (in Japanese)
- 2) 木村朋子: アメリカの精神科患者権利擁護プログラムと当事者活動(後篇)—アドボカシーの参考例, 当事者によるセルフ・アドボカシー, そしてこれから—. 季刊福祉労働, 65; 130-137, 1994 (in Japanese)
- 3) これからの精神保健医療福祉のあり方に関する検討会: 報告書(平成 29 年 2 月 8 日). (<https://www.mhlw.go.jp/file/05-Shingikai-12201000-Shakaiengokyokushougaihokenfukushi-bu-Kikakuka/0000152026.pdf>) (参照 2023-02-10) (in Japanese)
- 4) 厚生労働省: 障害者制度改革の推進のための基本的な方向について (6 月 29 日閣議決定). 2010
(https://www8.cao.go.jp/shougai/suishin/kaikaku/s_kaigi/k_16/pdf/ref.pdf) (参照 2023-02-10) (in Japanese)
- 5) 厚生労働省: 平成 30 年度障害保健福祉部概算要求の概要.
(<https://www.mhlw.go.jp/wp/yosan/yosann/18syokan/dl/gaiyo-11.pdf>) (参照 2023-03-05) (in Japanese)
- 6) 厚生労働省行政推進調査事業費補助金(精神障害者政策総合研究事業)「精神障害者の意思決定及び意思表示支援に関する研究」(研究代表者: 藤井千代).
(https://mhlw-grants.niph.go.jp/system/files/2019/192131/201918036A_upload/201918036A016.pdf) (参照 2023-02-10) (in Japanese)
- 7) 厚生労働省科学研究費補助金(疾患・障害対策分野障害者政策総合研究)「障害者ピアサポートの専門性を高めるための研修に関する研究」(研究代表者: 岩崎 香)平成 30 年度総括・分担研究報告書. 2019 (in Japanese)
- 8) 日本精神科病院協会: 入院に係る精神障害者の意思決定及び意思の表明に関するアドボケーターガイドライン.

(https://www.nisseikyo.or.jp/about/hojokin/images/2015_06.pdf) (参照 2023-02-10) (in Japanese)

9) 日本精神科病院協会: 平成 26 年度厚生労働科学研究補助金(障害者総合福祉推進事業)入院中の精神障害者の意思決定及び意思の表明に関するモデル事業. 2015 (<https://www.mhlw.go.jp/file/06-Seisakujouhou-12200000-Shakaiengokyokushougaihokenfukushibu/0000099367.pdf>) (参照 2023-02-10) (in Japanese)

10) 大阪精神医療人権センター: 意見書—精神科病院に入院中の人々のための権利擁護システムの構築を求め, 日本精神科病院協会によるアドボケーターガイドラインに反対する—. 2017 (<https://www.psy->

jinken-osaka.org/wp/wp-content/uploads/2017/11/171118-2.pdf) (参照 2023-02-10) (in Japanese)

11) 定藤丈弘: カリフォルニア州における障害者の権利擁護システム—PAI (権利保護・擁護機関) を中心に—. ノーマライゼーション 障害者の福祉, 17 (9); 51-55, 1997 (in Japanese)

12) 精神保健及び精神障害者福祉に関する法律 (昭和二十五年法律第二百二十三号). (https://elaws.e-gov.go.jp/document?lawid=325AC010000123_20221216_504AC0000000104) (参照 2023-02-10) (in Japanese)