ABSTRACT
This study explores the social movements of people with psychosocial disabilities in East Asia. Comparisons are drawn between the East Asian movements and those in other parts of the world – namely, the World Network of Users and Survivors of Psychiatry (movement from the Global North), and Transforming Communities for Inclusion Global (movement from the Global South). Contextual factors that shape the character of the East Asian movements are considered. It is argued that whilst the East Asian movements share certain characteristics with movements from the Global North and South, they cannot be categorized according to this dualism. The analysis reveals some of the limitations of the Global North/South dualism and suggestions are made for progressing beyond this dualism in order to identify certain commonalities between psychosocial movements, globally.

KEYWORDS
psychosocial disability, users and survivors of psychiatry, East Asia, social movements, critical disability studies, dualism
Criticism from Critical Disability Studies
This article seeks to contribute to the intellectual decolonization process within disability studies and is informed by Goodley’s (2013, 638–639) advice regarding the importance of recognizing “specific socio-historical conditions of oppression alongside wider considerations of the globalization of disablism”.

Disability Studies emerged as an area of academic research and professional education across much of the Western world in the 1970s. Disability Studies, and ideas such as the influential social model of disability, were systematized in the Western world and later introduced elsewhere. Unsurprisingly, many explanatory paradigms relevant to the Western world proved to be unsuitable or inappropriate within non-Western contexts. An important moment came in the 2000s with the emergence of what has come to be known as “critical disability studies” (CDS). Scholars who were part of this movement began to rethink many of the foundational ideas and perspectives of disability studies. We have witnessed a “social, political and intellectual re-evaluation of explanatory paradigms used to understand the lived experience of disabled people and potential ways for social, political and economic change” and a “significant development in critical theory emerged from scholars writing from the perspective of the colonised” (Meekosha and Shuttleworth, 2009, 49–62). It was around the emergence of CDS that academic communities for disability studies began to be established in East Asia. For example, the Japan Society for Disability Studies was established in 2004, the Korean Society in 2009, and the Taiwan Society in 2018.

According to Meekosha and Shuttleworth (2009) central to CDS is a move away from binary thinking and understanding. The social model’s distinction between impairment and disability is often quoted as one such binary that CDS has sought to “trouble”. This article also strives to think critically about certain dualisms. Whilst various dualisms, including that of impairment/disability, will be considered, the main focus is on the Global North vs Global South distinction. As other authors have identified in relation to wider geo-political issues, East Asia does not sit perfectly within this North/South binary. In this article, this issue is considered with regard to the characteristics of the movements of people with psychosocial disabilities in East Asia.

The following section provides further context for this study and justification for thinking critically about the North/South binary.

Global North and South
Global North
Research on the movements of people with psychosocial disabilities has primarily been the focus of movements in the Global North, especially in the US and the UK. In this field, anti-psychiatry movements have been active since the 1950s, led by psychiatrists and academic scholars. Thomas Szasz, a standard-bearer psychiatrist of the US movement, insisted that mental illness is a myth, criticized the treatment of psychiatric symptoms similar to bodily diseases, and opined that the concept of mental illness undermined the principle of personal responsibility (Szasz, 1974, 262).
Psychiatry is an important subject in social science. In the 1960s, Erving Goffman, a sociologist at the University of Chicago, conducted research within a mental institution and revealed that behaviours and phenomena perceived as symptoms of mental illness were in fact a feature of “total institutions” (Goffman, 1961). He demonstrated how in-patients were “normal” and criticized detention (Goffman, 1961). In the context of the United States, the care of persons with psychosocial disabilities was traditionally the responsibility of individual states. Lyndon Johnson’s Great Society programmes of the late 1960s provided some ex-patients with a guaranteed income for the first time. In both the UK and the US, the incentive to save costs resulted in a marked decline in beds for psychiatric cases (Scull, 2016, 370–371).

Ronald D. Laing, a standard-bearer psychiatrist of the UK movement, criticized psychiatry, stating that “in so far as psