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Considering the Implementation of Japan's CRPD Concluding Observations from the Perspectives of Disability Studies and *Tōjisha Kenkyū*”

Shinichiro Kumagaya*

** Professor, Research Center for Advanced Science and Technology / the University of Tokyo, Chair, Policy Commission of Disability, Cabinet Office*

Thank you for the introduction. I’m Kumagaya. Today, in the first part of my talk I would like to discuss the policy progress of the Japanese government concerning the implementation of the Convention on the Rights of Persons with Disabilities (CRPD) and introduce several issues that remain to be addressed based mainly on a recently published paper by Ishikawa Jun, a former chairperson of the Committee on Policy for Persons with Disabilities.

In the second part, from my own perspective as a researcher, I would like to then propose several topics of discussion concerning how disability studies and *tōjisha-kenkyū*[1)] can contribute to finding solutions for some of these problems.

I am a pediatrician and university faculty member who has cerebral palsy, and I use a wheelchair in my day-to-day life. I work and conduct daily activities using a personal assistant. At my university, I specialize in *tōjisha* research, a unique form of community-based participatory research that originated in Japan.

Based on Ishikawa’s work, I would like to look back at the CRPD initiative, which became a turning point in Japanese policy regarding persons with disabilities, from its initial stage. As you may know, the CRPD was adopted in December 2006 and came into effect in May 2008, and Japan became a signatory in September 2007. Some groups of persons with disabilities opposed early ratification, however, based mainly on the lesson of what had occurred surrounding the Convention on the Rights of the Child when a rush to ratification prevented domestic systemic reforms from moving forward. This determination was borne out, and later reforms of the Basic

Act for Persons with Disabilities, enactment of the Act for Eliminating Discrimination against Persons with Disabilities, and establishment of important policy committees were undertaken. Regarding provisions in domestic law, the Committee for the Reform of Policies for Persons with Disabilities was established under a Democratic Party administration, and first and second opinions were collected in 2010, both of which supported a reform of the Basic Act for Persons with Disabilities and enactment of the Act for Eliminating Discrimination against Persons with Disabilities. Regarding the reform of the Basic Act for Persons with Disabilities, three points were raised in 2011. First, to introduce a definition of persons with disabilities based on the social model of disability. Second, to stipulate a duty to provide reasonable accommodation. Third, to establish the Committee on Policy for Persons with Disabilities within the Cabinet Office to oversee the formulation, implementation and monitoring of a basic plan for persons with disabilities.

The Committee on Policy began by establishing a prohibition of discrimination subcommittee, and in September 2009 collected opinions on anti-discrimination legislation. In June 2013 the Act for Eliminating Discrimination was put in place, and the cabinet office was obligated to establish a basic policy. One of the major points of contention in the initial debate was support for individuals expressing their own will in the context of reasonable accommodation for people with intellectual, developmental, and mental disabilities. The CRPD was then ratified, and a domestic monitoring framework was put in place, but this then became a major issue to be addressed. On January 20th, 2014, Japan ratified the treaty and the Committee on Policy for Persons with Disabilities was designated as a monitoring framework independent of the government. This was limited, however, to monitoring the implementation of the basic plan for persons with disabilities.

In May of 2015, on the occasion of his second invitation [to Japan], Ronald McCallum, who was Chair of the Committee on the Rights of Persons with Disabilities, provided an opinion asserting that the degree of freedom of the activities of the Committee on Policy as an independent monitoring framework should be expanded. He emphasized that funding should be given to allow organizations of people with disabilities to produce reports in parallel, and that the Chair of the Committee on Policy should be allowed to speak independently when engaging in constructive dialogue. The timing of the Committee on Policy receiving this opinion was during the interim monitoring of the third basic plan, but the committee addressed themes thought to be the point of the CRPD such as assistance in expressing one's will, assistance in transitioning to living in the

community, an inclusive education system, employment, and information accessibility as major issues to be addressed, and held working sessions on each of them. Ultimately the understanding of the Committee on Policy regarding the text of the treaty considered in these sessions was submitted to the Committee on Rights by the Committee on Policy independently of the government report.

When the Act for Eliminating Discrimination against Persons with Disabilities was reexamined three years after having been passed, the major topic of debate, if I may diverge slightly, was making it mandatory for private corporations to provide reasonable accommodation. At first there was opposition from business groups, but after debate, hearings, and analysis of actual cases in the Committee on Policy, the Secretariat of the Cabinet Office solidified its decision to impose this obligation. In the revised basic policy, the legal interpretation was clarified, and it was explicitly stated that different treatment because of things like using supports such as a wheelchair, assistance dog, or being accompanied by a helper, while being categorized as "related discrimination," is nevertheless a type of unjust discriminatory treatment. It also made clear that environmental improvement and reasonable accommodation are complimentary and function together to advance the elimination of social barriers.

Then, as is well known, in September 2008 Japan had its first inspection. This was carried out in Geneva. The Committee on Policy submitted its opinion to the government in June 2006. As I stated earlier, this was then sent to the Committee on Rights, and Ishikawa, Chair of the Committee on Policy, was given an opportunity to speak at this venue for constructive criticism from the standpoint of a monitoring framework independent of the government. One of the main concerns highlighted by the government committee was a lack of consideration of improvements toward a system of self-determination with assistance. In concrete terms, this was the problem of the adult guardianship system. The second concern was involuntary hospitalization of persons with mental disabilities and the lack of a roadmap for physical restraint. The third was the paradigm shift from separate to inclusive education being too slow. These were the three main points.

The Committee on Policy, a committee of the governing administration, presenting its concerns about government policy to the treaty body was considered greatly significant; this was seen as evidence that it was functioning as an independent monitoring framework. This has continued to the present, with the Committee on Policy monitoring the achievement status of the

5th basic plan for persons with disabilities. For each plan, while elucidating the corresponding clauses of the Basic Act for Persons with Disabilities and the CRPD, it monitors the achievement status using "KPIs"[2].

Having given a broad account of developments thus far, I would now like to talk about what is needed and what should be considered from the perspective of *tōjisha* research and disability studies in regard to a few of the items highlighted in the Concluding Observations [of the Committee on the Rights of Persons with Disabilities' Initial Report of Japan].

Paragraph 8c of the Concluding Observations states that disqualifying clauses based on "physical or mental disorder" should be eliminated from national and municipal legislation, along with derogatory language. An investigation by the Association to Abolish Disqualifying Clauses in 2001 found that while absolute disqualifying clauses had been removed from laws, relative disqualifying clauses through language such as "mental or physical disorder" had on the contrary increased. I myself began working as a doctor in 2001 when absolute disqualifying clauses had been eliminated, and I directly experienced how, in workplaces meeting certain conditions, a disability can be a kind of expertise that in fact improves the quality of medical care. What are these conditions, and what kind of concrete transformation must be carried out in the healthcare system? I think a useful resource when examining these questions is the perspective of HROs, that is, highly reliable organizations. HROs deal not only with healthcare, but also important infrastructure such as aircraft control systems. They are organizations that handle complex technology in situations where the slightest mistake or technical failure can lead to catastrophe. The people who work in these organizations have qualifications and certifications, and the public places a great deal of faith in them. HRO research pursues methods of maintaining a dynamic calm amid changing circumstances. Since this research pursues methods of realizing high performance organizations, it originated in a context unrelated to disability, but in recent years, mainly in the UK, HRO knowledge has increasingly provided insight in the field of employment support for persons with mental disabilities who require a high degree of assistance. Reflecting on my own experience, I feel that the hospital where I found it easy to work also satisfied the conditions of an HRO. After an organization called AHRQ published a white paper on HROs in 2008, this approach began to be actively employed in healthcare settings. Several frameworks have been proposed for improving HROs, including healthcare organizations related to public services where people with advanced qualifications work, but they are all composed and

constructed out of the main strategies of leadership development, safety culture, data systems, training and learning, and intervention implementation.

There has also been effect verification research, and the four studies that implemented the most comprehensive and multifaceted HRO initiative among the 309 papers reported by nine healthcare organs saw a great reduction in “medical errors” or major safety incidents. Moreover, the effects of these initiatives increased the longer they were introduced, and it was reported that they were maintained for over nine years. What were the HRO principles that allowed these HROs to both enable the participation of persons with disabilities and maintain themselves as a high performance organization given a high degree of trust by the general population? Five such principles have been put forward, each of which corresponds to a particular organizational culture.

The first principle emphasizes the operation of the organization and corresponds to a culture of mindfulness that separates itself from misconceptions and bias. The second principle corresponds to a culture of justice in which mistakes are learned from, errors are not punished, reporting is encouraged, and there is collective responsibility and joint research at the level of the organization. The third principle opposes simplification and corresponds to a culture of customization that seeks creative approaches without simplifying complex realities. The fourth principle increases resilience and corresponds to an agile culture that responds promptly to indications of abnormality. The fifth principle emphasizes expertise and corresponds to a culture of humility in which the judgement of the person with the most expertise or specialized knowledge is prioritized, regardless of rank within the organization. Drawing on my own case, I will examine how each of these principles is connected to the conditions that allow for the active participation of people with disabilities who have expert knowledge and qualifications.

I will start with the culture of mindfulness. “Mindfulness” refers to a culture that does not overlook data that are outside the organization’s shared expectations, that is, unexpected from the perspective of the explicit and implicit experience handed down from senior members. What is important in conjunction with this is a culture of sensemaking in which unexpected data are treated as resources for updating expectations rather than being swept under the rug. I call these two approaches combined a “culture of research.” Places where persons with disabilities work must be extraordinarily creative. Because persons with disabilities may not be able to work well while sticking to the established ways of doing things, the implementation of a culture that seeks innovative solutions within organizational culture is crucial.

Next, I will turn to the culture of justice. To give an anecdote from my own experience, when I was a medical resident, I couldn't take blood samples from small children very well. The textbook had photographs and text explaining how to take blood, but these meticulous instructions were designed for the majority. I would stop at a dollar store every day after work to buy various tools, and eventually I built myself a device that enabled me to take a blood sample by myself. When I approached a child's bed with this device on my knees, my colleagues, my supervisor, and the children's parents stared at me with evident concern that I would fail. One of the characteristics of my body is that my muscles tense up from psychological stress, so in such an environment I couldn't move the same way I usually did when I practiced, and I failed to perform the blood draw in repeated attempts. Each time I failed I would go back to the dollar store and try to improve my device, but rather than increase its functionality these augmentations only made it more bizarre. I got to the point of wondering whether my decision to become a doctor itself was egotistical and went against justice or what is right. Around this time my supervisor asked if I would like to try moving to a different hospital. The hospital he suggested was very busy, so I wasn't confident, but I transferred anyway, having resolved to give up on being a doctor if I could not succeed there. At the busy hospital to which I had been transferred, the overwhelming volume of work meant nobody could get by on their own, and there was a culture of having to help each other. The established culture was one in which, rather than standardize the ability of the staff, everyone knew each other's strengths and weaknesses; the person who first discovered an unexpected problem became an improvisational leader, and this leader would then put together an improvised team of requisite members based on their knowledge of what each person was good or bad at. Within this organizational culture, I was just one of many doctors who weren't necessarily good at everything. Wanting to get me working as soon as possible to reduce his own duties, my supervisor put me in charge of taking blood samples for a whole day, calling it "intensive blood sample training." At that point I had not succeeded in taking a blood sample even once, so I was terrified. I told him it was impossible, but my supervisor, who was very good taking blood samples, said, "Kumagaya, even I am guessing when I stick it in. I don't always get it right. Just give it your all without hesitation. I'll take responsibility." Hearing these words, all the tension left my body, and I succeeded in taking a blood sample for the first time. Various workplaces have a limited period or space in which new staff members can grow through trial and error without being afraid to fail. In technical jargon, this is called an "experimental zone." By

confessing that he himself was not infallible and sometimes failed, and by declaring that the organization as a whole, or, in other words, he as a leader, would take responsibility for the failures of its members, this supervisor can be said to have secured an experimental zone for me. Unfortunately, organizations that look for an individual culprit when unforeseen incidents or failures such as this occur and proceed to punish or exclude this individual once they are found are not uncommon. Such organizations come to see human beings as fallible and untrustworthy and build up rules and monitoring systems to constrain them. People therefore come to fear punishment and hide failures when possible, and this in turn deprives individuals and the organization of the opportunity to learn from small mistakes and failures. As a result, even if the members of the organization are replaced, the same major accidents are repeated. A culture of justice, on the other hand, praises the reporting of unforeseen incidents and failures, takes collective responsibility for the mechanisms that cause them as an organization, and studies them without abstracting their complexity. Only in such a culture can an experimental zone be secured, and both individuals and the organization as a whole become able to learn from mistakes and grow through taking on challenges without fear of failure. I've come to feel that without this kind of space it is quite difficult to work while having a disability.

Next is a culture of customization. When I was a medical resident, a different supervisor said to me, "A hospital where you cannot take a blood sample is a hospital that cannot save patients." What did the supervisor mean by this? The essential purpose of taking a blood sample can be stated as, for example, the three highly abstracted goals of not injuring the patient, taking the sample quickly, and not ruining the blood sample, and if I did not fully commit to these goals and flexibly and creatively customize the method of taking a sample to accommodate my own body, I could not have done my job. The result of this, as you see on the bottom left, was the invention of a method of taking blood samples while holding the needle in my mouth. This kind of culture that distills the essential goal of a task and customizes the methods of attaining it doesn't apply only to a doctor with a disability like me – there are patients with disabilities, diverse genders, diverse sexual orientations, and diverse cultures, so patients also have diverse backgrounds and characteristics. This kind of customization is also important if we are to provide meticulous healthcare to this diversity of patients. A hospital whose entire staff only knows by-the-book healthcare described in textbooks cannot address diverse patients. In other words, a culture of

customization is a necessary condition for the inclusion of both diverse healthcare professionals and diverse patients.

Technological advances change the technical standards, that is, the essential capabilities, required of healthcare professionals. The framework of "reasonable accommodation" also changes. Examples of this include hearing aids that transmit sound even to people who cannot hear and wheelchairs designed for surgeons that allow them to rise to a standing position. Personal assistants, like the ones I employ, also expand work opportunities for healthcare professionals with disabilities.

Next is a culture of agility. It is said that the secret to successfully transforming into an agile organization capable of rapidly responding to a crisis lies in increasing psychological safety. Psychological safety is the belief that you will not be punished or rebuked by your team if you communicate your ideas, questions, concerns, or failures. This psychological safety is essential for connecting diversity to performance. Research on research and development teams at pharmaceutical companies has indicated that teams with a high degree of diversity tend to have lower performance. When it comes to teams with high psychological safety, however, the higher their diversity the higher their performance is found to be. In the places where healthcare is provided, too, psychological safety is known to increase staff wellbeing, decrease stress, and lead to an improvement in quality through learning from failures. A culture where people speak forthrightly and openly rather than keeping their thoughts to themselves or making veiled comments is crucially important for working while having a disability.

Finally, there is the culture of humility. Along with the high economic cost of healthcare and inadequate services for persons with disabilities, the WHO has also cited healthcare professionals having inadequate knowledge regarding the needs and experiences of persons with disabilities as one of the causes of disparities in health between persons with and without disabilities. There is data showing that persons with disabilities are more than twice as likely to feel a healthcare provider's skills are inadequate, four times as likely to feel they have been treated inappropriately, and three times as likely to feel they have been refused healthcare [as persons without disabilities]. When the doctor has the same attributes as the patient, service satisfaction, adherence, and prognosis all tend to improve. This is called the patient-doctor concordance effect. For example, the myocardial infarction survival rate is lower for women than for men, but when the gender of doctor and patient is the same the survival rate increases. In other words, the fact there are more

male than female doctors may be one of the causes of a lower survival rate in female patients. Expanding on this, there is also the assertion that increasing the number of doctors with disabilities may decrease the disparity in health between persons with and without disabilities. Many healthcare professionals have a stigma towards persons with disabilities, and based on intergroup contact theory it is known that the most dramatic learning effect for reducing this stigma is not contact between doctors without a disability and patients with a disability, but rather contact on an equal footing as colleagues between doctors with and without a disability. This implies that having a disability is itself a kind of expertise and can lead to an improvement in the quality of healthcare. “Disability expertise” is a concept put forward by medical anthropologist Cassandra Hartblay, and refers to the knowledge and skills persons with disabilities acquire amid conflict with societies and institutions that exclude them.

The importance of humility has been highlighted in recent organizational science. Here “humility” means first making an effort to take an accurate view of yourself in regard to your own strengths, vulnerabilities, and non-discrimination and second acknowledging the strengths and contributions of other people. Third, it also means teachability in the sense of a learning posture and atmosphere that encourages teaching. It is quantified in terms of these three factors. The second factor, persons without disabilities acknowledging the strengths and contributions of persons with disabilities, is particularly essential for the demonstration of disability expertise. I think the words of my two supervisors I quoted earlier are examples of a culture that accepts disability expertise. The role of leaders is crucial to fostering a culture of humility. In the study we conducted, we found that when there are humble leaders in a company, psychological safety increases and the numbers expressing employee presenteeism, that is, what percentage of their own ability in their domain employees feel they are unable to demonstrate, go down. In government organizations, too, humility in leaders was also found to improve employee engagement and mental health through psychological safety.

To summarize what I have discussed so far, public institutions where people with qualifications work can be described as organizations that must work towards being HROs. We are conducting intervention research based on the hypothesis that by introducing *tōjisha* research we can increase the humility of leaders, and by raising the level of psychological safety we can help organizations get closer to being HROs.

As we have seen, far from being contradictory, aiming toward the realization of an HRO and aiming toward the inclusion of persons with disabilities, that is, persons with disabilities who have disability expertise, are approaches with an extremely high degree of compatibility. Services provided by public institutions must be inclusive of users with disabilities. The demonstration of a concordance effect through the presence of qualified persons with disabilities is crucial to this end, and since stipulating disqualifying conditions in general can be said to invite a decrease in the quality and inclusivity of services, it can be concluded that this practice must be abolished.

Moving to the next topic, an issue highlighted in the Concluding Observations was the need to build a community foundation and promote support and independent living along with prohibiting involuntary confinement for mental disabilities and integrating mental health and general healthcare. For example, there are 800,000 people who have been diagnosed with schizophrenia in Japan, for 30% of whom, that is, 240,000 people, the effectiveness of existing medication is limited, and for 15% of whom, that is, 120,000, an effect is not found even when they take clozapine.

As I will discuss later, there are several menus of support that can enable *tōjisha* for whom treatment with medication is ineffective and who live with hallucinations or delusions to live in the community. Despite this, the state of mental healthcare in Japan is such that long-term hospitalization and restraint in isolation without consent has been normalized. At present there are roughly 170,000 people in Japan who have spent at least one year living in a hospital. My field of expertise, *tōjisha* research, emerged in the context of support for the daily life and employment of people with mental disabilities in the community after long-term hospitalization. Here I would like to present a case study. A-san, who had been suffering from paranoid delusions, inflicted injuries on his mother, and was hospitalized under the Medical Treatment and Supervision Act. On the 96th day of his hospitalization he was prescribed clozapine, but while his symptoms improved, his powerful, fantastical delusions of battling *yamanba*[3)] continued to impede his daily life. There is a common evaluation scale used by all treatment and observation wards in Japan as a standard for releasing patients. Looking at the changes in A-san's scores during his hospitalization, there was little improvement after the administration of clozapine on day 96. Following the introduction of *tōjisha* research on day 929 during his third year, his scores fell dramatically and his condition became stable. A-san was then able to leave the hospital and successfully transition to life in the community. What exactly was this *tōjisha* research? It was a

simple approach of visualizing A-san's subjective experiences through one-on-one interviews and joint research with the [ward] staff and proceeding while consulting with the patient himself. The primary aim of the staff was not to evaluate A-san's experiences in terms of illness or abnormality, but to understand and share these experiences as a whole, and they adopted a stance of taking an interest and asking detailed questions. This is the complete reverse of what is advocated in old mental health textbooks in which it is written that we must not ask patients about their hallucinations or delusions. This approach differs from both the healthcare of the past that tried to change the *tōjisha* and the *tōjisha* movement that tried to change the environment, seeking instead only to understand and share the *tōjisha*'s experiences, and can be described as the "knowing and sharing paradigm."

Amid taking an interest and asking about A-san's experiences, while a complete picture of these experiences gradually emerges, at the same time, through this process of asking and listening, A-san's experiences also change – this is the true value of *tōjisha* research. What *tōjisha* research showed was that for over 20 years A-san had been fighting against dozens of *yamanba*. I think this must be very hard. The *yamanba* had been constantly crossing A-san's boundaries and excessively interfering in his life, making it impossible for him to have a job and breaking his plastic models. Through repeated research efforts, we learned that A-san had comrades on his side, like Gundam, an older female relative, or voice actors, even in the world of his hallucinations and delusions, that is, in his "other world." Forming a team with these comrades, he shifted his relationship with the *yamanba* from fighting to negotiation. This kind of team approach is also a concept employed at the treatment and supervision ward, and it is possible that the actual community around A-san was reflected in his "other world." One day, A-san's comrades from his other world suggested he make peace and stop fighting, and when he said it was over and they were under police supervision not to fight anymore, the *yamanba* apologized and surrendered. Everyone in the ward seems to have celebrated this moment the fighting ended with tears in their eyes. The *yamanba* sometimes still appeared, however, and A-san would resist them together with his comrades from the other world. A staff member said, "Maybe the *yamanba* want to be friends with you," but A-san replied, "They absolutely do not." Surprisingly, however, after this one of the *yamanba* proposed to him. Here the relationship with the *yamanba* changed from hostile interference in which they crossed each other's boundaries to friendly relations in which

boundaries were respected. In the end, A-san indicated that even he himself respected the *yamanba*'s efforts, saying, "Sometimes it's better to let things go. To only fight is not the way."

According to epidemiological research on the auditory hallucinations , 17% of children aged 9 to 12 and 7.5% of children aged 13 to 18 have experienced auditory hallucinations. In other words, experiencing auditory hallucinations is about as common as being left-handed. However, most people who experience auditory hallucinations build a friendly relationship with them, and only 5.3% have been bothered by voices in their daily lives. The difference between those who are bothered by voices and those who are not lies in the character of the voices they hear. People who believe the voices are extremely powerful and knowledgeable and cannot be controlled respond with fear and resistance as soon as they perceive the voices to have malicious intentions. On the other hand, those who interpret the voices as deeply compassionate have a high probability of getting along well with them.

Here, rather than regarding auditory hallucinations as something to be gotten rid of or pathological as in the past, an approach of considering it sufficient to change the character of the hallucinations from hostile to friendly comes into view. In avatar therapy, which has received a great deal of attention in the past ten years, an avatar is created based on asking the person having auditory hallucinations about the character of these hallucinations. The therapist then becomes the person in the avatar and converses with the person having hallucinations, and this therapy gradually deepens mutual understanding between the person and their hallucinations and shifts their relationship toward being friendly. This approach is significantly more effective than the counseling used in the past, but the fact that when the therapy stops the relationship returns to a hostile state is an issue that remains to be addressed. Behind the effect of avatar therapy not lasting lies the fact that the relationship with auditory hallucinations reflects relationships with real people. If there are once again hostile interpersonal relationships when it is decided that the person with hallucinations will leave the ward and return to the community, sooner or later their relationship with their hallucinations will revert to being hostile. A social model approach that targets the society around the person in question rather than them or their hallucinations is therefore essential. For example, if doctors and support providers have an excessively interfering, dominating relationship with the *tōjisha*, then their hallucinations will take on a dominating character in which they order and judge the *tōjisha* without respecting their wishes. Through *tōjisha* research, the staff at the ward adopted a stance of interacting with A-san on an equal

footing as a co-researcher, and A-san's relationship with the other people around him also changed. This then brought about a change in his relationship with the *yamanba*. To support the cessation of long-term hospitalization and the transition to living in the community, it is therefore necessary to implement *tōjisha* research not only in the hospital but also in the community. Urakawa, a town in Hokkaido where *tōjisha* research has been widely implemented, has succeeded in eliminating long-term psychiatric wards. Stanford University Professor Tanya Luhrmann has reported that while American auditory hallucinations tend to be aggressive and negative, those in India and Ghana are often supportive and positive. The content of auditory hallucinations is affected by the culture surrounding the person who has them. Auditory hallucinations are said to be closer to thoughts than perceptions; thoughts are nothing other than auditory hallucinations heard in one's own voice. Just as a certain number of people suffer from hostile auditory hallucinations, there is also a certain number of people who harshly criticize themselves and get caught up in negative thoughts when they are alone. As the political philosopher Hannah Arendt observed, hallucinations and thoughts reflect your relationships to real people and the community around you. Rather than saying hallucinations are pathological while thoughts are normal, it therefore seems better to say that both hallucinations and thoughts are normal, and look for a difference in whether their content is malignant or not.

It is important to develop a new community-based avatar therapy that combines avatar therapy with *tōjisha* research targeting real interpersonal relationships and a narrative community, and right now we are engaged in joint research involving *tōjisha*, support providers, and VR researchers. One approach that must be pursued is not distinguishing between mental healthcare and other, general healthcare, and I think the idea that there is no great difference between thoughts and hallucinations is an insight that can ground this view. In this research, we plan to use VR within a narrative community as a common language and medium of dialogue for mutual communication of struggles and experiences and verify the effectiveness of this approach.

Looking around the world, we also find the "hearing voices movement (HVM)" in the Netherlands as something similar to *tōjisha* research. HVM gave rise to a new form of therapy called "talking with voices." In this therapy, the therapist poses questions not to the person themselves but to their auditory hallucinations, and the person then listens to what their hallucinations say and conveys it to the therapist. This has been found to be extremely effective.

I would like to conclude by discussing several other issues pointed out in the Concluding Observations. Paragraph 10b states that the Tsukui Yamauri-en case should be reviewed from a perspective based on discrimination against persons with disabilities, whether referred to as eugenic thought, anti-person with disabilities thought, or ableist thought, and legal consequences for those promoting such views in society should be ensured. Regarding this point, we have allied with Kanagawa Prefecture and members of People First, and the Kanagawa Prefectural Welfare Organization, to be established in April 2026, is expected to address this issue. One of the important insights our work has produced is that, regarding Tsukui Yamauri-en, support providers have a strong stigma towards *tōjisha* with autistic tendencies. At the extreme end of this kind of attitude there are criminals, but it has come to be known and understood that when people work in a place with low psychological safety discrimination and prejudice is strengthened. In other words, rather than simply saying the workplace and those who committed crimes were bad, considering the situation from the perspective of whether the workplace had high psychological safety is a task that remains to be addressed.

Regarding the realization of inclusive education that is also demanded by the CRPD, this too is essential to eliminating social stigma. This stigma has profound effects on employment and health. According to Gordon Allport's intergroup contact theory, only contact that meets four conditions is significant in reducing stigma. The most important of these conditions is contact in a position of equality. In the case of inclusive education, too, when it is conducted in a form that is not based on equality it can conversely increase stigma, and I think Allport's four conditions are extremely important in calling out this kind of phony inclusive education. We believe it is important to realize social model-based inclusive education that leads to changes in the school system without individuals blaming themselves when difficulties occur. This means a culture of students' opinions changing schools taking root. This kind of culture has been found to have a positive influence on all students, whether or not they have disabilities. In research conducted together with Tokyo Metropolitan Institute of Medical Science targeting junior high schools and high schools in Tokyo, we reported that the implementation of this kind of social model markedly reduced depression and bullying among students.

Finally, I believe that close collaboration between the community of persons with disabilities and educational institutions such as universities is extremely important in realizing the spirit of the CRPD. The Tokyo University Center for Coproduction of Inclusion Diversity and Equity, of

which I serve as Vice Director, was established in April 2024. At this center, research and practice are brought together, and research jointly produced by researchers and *tōjisha* through special tōjisha discussion meetings is promoted. It is a center where the "nothing about us without us" approach is developed in research activities. These meetings are composed of members of groups of persons with diverse disabilities with consideration being given to gender balance. Each raises a research topic considered to have a high degree of priority, and we plan to collaborate with Tokyo University researchers in various fields.

Thank you for listening to my talk.

Notes

1) *Tōjisha-kenkyū* roughly translates as 'the science of the self' or 'self-supported research', in which people with disabilities and/or mental illness learn to study their own experiences. For further information regarding *Tōjisha-Kenkyū*, please consult the following references. Ayaya, S. (2025). *Tōjisha-Kenkyū* on Autism in Japan: Against Epistemic Injustices and Tokenism. Journal of Social Issues, 81(4), e70026. Ayaya, S., Kitanaka J. (2023). *Tōjisha kenkyū*. Aeon, June 12. https://aeon.co/essays/japans-radical-alternative-to-psychiatric-diagnosis

2) Key performance indicators

3) *Yamanba*, literally "mountain crones," are supernatural entities in Japanese folklore. They usually appear as elderly women and are found in wild or mountainous areas.

East Asia Disability Studies Forum 2025

Keynote speech 2

Considering the Implementation of Japan's CRPD Concluding Observations from the Perspectives of Disability Studies and Tōjisha Kenkyū”

Date & Time: October 26, 2025 (Sun), 10:00–11:00
Venue: Ritsumeikan University Osaka Ibaraki Campus Event Hall (ground floor), Ritsumeikan Ibaraki Future Plaza

Shin-ichiro Kumagaya
Research Center for Advanced Science and Technology, the University of Tokyo

Lecturer Introduction: Shin-ichiro Kumagaya

I have cerebral palsy
and use a powered wheelchair (Storm 3).
Width: 63 cm
Height: 98 cm
Depth: 110 cm
Weight: 140 kg

March 2001	Graduated from the Faculty of Medicine, The University of Tokyo
June 2001	Resident in Pediatrics, The University of Tokyo Hospital
June 2002	Department of Pediatrics, Chiba Nishi General Hospital
August 2004	Department of Pediatric Cardiology, Saitama Medical University Hospital
November 2009	Project Lecturer, Research Center for Advanced Science and Technology (RCAST), The University of Tokyo – Barrier-Free Research Division
April 2015	Associate Professor, RCAST, The University of Tokyo – Tojisha-Kenkyu (Self-Directed Research) Division
April 2017	Director, Disability Services Office, The University of Tokyo
April 2024	Professor, RCAST, The University of Tokyo – Tojisha-Kenkyu (Self-Directed Research) Division (current position)
October 2024	Deputy Director, Center for Coproduction of Inclusion, Diversity and Equity (IncluDE), The University of Tokyo (current position)

Opposition to the Early Ratification of the Convention on the Rights of Persons with Disabilities

- The Convention on the Rights of Persons with Disabilities was adopted in December 2006 and entered into force in May 2008.
- Japan signed the Convention in September 2007, but disability organizations such as DPI Japan opposed early ratification, believing that rushing ratification would impede domestic institutional reform—a lesson learned from the Convention on the Rights of the Child. They argued instead that reforms should be advanced while enthusiasm for ratification remained high.
- This approach led to subsequent achievements, including the revision of the Basic Act for Persons with Disabilities, the enactment of the Act for Eliminating Discrimination against Persons with Disabilities, and the establishment of the Council for Disability Policy.

Activities of the Council for the Promotion of Reform of Systems for Persons with Disabilities

- Under the Democratic Party administration, the Council for the Promotion of Reform of Disability Systems was established.Under the leadership of Director Toshihiro Azuma of the Council's Secretariat, the Council created two subcommittees: the Comprehensive Welfare Subcommittee and the Anti-Discrimination Subcommittee.
- In 2010, it compiled the "First Opinion" and "Second Opinion."As a result of these activities, the revision of the Basic Act for Persons with Disabilities and the enactment of the Act for the Elimination of Discrimination against Persons with Disabilities were realized.

石川准 (2024). 当事者参画のポリティクス――内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Key Points of the Basic Act for Persons with Disabilities (Amended in 2011)

- Introduce the definition of persons with disabilities based on the social model of disability:"Persons who, due to disabilities and social barriers, are in a condition in which their daily life or social life is substantially and continuously restricted."
- Establish a legal obligation to provide reasonable accommodation (to remove social barriers unless doing so would impose a disproportionate or undue burden).
- Reorganize the "Central Council for the Promotion of Measures for Persons with Disabilities" and establish within the Cabinet Office a **Disability Policy Committee**, responsible for formulating and monitoring the implementation of the Basic Plan for Persons with Disabilities.

Establishment and Early Discussions of the Council for Disability Policy

- The Subcommittee on the Prohibition of Discrimination was positioned under the Policy Committee and completed its mission in September 2012 by compiling its recommendations on "legislation concerning the prohibition of discrimination."
- Thanks in part to the efforts of Policy Coordinator Shiro Yamazaki, the Act for the Elimination of Discrimination against Persons with Disabilities was enacted in June 2013. The Cabinet was required to formulate a "Basic Policy," and drafting its proposal became the responsibility of the Policy Committee.
- One of the major points of debate was the provision of support for expressing one's will in the context of reasonable accommodation.

石川准 (2024). 当事者参画のポリティクス――内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Establishment of a national monitoring framework for the Convention on the Rights of Persons with Disabilities

- In December 2012, the Japan Disability Forum (JDF) invited Ron McCallum, Chair of the UN Committee on the Rights of Persons with Disabilities, and expressed its expectation for Japan's early ratification of the Convention.
- Japan ratified the Convention on January 20, 2014, and the Disability Policy Committee was designated as the independent monitoring framework (albeit with the limitation that this applies only "through monitoring the implementation of the Basic Plan for Persons with Disabilities").

The government statement from the 10th meeting of the Foreign Affairs and Defense Committee of the 185th Diet session on December 3, 2013:

"With regard to the monitoring of the implementation status of the Convention as referred to in Article 33(2), it is envisaged that the Council for Policy of Persons with Disabilities (Shōgaisha Seisaku Iinkai) will carry out this task through its monitoring of the implementation of the Basic Plan for Persons with Disabilities.
> We will strive to ensure appropriate administrative support so that the Council for Policy of Persons with Disabilities can fully perform its duties.
In addition, in preparing the government report based on the Convention on the Rights of Persons with Disabilities, we intend to hear the Council's opinions—provided through the Basic Plan for Persons with Disabilities—on matters contributing to the implementation of the Convention, and to reflect those views in the government report."

石川准. (2024). 当事者参画のポリティクス——内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Establishment of a national monitoring framework for the Convention on the Rights of Persons with Disabilities

- The reappointment of McCallum in May 2015 significantly expanded the policy committee's freedom to operate as an independent monitoring framework.

"In its initial report, the State should write in detail about what it has achieved and what it still lacks, and it should do so honestly. … When preparing the initial report, the government is required to consult with organizations of persons with disabilities, such as the Japan Disability Forum. … I hope that the Japanese government will also provide financial support to enable organizations of persons with disabilities to prepare their own parallel reports. I believe it is very important for the Policy Committee to be able to monitor and take part in the drafting of Japan's initial report to be submitted to the Committee on the Rights of Persons with Disabilities. … Several independent monitoring bodies also submit their own reports to the Committee on the Rights of Persons with Disabilities. … I think the Chairperson of the Policy Committee should be able to speak independently during the constructive dialogue."
(Cabinet Office, Disability Policy Committee, 2015: 4–9)

石川准. (2024). 当事者参画のポリティクス——内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Establishment of a national monitoring framework for the Convention on the Rights of Persons with Disabilities

- The mid-term review of the **Third Basic Plan for Persons with Disabilities** was conducted by **hearing reports from relevant ministries and agencies**. Four key themes were designated as *priority areas* for monitoring:
- (1) decision-making support, including the adult guardianship system;
- (2) support for community transition of persons with mental disabilities and those with severe disabilities requiring medical care;
- (3) inclusive education systems and employment; and
- (4) information accessibility.
- For each of these themes, a **working session** was organized, with **four members of the Policy Committee** serving as coordinators. Persons with disabilities, representatives of relevant organizations, and experts with deep knowledge of each theme were selected to participate. Through these sessions, the committee conducted **in-depth discussions and hearings**.
- In addition, at the plenary meetings, the committee also discussed issues concerning **women with disabilities** and **statistics on persons with disabilities**.
- In total, **nine meetings** were held. The results of the Policy Committee's monitoring of the domestic implementation of the **Convention on the Rights of Persons with Disabilities (CRPD)** were compiled in detail as an **annex to the government report**. Furthermore, the Committee's opinions on **eight specific articles (6, 12, 14, 19, 21, 24, 27, and 31)**—which were examined mainly through the working sessions—were incorporated into the **main text of the government report**, explicitly identified as views of the Policy Committee, and submitted to the **Committee on the Rights of Persons with Disabilities**.

石川進. (2024). 当事者参画のポリティクス――内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Three-year post-enforcement review of the Act for Elimination of Discrimination against Persons with Disabilities

- The main point of contention was the **mandatory provision of reasonable accommodation by private businesses**.
- There was **strong opposition and concern** from business federations and industry groups.
- After **discussions, hearings, and case analyses** at the Policy Committee, the **Cabinet Office Secretariat decided to move forward with making it mandatory**, securing agreement from relevant ministries and business organizations.
- From the business side, there were **calls for measures to address the concerns of small and medium-sized enterprises**, for **building a shared understanding**, for **adequate dissemination**

Formulation of the Revised Basic Policy for the Elimination of Discrimination against Persons with Disabilities

- Clarification of legal interpretation: It is explicitly stated that "unfair discriminatory treatment on the grounds of using a wheelchair, an assistance dog, or other assistive devices, or being accompanied by a caregiver, constitutes unfair discriminatory treatment on the basis of disability" (indicating the inclusion of related forms of discrimination).
- It is also specified that environmental improvements and reasonable accommodation must function in tandem as dual pillars to eliminate social barriers.
- Interpretation of indirect discrimination: Although many committee members requested an explicit statement in the legal interpretation, it was not included. However, it is suggested that indirect discrimination may be interpreted as a form of failure to provide reasonable accommodation.

石川進. (2024). 当事者参画のポリティクス――内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Japan’s review by the Committee on the Rights of Persons with Disabilities (CRPD)

- Japan’s initial review took place in Geneva on August 22–23, 2022.
- The Policy Committee examined progress and remaining concerns since the government’s report and submitted its *Opinion on the Implementation of the Convention on the Rights of Persons with Disabilities* to the Committee on the Rights of Persons with Disabilities in June 2022.
- During the constructive dialogue, the chairperson of the Policy Committee, speaking from the standpoint of an independent monitoring framework, sought an opportunity to make an opening statement and successfully obtained five minutes to speak through direct negotiation.
- The main concerns raised by the Policy Committee were as follows:
- * Insufficient consideration of reform toward a supported decision-making system (adult guardianship system)
- * Absence of a roadmap for eliminating involuntary hospitalization and physical restraints of persons with mental disabilities
- * Delayed paradigm shift from segregated education to inclusive education
- Significance:
- It was unprecedented for a government advisory body to express concerns about government policies before a UN treaty body. This marked the first concrete demonstration that Japan’s independent monitoring framework was functioning effectively.

石川准. (2024). 当事者参画のポリティクス――内閣府障害者政策委員会を舞台に. 障害学会20周年記念事業実行委員会(編). 障害学の展開, pp. - , 明石書店.

Monitoring and Evaluation of Progress under the Fifth Basic Plan for Persons with Disabilities

資料２－２

（別表）障害者基本計画（第５次） 関連成果目標

1．差別の解消、権利擁護の推進及び虐待の防止 （基本法第 23 条関係、条約第 10,12,14,16 条関係）

目標分野	把握すべき状況	指標	計画策定時の現状値	実績値（令和５(2023 年度)	目標値
権利擁護の推進、虐待の防止	成年後見制度の適切な利用のための支援の実施状況	地域生活支援事業（成年後見制度利用支援事業）を実施する地方公共団体の数【厚生労働省】	1,650 団体（2020 年度）	**1,708 団体（2023 年度）**	1,741 団体（2024 年度末）
		担い手（法人後見実施団体）の養成研修を実施する都道府県の数【厚生労働省】	15 都道府県（2020 年度）	**18 都道府県（2023 年４月１日時点）**	全都道府県（2024 年度末）
	ピアサポートの実施状況	精神障害にも対応した地域包括ケアシステムの構築推進事業（ピアサポートの活用に係る事業）を実施する地方公共団体の数【厚生労働省】	52 団体（2020 年度）	**集計中 ※本年９月頃判明予定**	前年度比増（～2027 年度）
		障害者ピアサポート研修事業を実施する都道府県の数及び研修修了者数【厚生労働省】	9 都道府県（2021 年度）	**集計中 ※本年９月判明予定**	全都道府県（2023 年度末）
			641 人 ※ピアサポーター、管理者及び基礎・専門・フォローアップ研修の合計値	**集計中 ※本年９月判明予定**	前年度比増（～2027 年度）
	ピアカウンセリングの実施状況	地域生活支援事業（ピアカウンセリングの活用に係る事業）を実施する地方公共団体の数【厚生労働省】	634 団体（2021 年４月）	**636 団体（2023 年４月）**	前年度比増（～2027 年度）
障害を理由とする差別の解消の推進	障害者差別解消に向け行政機関職員が遵守すべき服務規律の整備状況	障害者差別解消法に基づく対応要領を策定している地方公共団体の割合【内閣府（共生・共助）】	市町村※1：73.5%（2021 年４月）	**市町村※1：76.6%（2023 年４月）**	100%（2027 年度）
	地域で取組を効果的かつ円滑に行うためのネットワークの形成状況	障害者差別解消支援地域協議会を組織している地方公共団体の割合【内閣府（共生・共助）】	中核市等※2：83%（2021 年４月）	**中核市等※2：87.6%（2023 年４月）**	100%（2027 年度）
			その他市町村※1：55.9%（2021 年４月）	**その他市町村※1：60.7%（2023 年４月）**	80%以上（2027 年度）

※１：政令指定都市及び中核市等（※２）以外の市並びに町村
※２：中核市、特別区及び県庁所在地（政令指定都市を除く。）

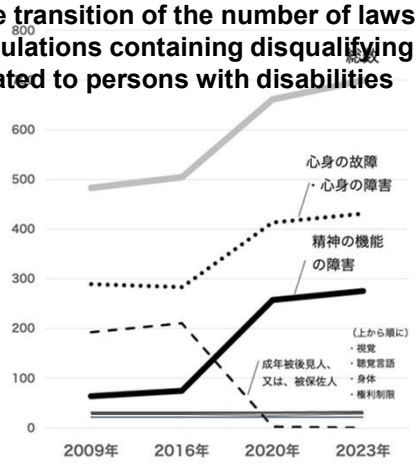
- Monitor the achievement status of each KPI while indicating the corresponding articles of the Basic Act for Persons with Disabilities and the Convention on the Rights of Persons with Disabilities.

https://www8.cao.go.jp/shougai/suishin/seisaku_iinkai/k_81/pdf/s2-2.pdf

Concluding Observations on the Initial Report of Japan under the Convention on the Rights of Persons with Disabilities (CRPD)

Paragraph 8 (c) Abolish derogatory language and legal restrictions, such as disqualifying clauses, based on "physical or mental disorder", in its national and municipal legislation

The transition of the number of laws and regulations containing disqualifying provisions related to persons with disabilities



Survey by the Secretariat of the Association for Eliminating Disqualification

High Reliability Organization(HRO)

Research on how organizations that manage complex technological systems—where minor mistakes or troubles can escalate into major crises amid diverse stakeholder demands—maintain a state of "dynamic non-events" (Weick & Sutcliffe, 2001, 2015) under ever-changing conditions.

Examples: nuclear-powered aircraft carriers, nuclear power plants, submarines, air traffic control systems, power distribution facilities, international banks, the medical field, and critical infrastructure systems.

This line of research began in the late 1980s at the University of California, Berkeley, bringing together scholars from business administration, political science, social psychology, and engineering, among other diverse disciplines. Each researcher had their own area of concern, but they formed a single investigative group and conducted field studies of the same organizations.

Application of HROs in Healthcare

Since the white paper published by the Agency for Healthcare Research and Quality (AHRQ) in 2008, the principles of High Reliability Organizations (HROs) have begun to be applied to the healthcare field.

> Hines, S., Luna, K., Lofthus, J., et al. (2008). Becoming a High Reliability Organization: Operational Advice for Hospital Leaders. AHRQ Publication No. 08-0022. Rockville, MD: Agency for Healthcare Research and Quality.

Since then, national leaders in healthcare quality improvement—such as AHRQ, The Joint Commission (TJC), and the Institute for Healthcare Improvement (IHI)—have made extensive statements on how HRO principles can be applied to healthcare.

> Chassin, M. R., and Loeb, J. M. (2013). High-reliability health care: getting there from here. Milbank Q, 91, 459–490.

> Frankel, A., Haraden, C., Federico, F., et al. (2017). A Framework for Safe, Reliable, and Effective Care. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare.

In February 2019, the U.S. Department of Veterans Affairs (VA) launched a nationwide HRO initiative by designating 18 Veterans Affairs sites as lead facilities, establishing workgroups, conducting readiness assessments, and providing training events for leaders. In December 2019, the VA Evidence Synthesis Program published a review to inform this initiative, focusing on "HRO implementation frameworks," "measurement," and "evidence of HRO implementation outcomes" from studies published since 2010.

> Veazie, S., Peterson, K., Bourne, D., et al. (2022). Implementing High-Reliability Organization Principles Into Practice: A Rapid Evidence Review. Journal of patient safety, 18(1), e320–e328.

Framework for Implementing High Reliability Organizations

Key Strategy:	Developing leadership	Culture of safety	Data systems	Training and learning	Implementing interventions
ACHE Framework[16]	✓	✓	✓		
Air Force Trusted Care[19]	✓	✓	✓	✓	✓
ARCC Model[20]		✓	✓	✓	✓
High reliability team model[21]		✓		✓	✓
IHI Framework[18]	✓	✓	✓	✓	✓
JH's Operating Management System[17]	✓		✓		
JH's Safety and Quality Framework[15]	✓		✓	✓	✓
Joint Commission's HRHCM[3]	✓	✓	✓	✓	✓
Number of frameworks addressing this strategy	**6**	**6**	**7**	**6**	**6**

Veazie, S., Peterson, K., Bourne, D., et al. (2022). Implementing High-Reliability Organization Principles Into Practice: A Rapid Evidence Review. Journal of patient safety, 18(1), e320–e328.

Effectiveness studies of HRO interventions

- A total of **309 studies** were identified from reports by **nine healthcare institutions** examining the effects of implementing **High Reliability Organization (HRO) initiatives** on **patient safety, safety culture,** and/or other **process outcomes**.
- Among these, **only one study** explicitly stated that it used a specific framework—the **IHI (Institute for Healthcare Improvement) framework**.
- Of the 309 studies, **four** implemented the most **comprehensive and multifaceted HRO initiatives**, and these studies showed a **substantial reduction in Serious Safety Events (SSEs)**, ranging from **55% to 100%**.
- In these four studies, **longer implementation periods** were associated with **greater effects**, and the **improvements in outcomes were sustained for more than nine years**.
- While the results of these studies are promising, **the overall strength of the evidence remains low**. Each initiative was evaluated in a **single study**, and all studies were rated as **low or moderate quality**, failing to establish **causal relationships** between HRO interventions and outcomes. This limitation arises because **none of the studies employed control groups** capable of excluding the influence of **other simultaneous changes** (for example, the concurrent introduction of electronic medical records) that might have affected the outcomes.

Veazie, S., Peterson, K., Bourne, D., et al. (2022). Implementing High-Reliability Organization Principles Into Practice: A Rapid Evidence Review. Journal of patient safety, 18(1), e320–e328.

High Reliability Organization: HRO

Culture of Mindfulness: A culture that takes distance from assumptions and biases.
Just Culture: A culture that responds to failure not with blame or punishment, but through welcoming reporting, collective responsibility at the organizational level, collaborative research, and mutual interdependence.
Culture of Customization: A culture that avoids overly simplifying complex realities or rigid, rule-bound responses, instead seeking creative solutions.
Agile Culture: A culture that responds swiftly to early signs of abnormalities.
Culture of Humility: A culture that prioritizes the judgment of those with the greatest expertise, regardless of organizational hierarchy.

Weick KE, Sutcliffe KM. Managing the unexpected: Resilient performance in the age of uncertainty., 2nd ed. San Francisco, CA: Jossey-Bass; US; 2007.

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The culture that shapes the process of organizing

Mindfulness
The ability to notice and not overlook unexpected data that fall outside an organization's shared assumptions—its theories, beliefs, or rules of thumb.

Sense-making
The process of not ignoring unexpected data but instead using them as resources to revise and update existing assumptions.

Research culture
A culture in which an organization learns from failure and is capable of change.
Members desire and have the capacity to draw correct conclusions from available information,
and they possess the willingness to implement modifications and adjustments to mitigate risk.

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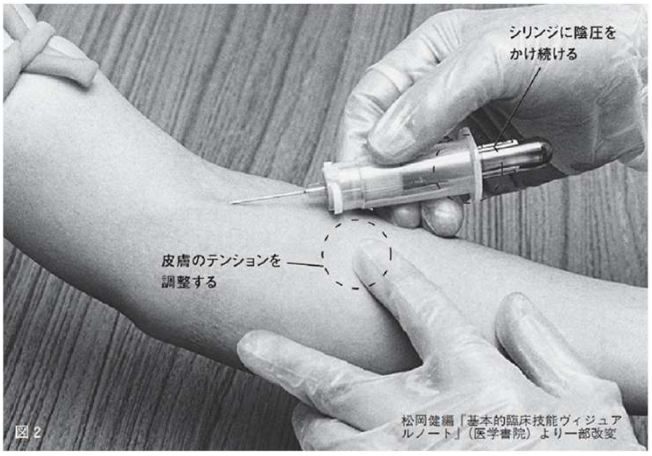
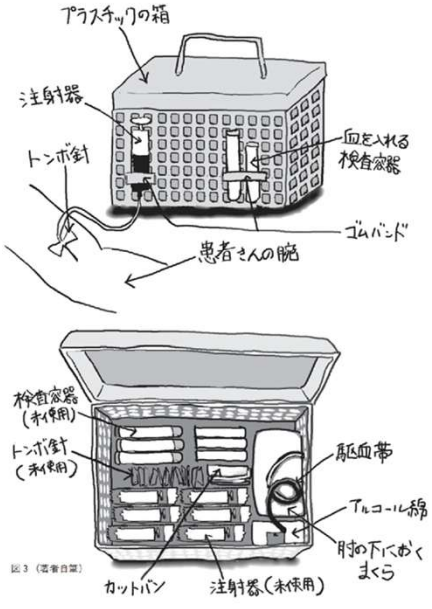
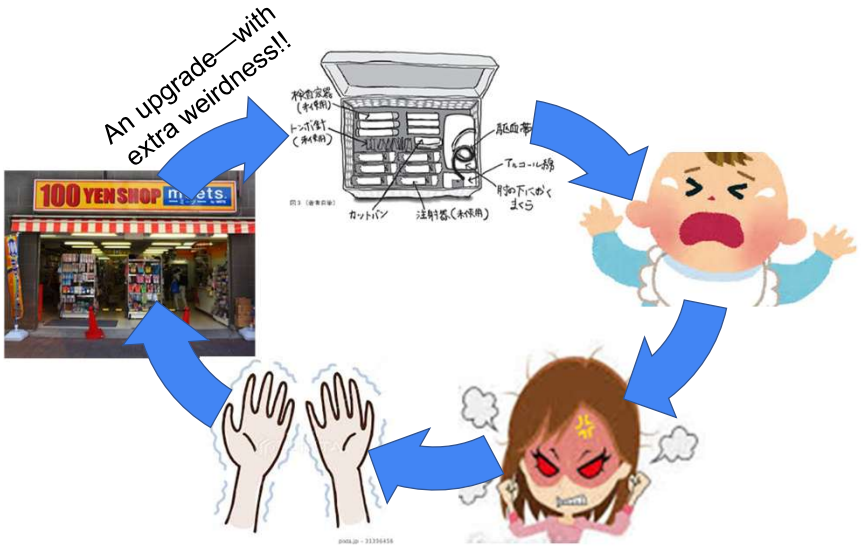
Verbalizing the experiences of medical residents with disabilities

A culture that prioritizes performing exactly as instructed





Verbalizing the experiences of medical residents with disabilities



Leadership that ensures a space for experimentation

Take the leap, Dr. Kumagaya. I'll take full responsibility.

Encouraging staff to experiment and grow without fear of failure,
and fostering an organization that learns from mistakes and adapts flexibly,
↓
requires reducing the risks borne by staff and having leaders take on those risks themselves.

The culture that shapes the process of organizing

Just culture（Dekker 2008）

unexpected event failure

1. * Shifting organizational responsibility onto individuals through blame and punishment
2. * Tightening of rules
3. * Cover-up / concealment

1. * Accountability and a non-blaming culture
2. * Revisiting and refining assumptions
3. * Viewing issues as organizational rather than individual problems

A culture that fosters trust, encourages and rewards the sharing of critical safety information, while maintaining a clear boundary between acceptable and unacceptable behavior.

High Reliability Organization: HRO

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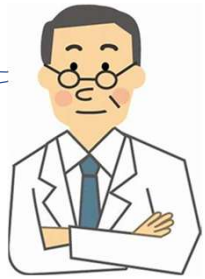
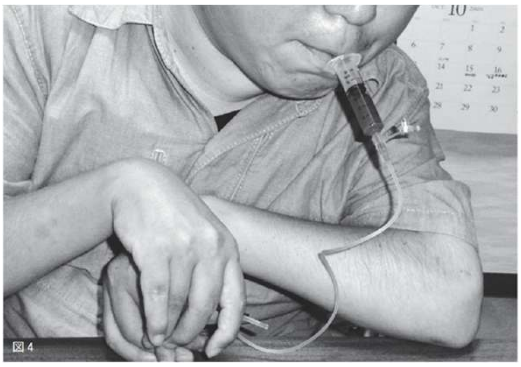
High-level goal alignment coupled with redundancy in concrete measures

A hospital that can't train you to draw blood is a hospital that can't save patients.





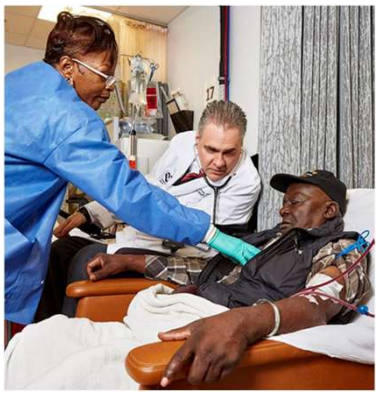
Review and update of goals + expansion of methods

Diversifying membership

Technological advances and environmental improvements are changing the *technical standards* (essential competencies) required of healthcare professionals with disabilities.

https://stethoscope.eu/littmann-electronic-stethoscopes/?utm_source=blog&utm_medium=post&utm_campaign=Can+a+Deaf+Person+Become+a+Doctor+and+Which+Littmann+Stethoscope+to+Use%3F

https://www.dailyrounds.org/blog/the-paralyzed-surgeon-who-can-still-performs-surgeries-thanks-to-his-determination-and-a-remarkable-stand-up-wheelchair/



https://newmobility.com/disabled-doctors/

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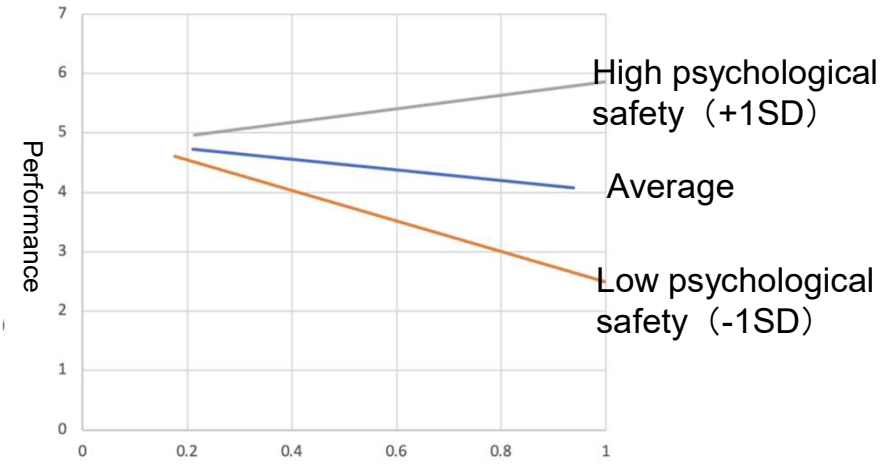
Weick KE, Sutcliffe KM. Managing the unexpected: Resilient performance in the age of uncertainty., 2nd ed. San Francisco, CA: Jossey-Bass; US; 2007.

Psychological safety is what turns diversity into performance



Bresman, H., and Edmondson, A. C. (2022). Exploring the relationship between team diversity, psychological safety and team performance: Evidence from pharmaceutical drug development. Harvard Business School Working Paper, No. 22-055.

Organizational transformation toward agility

Attempts to make organizations more agile fail about half the time. The key to success lies in fostering psychological safety.

Timothy R. Clark. (2022-02-21). Agile Doesn't Work Without Psychological Safety. Harvard Business Review.

Psychological safety

the belief that one can speak up without risk of punishment or humiliation

Edmondson, A., and Mortensen, M. (2021-04-19). What Psychological Safety Looks Like in a Hybrid Workplace. Harvard Business Review.

Sense of being able to show and employ self without fear of negative consequences to self-image, status, or career

Kahn, W. A. (1990). Psychological conditions of personal engagement and disengagement at work. Academy of Management Journal, 33, 692–724.

The Importance of Psychological Safety in Medical Settings

In healthcare settings, the benefits of psychological safety include enhanced employee well-being, increased job satisfaction, reduced workplace stress, and greater interest and engagement in quality improvement initiatives through learning from failures.

Grailey KE, Murray E, Reader T, Brett SJ: The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis. BMC Health Serv Res 2021; 21(773): 1–15.

High Reliability Organization: HRO

Culture of Mindfulness: A culture that takes distance from assumptions and biases.
Just Culture: A culture that responds to failure not with blame or punishment, but through welcoming reporting, collective responsibility at the organizational level, collaborative research, and mutual interdependence.
Culture of Customization: A culture that avoids overly simplifying complex realities or rigid, rule-bound responses, instead seeking creative solutions.
Agile Culture: A culture that responds swiftly to early signs of abnormalities.
Culture of Humility: A culture that prioritizes the judgment of those with the greatest expertise, regardless of organizational hierarchy.

Weick KE, Sutcliffe KM. Managing the unexpected: Resilient performance in the age of uncertainty., 2nd ed. San Francisco, CA: Jossey-Bass; US; 2007.

WHO 'Disability & Health'
Four reasons for health disparities among persons with disabilities

*1. High Economic Costs

The high costs of health services and transportation are two major reasons why persons with disabilities in low-income countries cannot access the medical care they need.

Among people without disabilities, 32–33% cannot afford necessary health expenses, whereas among persons with disabilities, this figure rises to 51–53%.

2. Limited Availability of Services

The lack of appropriate services for persons with disabilities itself constitutes a major barrier to accessing healthcare.

A study conducted in Uttar Pradesh and Tamil Nadu, India, found that, after economic costs, the shortage of services in the area was the next most significant barrier to using healthcare facilities.

3. Physical Barriers

Buildings (hospitals, health centers), inaccessible medical equipment, inadequate signage, narrow entrances, interior steps, insufficient toilets, and inaccessible parking areas all create barriers within medical facilities.

Women with mobility difficulties often cannot access mammography equipment designed for standing positions, and therefore are unable to undergo breast- and cervical-cancer screening.

4. Inadequate Skills and Knowledge among Health-care Workers

Persons with disabilities are more than twice as likely to feel that medical providers lack adequate skills, four times more likely to feel they have been treated inappropriately, and three times more likely to feel they have been refused treatment.

World Health Organization & World Bank. (2011). World report on disability 2011.

Physician-patient concordance effect

When patients and physicians share similar attributes, satisfaction, adherence, and prognosis tend to improve.

The survival rate after acute myocardial infarction is lower for women than for men, but gender concordance between patient and physician increases survival among female patients.

Greenwood, B. N., Carnahan, S., & Huang, L. (2018). *Patient-physician gender concordance and increased mortality among female heart attack patients.* *Proceedings of the National Academy of Sciences of the United States of America, 115*(34), 8569–8574.

An increase in the number of physicians with disabilities may help reduce health disparities experienced by patients with disabilities.

Spillman, M. A. *Amendment to Opinion E-9.3.2, “Physician responsibilities to impaired colleagues.”* Council on Ethical and Judicial Affairs, American Medical Association.

Perhaps the most transformative learning in reducing stigma toward patients with disabilities occurs not from patients, but from colleagues who have disabilities themselves.

Shakespeare, T., Iezzoni, L. I., & Groce, N. E. (2009). *Disability and the training of health professionals.* *Lancet (London, England), 374*(9704), 1815–1816.

UTokyo Center for Diversity in Medical Education and Research

The three elements of humility

① To see oneself accurately

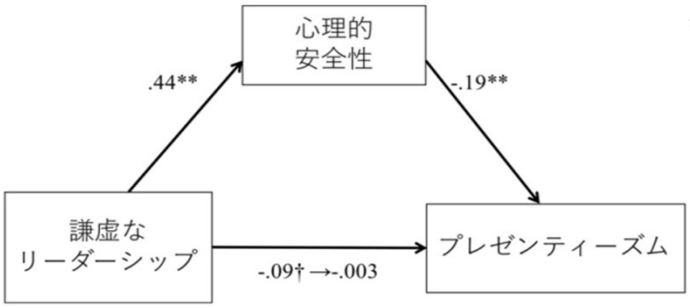
② To recognize and appreciate others' strengths and contributions that one does not possess

③ Teachability (or the capacity to learn from others)

Owens, Johnson, and Mitchel (2013). Expressed Humility in Organizations. Organization Science, 24(5), 1517–1538.

Effects of humble leadership in corporations

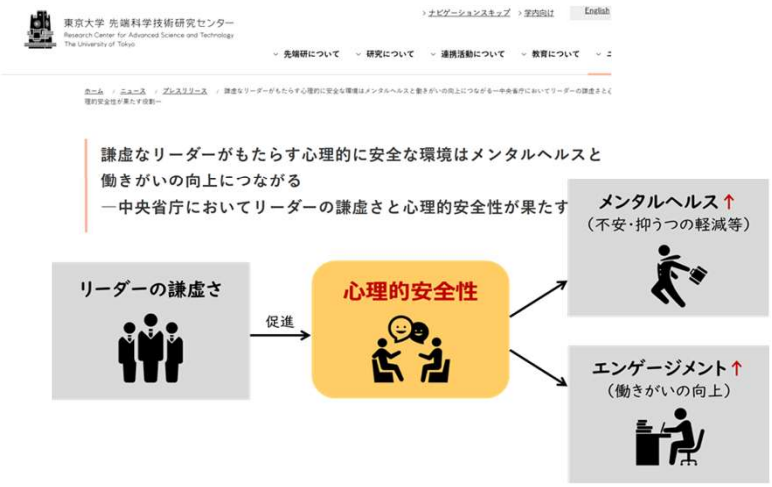
- A total of 462 participants (average age = 35.67 years) recruited from multiple companies completed an online survey.
- The results showed that leaders' humility enhanced psychological safety, which in turn reduced presenteeism.



Matsuo, A., Tsujita, M., Kita, K., Ayaya, S., & Kumagaya, S. I. (2024). The mediating role of psychological safety on humble leadership and presenteeism in Japanese organizations1. Work, 10.3233/WOR-230197. Advance online publication. https://doi.org/10.3233/WOR-230197

The effects of humble leadership in Ministry of Justice

- A survey was conducted among government organization employees, revealing that leaders' humility influences multiple performance indicators through the mediating role of psychological safety.
- These findings offer important insights into how government organizations can achieve key goals—such as evidence-based policy making (EBPM) and organizational agility—while maintaining high levels of employee engagement and mental health.



Kumagaya*, Matsuo*, Yui, Ayaya, Kawahara, Kashiwabara, Koto, & Kamioka (2025). Workplace psychological safety mediates the impact of leader humility on employee engagement and mental health in the Japanese central government. *International Review of Public Administration*. (*Equal contribution)

Concluding Observations on the Initial Report of Japan under the Convention on the Rights of Persons with Disabilities (CRPD)

To prohibit involuntary hospitalization and treatment on the grounds of mental disability; abolish related laws; guarantee free and fully informed consent; and establish independent monitoring and redress mechanisms to prevent coercive treatment and abuse — thereby integrating mental health into general healthcare while promoting community-based support and independent living. [Paragraph 24(b)、32(a)(b)(c)、34(a)(b)(c)、42(b)、54(d)]

Schizophrenia

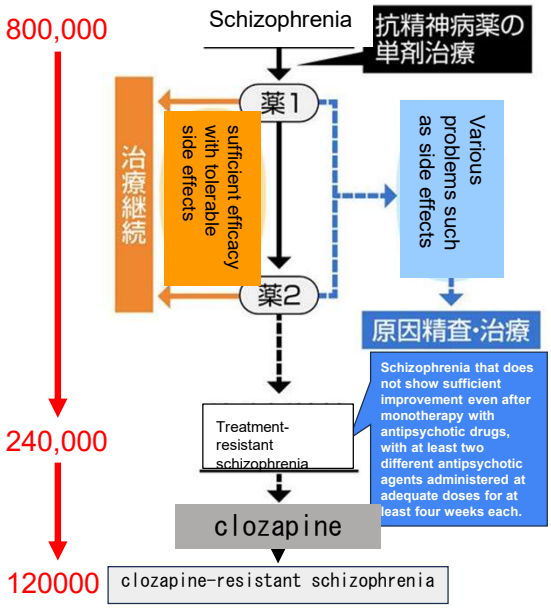
A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be 1), 2), or 3):

1) Delusions
2) Hallucinations
3) Disorganized speech (e.g., frequent derailment or incoherence)
4) Grossly disorganized or catatonic behavior
5) Negative symptoms (i.e., diminished emotional expression or avolition)

B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset.

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms.

American Psychiatric Association, 2022, Diagnostic and statistical manual of mental disorders (5rd ed. text revision), Washington, DC: Author.



https://www.tokyo-np.co.jp/article/263813
https://www.ncnp.go.jp/topics/2021/20211203p.html

Japanese Mental Health System: Long-term Non-consensual Seclusion and Restraint.

In 2016, Japan ranked first among OECD member countries, with 2.6 psychiatric beds per 1,000 population.

In fiscal year 2017, the average length of hospital stay was 267.7 days (301.8 days in psychiatric-only hospitals).

Patients hospitalized for over one year accounted for 61%, and even among those hospitalized for over five years, the proportion was as high as 33%.

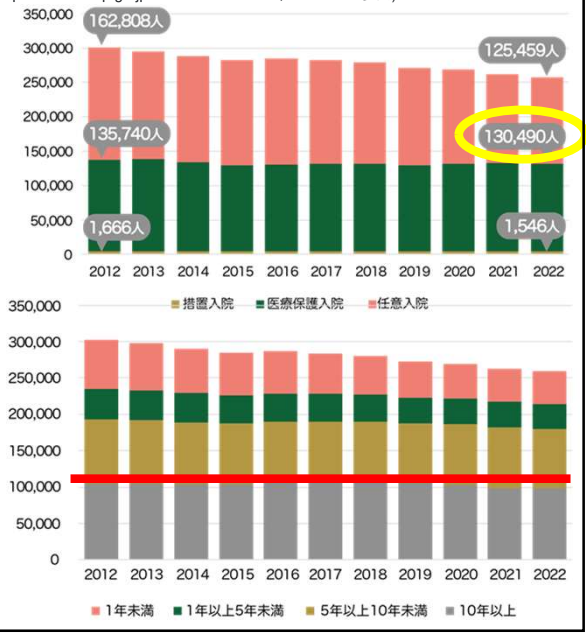
As many as 25,932 patients (9%) had been hospitalized for over 20 years.

Since 2000, the number of voluntary admissions has declined, while *medical protection hospitalization*—a form of involuntary admission—has remained roughly constant.

During the 2000s, open wards decreased, and by 2017, 68% of wards were closed wards.

There were 12,817 cases of seclusion (placement in protective rooms) and 12,528 cases of physical restraint.

国立研究開発法人 国立精神・神経医療研究センター (n.d.)『2012-2016 年度精神保健福祉資料』「精神保健福祉資料[630]」(https://www.ncnp.go.jp/nimh/seisaku/data/630/, 2020.7.5.参照).
国立研究開発法人 国立精神・神経医療研究センター (n.d.)『2017-2022 年度精神保健福祉資料』「630 集計：従来フォーマットでの集計」(https://www.ncnp.go.jp/nimh/seisaku/data/, 2023.4.11.参照).



Before admission, Mr. A

He had a delusional belief that while he was asleep, his mother would bring a young woman into the house and allow her to sexually assault him. His relationship with his mother was poor. One day, when his mother did something that offended him, he decided to “teach her a lesson” and caused her physical injury. As a result, he became subject to the Medical Treatment and Supervision Act and was admitted to Hospital B.

Before starting Tojisha-Kenkyu

* Four years have passed since the patient was admitted under the Medical Treatment and Supervision Act.

* As the patient met the criteria for treatment-resistant schizophrenia, clozapine was introduced on the 96th day of hospitalization. The hallucinations and delusions caused by schizophrenia—particularly persecutory delusions involving the parents, which were related to the index offense—have improved.

* Insight into the illness and symptoms has improved through psychosocial interventions.

* However, delusions with strong fantastical elements (e.g., conflicts with a “Yamanba”)—believed to be associated with pervasive developmental disorder—have persisted, affecting the patient’s physical condition and interfering with daily life.

「精神看護」第20巻3号（医学書院、2017）

Common Evaluation Items

The Common Evaluation Items are an assessment scale used across all designated medical institutions (both inpatient and outpatient) under the *Medical Treatment and Supervision Act* in Japan.

They are designed to evaluate the target individuals of the Act from multiple perspectives and to help identify specific areas of concern or difficulty.

The scale uses a three-point rating system (0, 1, 2):

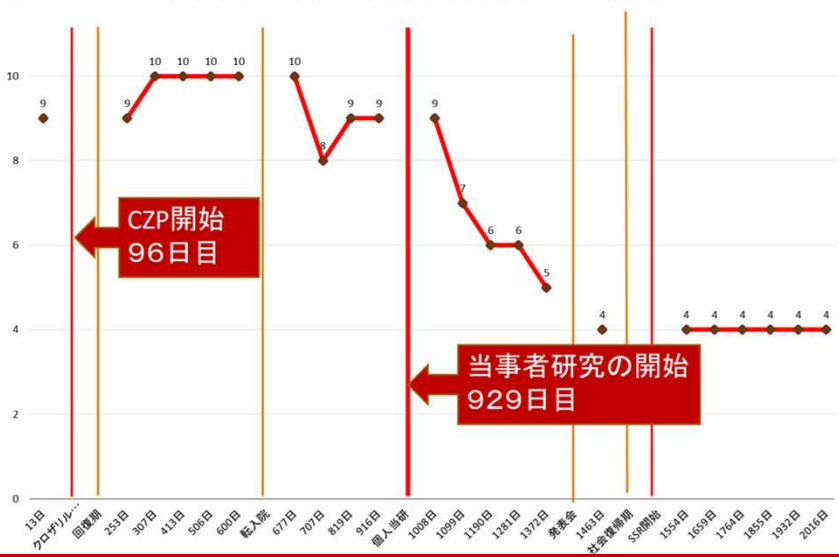
* 0 = No problem

* 1 = Some problems

* 2 = Significant problems

Evaluations are conducted once every three months by a multidisciplinary team, and the score reflects the worst condition observed during the three-month period. This approach is intended to assess the long-term stability of the individual's condition.

Changes in A's scores on common evaluation items



The pilot project for treating inmates with mental disabilities at Sapporo Prison (2023–) incorporates Tōjisha-Kenkyū.

Tōjisha-Kenkyū.

1) We conducted individual interviews in which Mr. A described his own experiences, and we created slides while confirming the content with him. Whenever possible, we used various types of diagrams to visualize the information.
2) We also conducted joint tojisha-kenkyū (self-directed participatory research) sessions with multiple staff members. In those cases, we wrote the content on a whiteboard as the discussion progressed, again striving to visualize it through diagrams.
3) The findings from 1) were reported in 2), and conversely, the discussions in 2) were organized and analyzed in 1).

Staff Ethos

- Listening to Mr. A with the primary aim of understanding and sharing his experiences, maintaining an attitude of genuine interest and inviting him to elaborate further.
- Refraining from making any evaluative judgments such as labeling the content as “pathological” or “abnormal.”
- While accepting his sometimes disorganized explanations as they were, asking clarifying questions to elicit more detailed information and gradually constructing an overall picture of his experience.

Staff Ethos

Changing paradigm

Changing the person... Medical intervention / Rehabilitation
Changing the environment... Disability movement

↓

Knowing & Sharing paradigm

Knowing and sharing... Tojisha-kenkyu

Tōjisha-Kenkyū.

Person A has been fighting dozens of yamauba (mountain hags/witches) for more than twenty years.
The yamauba would say things like, “I’ll make sure you can’t get a job,” and “I’ll smash your plastic models.”

Through repeated research, A discovered that in the Other World there were also many allies who would side with them: Gundam, a cousin’s older sister, a voice actress.
After watching TV news and thinking, “Oh, the police work as a team too,” they decided to ask the Public Security and police of the Other World for help, and along with other allies began fighting the yamauba as a team.
The idea of working “as a team” is a key medical concept in the Medical Observation Act, so this may have been reflected.

As they kept teaming up to fight the yamauba, they didn’t just fight — they began to negotiate as well.
The Other World’s public security police advised, “Take a firm stance toward the yamauba. Don’t speak to them, cu off contact, avoid them as much as possible.”

One day, a companion from the Other World suggested, “Why don’t you try reconciling and ending the war?” With the police present, they said, “This ends now—stop doing this.” The yamauba apologized and surrendered.

Tōjisha-Kenkyū.

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Epidemiology of Auditory Hallucinations:
Importance of Voice Characteristics and Relationship with Voices

17% of children aged 9-12 and 7.5% of adolescents aged 13-18 experience auditory hallucinations daily.

Kelleher, I., Connor, D., Clarke, M. C., Devlin, N., Harley, M., & Cannon, M. (2012). Prevalence of psychotic symptoms in childhood and adolescence: a systematic review and meta-analysis of population-based studies. Psychological Medicine, 42, 1857-1863.

5.3% reported having daily experiences of being troubled by voices.

Kompus, K., Løberg, E. M., Posserud, M. B., & Lundervold, A. J. (2015). Prevalence of auditory hallucinations in Norwegian adolescents: results from a population-based study. Scandinavian journal of psychology, 56, 391–396.

People who believe voices are very powerful, knowledgeable, and uncontrollable react with fear and resistance as soon as they perceive the voices as malicious.

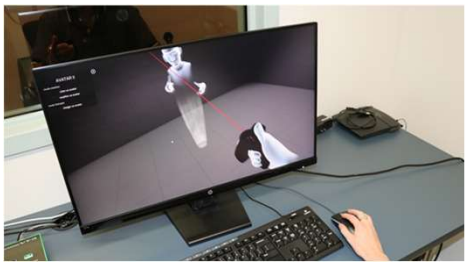
Johns, L. C., Kompus, K., Connell, M., Humpston, C., Lincoln, T. M., Longden, E., Preti, A., Alderson-Day, B., Badcock, J. C., Cella, M., Fernyhough, C., McCarthy-Jones, S., Peters, E., Raballo, A., Scott, J., Siddi, S., Sommer, I. E., & Larøi, F. (2014). Auditory verbal hallucinations in persons with and without a need for care. Schizophrenia bulletin, 40 Suppl 4(Suppl 4), S255–S264.

People who interpret voices as benevolent are more likely to get along well with them.

Peters, E. R., Williams, S. L., Cooke, M. A., & Kuipers, E. (2012). It's not what you hear, it's the way you think about it: appraisals as determinants of affect and behaviour in voice hearers. Psychological medicine, 42(7), 1507–1514.

Avatar Therapy

Impact of "Voice Persona Shift"



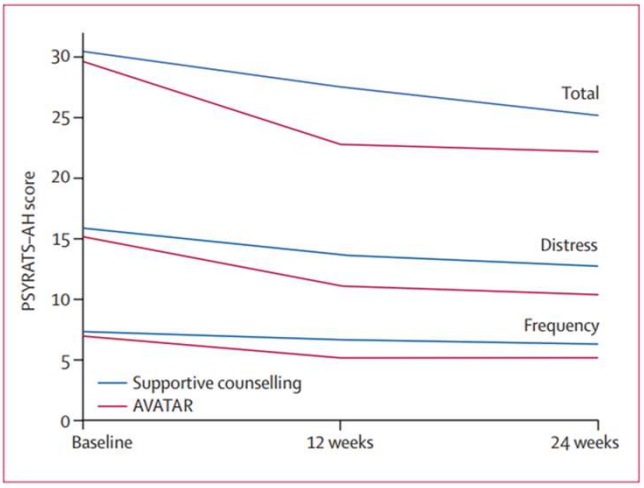


Figure 3: **PSYRATS–AH total, distress, and frequency scores**

Craig, T. K., Rus-Calafell, M., Ward, T., Leff, J. P., Huckvale, M., Howarth, E., Emsley, R., & Garety, P. A. (2018). AVATAR therapy for auditory verbal hallucinations in people with psychosis: a single-blind, randomised controlled trial. The lancet. Psychiatry, 5(1), 31–40. https://doi.org/10.1016/S2215-0366(17)30427-3

The relationship with auditory hallucinations is linked to actual human relationships.

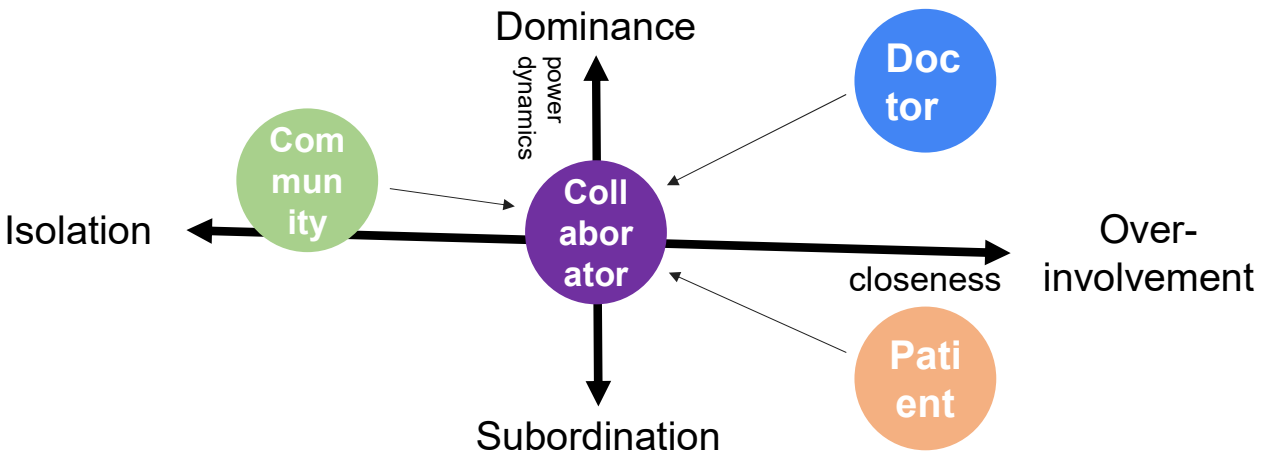
- People who have experienced feelings of helplessness or inferiority in social relationships are more likely to report similar experiences in their relationship with voices.

  Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: subordination and entrapment by voices and significant others. Psychological medicine, 30(2), 337–344.

- Since social schemas mediate the relationship between evaluation and distress, therapies targeting actual social and interpersonal relationships are beneficial.

  Paulik G. (2012). The role of social schema in the experience of auditory hallucinations: a systematic review and a proposal for the inclusion of social schema in a cognitive behavioural model of voice hearing. Clinical psychology & psychotherapy, 19(6), 459–472.

If actual human relationships change, the relationship wit voices also changes.



Hayward, M., Overton, J., Dorey, T., & Denney, J. (2009). Relating therapy for people who hear voices: a case series. Clinical psychology & psychotherapy, 16(3), 216–227.

Hayward, M., Berry, K., & Ashton, A. (2011). Applying interpersonal theories to the understanding of and therapy for auditory hallucinations: a review of the literature and directions for further research. Clinical psychology review, 31(8), 1313–1323.

The content of auditory hallucinations depends on local culture.

- While American auditory hallucinations are often aggressive and negative, those in India and Ghana are often supportive and positive.
- The content of auditory hallucinations is influenced by the culture surrounding the individual.

Stanford Univ. Professor Tanya Luhrmann

Luhrmann, T.M., Padmavati, R., Tharoor, H., & Osei, A. (2015). Differences in voice-hearing experiences of people with psychosis in the U.S.A., India and Ghana: interview-based study. British Journal of Psychiatry, 206, 41-44.

"Loneliness and Isolation: The Continuum of Auditory Hallucinations and Thought"

“As Epictetus sees it (Dissertationes, Book 3, ch. 13) the lonely man (erēmos) finds himself *surrounded by others with whom he cannot establish contact or to whose hostility he is exposed*. The solitary man, on the contrary, is alone and therefore ‘*can be together with himself* since men have the capacity of “talking with themselves.”* In solitude, in other words, I am ‘by myself,’ together with my self, and therefore **two-in-one**, whereas in loneliness, I am actually one, deserted by all others.”

“... All thinking, strictly speaking, is done in solitude and is a dialogue between me and myself; but this dialogue of the two-in-one does not lose contact with the world of my fellow-men because they are represented in the self with whom I lead the dialogue of thought.”

“The problem of solitude is that this two-in-one needs the others in order to become one again: one unchangeable individual whose identity can never be mistaken for that of any other. For the confirmation of my identity I depend entirely upon other people; and it is the great saving-grace of companionship for solitary men that it makes them ‘whole’ again.”

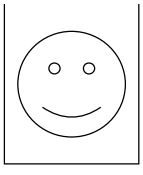
[Arendt 1981:320-321]

Establishment of a User-Led Research Promotion System

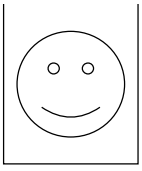
October 2021 - March 2027 CREST "Elucidation of the principles of cognitive feelings mediating perception and emotion"

Tojisha-Kenkyu Researcher of Mental Illness
Urakawa Bethel’s House

Yamane Kohei (psychiatric social worker)



Takahashi Miho (phychiatrist)



Niahizaka Jinen (psychiatric social worker)

Researcher of HV Movement

Sato Wakio (chairman)

Tojisha-Kenkyu Researcher
Research Center for Advanced Science and Technology, The University of Tokyo

Shin’ichiro Kumagaya (professor)

Ayaya Satsuki (professor)

Katsuya Noriko (assistant professor)

Kita Kotoko (user researcher)

Tojisha-Kenkyu Researcher
Department of Welfare Management, Faculty of Nursing and Social Welfare, Health Sciences University of Hokkaido

Mukaiyachi Ikuyoshi (professor)

Hashimoto Kikujiro (associate professor)

Okuda Kaori (lecturer)

Suzuki Wataru (assistant professor)

Researchers of VR/Metaverse
Graduate School of Interdisciplinary Information Studies, The University of Tokyo

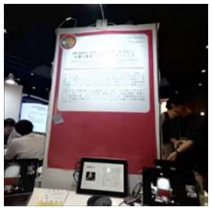
Narumi Takuji (assistant professor)

Hatada Yuji PD

VR Utilization in the Field of User-Led Research on Visual and Auditory Hallucinations

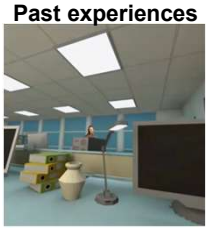
■ Developed VR experiences reproducing visual and auditory hallucinations based on interviews with users

"I have schizophrenia, [...] **no matter what I do or try to remember, the scenes from that time vividly come to mind first,** and I become unable to move, my body freezing with fear [...]."



Real-world scenery and sounds

Past experiences



VR environment reproducing the painful past

Current experience

Past memories translucently overlapping with

■ Co-creation of workshops

- Utilizing VR as a "common language" to convey each other's difficult experiences
- Dialogue unique to user-led research, without a doctor vs. patient confrontational structure

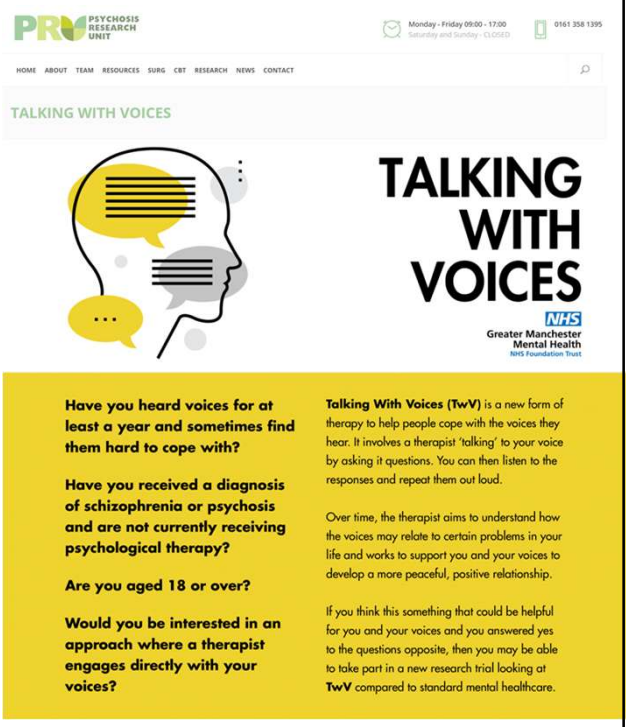
→Investigating the impact of sharing visual/auditory hallucination experiences with others on users and the community

Hearing Voices Movement

- A user-led initiative where individuals explore the content of their voices (auditory hallucinations), exchange information on coping strategies, and connect with others.
- A key goal of HVM is to foster a positive identity as a voice-hearer and to help build a more peaceful and constructive relationship with voices. Therefore, it is considered important to support engagement with voices and living with voices, rather than solely focusing on eliminating them as a measure of success.

Talking with Voices @ PRU

・A new form of therapy born from the activities of the International Hearing Voices Movement.
・It is based on the idea that the content of voices may reflect real conflicts and difficulties in the life of the voice-hearer.
・TwV believes that by gaining a deeper understanding of the connection between voices and negative events or emotions, it can provide information that helps people find meaning in their experiences.
・In the long term, it may help people learn new ways to cope with voices and reduce distress caused by them.
・During sessions, the therapist asks questions to the participant's voice, and the participant then listens to the voice's response and shares it with the therapist.
・The goal of this therapy is to understand how you and your voice feel and to use that information to work together to build a more peaceful and positive relationship with your voice.



Concluding Observations on the Initial Report of Japan under the Convention on the Rights of Persons with Disabilities (CRPD)

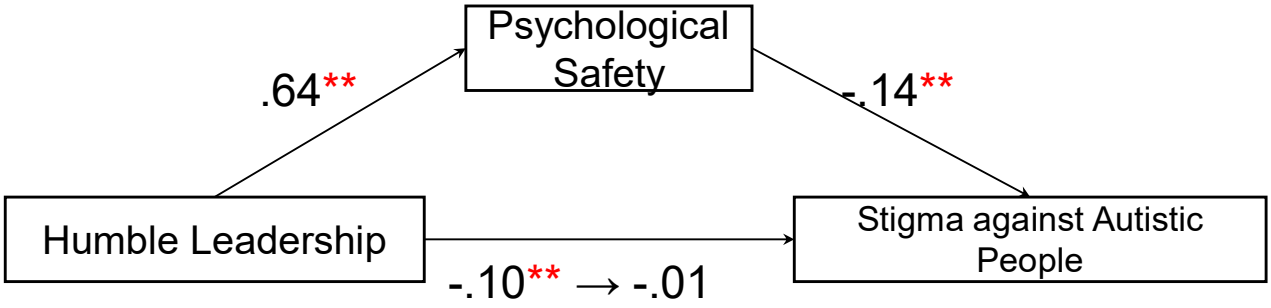
Paragraph 10(b) Review the Tsukui Yamayuri-en case with a view to combating eugenic and ableist attitudes and ensure legal liability for the promotion of such attitudes in society

April 2026: Establishment of Kanagawa Prefectural Welfare Organization (Local Independent Administrative Agency)

これまでの福祉では職員の知見・経験に頼りがちで、利用者の状況・感情・要望に応えるサービスの提供が難しい場面がありました。
そこで科学的に分析してデータ化することなどにより、利用者の心身の状態を見える化し、利用者・支援員双方の満足度・幸福度を向上させるサービスの提供を目指します。

Where does stigma among supporters come from?
: Questionnaire survey targeting staff of disability support facilities

- An online questionnaire survey was conducted with 343 staff members (79 facilities) of disability support facilities nationwide.
- Since tendencies were similar (not independent) across facilities, a multilevel mediation analysis was conducted.



** $p < .01$, * $p < .05$, + $p < .10$

Concluding Observations on the Initial Report of Japan under the Convention on the Rights of Persons with Disabilities (CRPD)

Paragraph 52(a) Recognize the right of children with disabilities to inclusive education within its national policy on education, its legislation and its administrative arrangements, with the aim of ceasing segregated special education, and adopt a national action plan on quality inclusive education, with specific targets, time frames and a sufficient budget, to ensure that all students with disabilities are provided with reasonable accommodation and the individualized support they need at all levels of education

Paragraph 52(b) Ensure access to regular schools for all children with disabilities, and put in place a "non-rejection" clause and policy to ensure that regular schools are not allowed to deny regular school for students with disabilities, and withdraw the ministerial notification relating to special classes

Paragraph 52(c) Guarantee reasonable accommodation for all children with disabilities to meet their individual educational requirements and to ensure inclusive education

The Impact of Stigma on Employment and Health

Review Studies Documenting Effects of Stigma

Stigmatized Status	Prevalence in General Population, %	Housing[a]	Employment/Income	Education/Academic Outcomes	Social Relationships	Psychological/Behavioral[b]	Health Care[c]	Health
Mental illness	2.4 (current)[13]; 46.4 (lifetime)[14]	Link and Phelan,[9] Hinshaw and Cicchetti	Link et al.,[16] Corrigan and Penn,[17] Link and Phelan[18]	Link et al.[16]	Hinshaw and Cicchetti,[15] Link and Phelan[18]	Pachankis,[19] Livingston and Boyd,[20] Hinshaw and Stier,[21] Rüsch et al.[22]	Hinshaw and Cicchetti,[1] Corrigan et al.,[23] Ross and Goldner[24]	Mak et al.[25]
Minority sexual orientation	3.5[26]	Coker et al.[27]	Badgett[28]		Hatzenbuehler,[29] Meyer,[30] Friedman et al.[31]	Pachankis,[19] Hatzenbuehler,[29]	Coker et al.[27] Cochran[32]	Meyer,[30] Cochran
Obesity	33.8[33]		Puhl and Brownell[34]	Puhl and Brownell,[34] Puhl and Latner,[35] Puhl and Heuer[36]	Puhl and Latner,[35] Puhl and Heuer,[36] Pettit[37]	Puhl and Brownell[38]	Puhl and Brownell,[34] Puhl and Heuer[36]	Puhl and Latner, Puhl and Heuer
HIV/AIDS	0.003[39]	Leaver et al.[40]	Herek[41]	Herek[41]	Herek,[41] Crawford[42]	Pachankis,[19] Herek[41]	Mawar et al.[43] Mahajan et al.[44]	Rabkin,[45] Logie a Gadalla,[46]
Disability	21.8[47]		Smeets et al.[48]	Smeets et al.[48]	Jacoby et al.,[49] de Boer et al.[5]	Smeets et al.,[48] Beart et al.,[51] Livneh et al.	MacLeod and Austin[53]	Jacoby et al.[49]
Minority race/ethnicity	Hispanic, 16.3; non-White, 27.6[54]	Massey and Denton,[55] Williams and Collins[56]	Williams[57]	Steele,[58] Zirkel[59]	Williams and Collins[56]	Smart Richman and Leary[60]	Williams[57]	Paradies,[61] Williams et al., Clark et al.[63]

Note. We included review articles that discussed more than 1 article in each domain.
[a]Being denied housing as a result of discrimination or being overrepresented among the homeless population because of stigma.
[b]Self-esteem, emotion regulation processes, and coping responses to stigma-related stressors.
[c]Attitudes of health care providers, suboptimal treatment, or reduced likelihood of accessing prevention and intervention services.

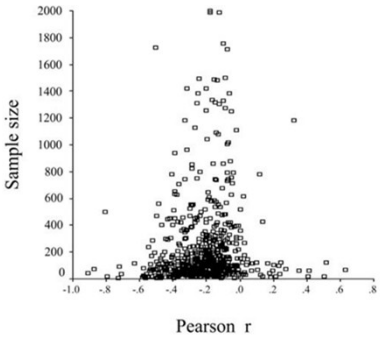
Hatzenbuehler, M.L., Phelan, J.C., and Link, B.G. (2013). Stigma as a fundamental cause of population health inequalities. American Journal of Public Health, 103, 813–821.

The Effects of Inclusive Education and Inclusive Society

Allport(1954) Intergroup Contact Theory

If different groups have opportunities for contact that meet the following four conditions, mutual prejudice decreases. Allport GW. The Nature of Prejudice. Doubleday; Garden City, NY: 1954.

①Equal Status ②Intergroup Cooperation ③Common Goals ④Institutional and organizational authorization



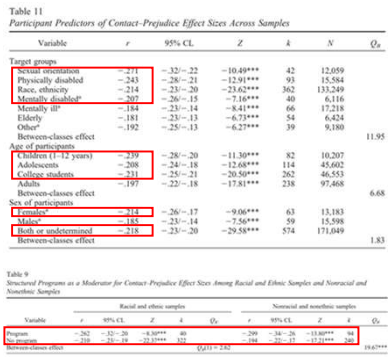


Table 11
Participant Predictors of Contact–Prejudice Effect Sizes Across Samples

Variable	r	95% CL	Z	k	N	Q_B
Target groups						
Sexual orientation	−.271	−.32/−.22	−10.49***	42	12,059	
Physically disabled	−.243	−.28/−.21	−12.91***	93	15,584	
Race, ethnicity	−.214	−.23/−.20	−23.62***	362	133,249	
Mentally disabled[a]	−.207	−.26/−.15	−7.16***	40	6,116	
Mentally ill[b]	−.184	−.23/−.14	−8.41***	66	17,218	
Elderly	−.181	−.23/−.13	−6.73***	54	6,424	
Other[c]	−.192	−.25/−.13	−6.27***	39	9,180	
Between-classes effect						11.95
Age of participants						
Children (1–12 years)	−.239	−.28/−.20	−11.30***	82	10,207	
Adolescents	−.208	−.24/−.18	−12.68***	114	45,602	
College students	−.231	−.25/−.21	−20.50***	262	46,553	
Adults	−.197	−.22/−.18	−17.81***	238	97,468	
Between-classes effect						6.68
Sex of participants						
Females[a]	−.214	−.26/−.17	−9.06***	63	13,183	
Males[a]	−.185	−.23/−.14	−7.56***	59	15,598	
Both or undetermined	−.218	−.23/−.20	−29.58***	574	171,049	
Between-classes effect						1.83

Table 9
Structured Programs as a Moderator for Contact–Prejudice Effect Sizes Among Racial and Ethnic Samples and Nonracial and Nonethnic Samples

	Racial and ethnic samples					Nonracial and nonethnic samples				
Variable	r	95% CL	Z	k	Q_B	r	95% CL	Z	k	Q_B
Program	−.262	−.32/−.20	−8.39***	40		−.299	−.34/−.26	−13.80***	94	
No program	−.210	−.23/−.19	−20.33***	322		−.194	−.22/−.17	−17.21***	240	
Between-classes effect					$Q_B(1) = 2.82$					10.67***

Contact that satisfies these four conditions is particularly effective in reducing stigma, but contact that does not satisfy these conditions also reduces stigma.

Pettigrew, T. F., & Tropp, L. R. (2006). A meta- analytic test of intergroup contact theory. Journal of Personality and Social Psychology, 90 (5), 751.

In reaction time tasks using computers, contact reduces unconscious bias.

Aberson, C. L., & Haag, S. C. (2007). Contact, perspective taking, and anxiety as predictors of stereotype endorsement, explicit attitudes, and implicit attitudes. Group Processes and Intergroup Relations, 10, 179–201.

Positive contact reduces physiological threat responses to outgroup members.

Blascovich, J., Mendes, W. B., Hunter, S. B., Lickel, B., & Kowai-Bell, N. (2001). Perceiver threat in social interactions with stigmatized others. Journal of Personality and Social Psychology, 80, 253–267.

Contact leads to a reduction in differences in facial information processing in the brain, increasing the perception of similarity.

Walker, P. M., Silvert, L., Hewstone, M., & Nobre, A. C. (2008). Social contact and other-race face processing in the human brain. Social cognitive and affective neuroscience, 3(1), 16–25.

School Climate Improvement Program

Practicing the social model together, regardless of disability, significantly reduces depression and bullying among children.

It is important for mental well-being to

(1) have someone with whom you can share your vulnerabilities, and

(2) take collective action with people who have similar struggles to create a more livable society.

Hosozawa & Nishida,
Journal of American Academy of Child & Adolescent Psychiatry (IF=9), 2024
Yamaguchi & Nishida, Psychological Medicine, in revision

Increasing opportunities for 16-year-old students to feel that they can participate in and contribute to the management and improvement of their school is most crucial for reducing depression and bullying, as well as for enhancing well-being at age 20.

Shinde & Patel, Lancet, 2018

https://include.u-tokyo.ac.jp/whoweare/

01 Coproduce research results with underrepresented members
02 Achieve a virtuous cycle of synergy between research and practice
03 Achieve gender equity
04 Provide a seamless support system that covers every stage of life
05 Respond to the needs of contemporary intersectionality

Members of the Council of Underrepresented People, Center for Coproduction of Inclusion, Diversity and Equity, The University of Tokyo

Name	Affiliation / Position / Disability	Research Proposal
Kumiko Fujiwara	Representative, DPI Women with Disabilities Network / Visual impairment	Research on the intersectional discrimination of gender and disability
Yoko Kato	Representative, Matsuyama Center for Independent Living / Mild intellectual disability, Cerebral palsy	Developing guidelines and programs for decision-making support through participation of people with disabilities
Yumi Okayama	Staff member, Japan Center for Independent Living / Member, Muscular Dystrophy Project Women's Network / Muscular dystrophy	Addressing the issue of cross-gender personal assistance in muscular dystrophy wards
Chinami Kawai	Member, DPI Women's Network / Regular employment / Cerebral palsy	Research on siblings of people with disabilities from the perspective of disabled persons
Karin Matsumori	Universal Design Advisor / Hearing impairment	Undecided
Koji Onoe	Vice Chairperson, DPI Japan / Cerebral palsy	Historical study on expert-led treatments for cerebral palsy in the past
Satoshi Sato	Secretary-General, DPI Japan / Spinal cord injury	Research on how cultural differences affect the realization of disability policies
Nobuaki Tanaka	Chairperson, Policy Committee, Japan Disability Forum (JDF) / Visual impairment	Research on the effects of camouflaging invisible disabilities at work and conditions for creating workplaces where disabilities can be openly disclosed without threat
Yuhei Yamada	Representative, Porque (Association of People with Mental Health Conditions) / Mental health condition	Participation of people with lived experience in psychiatry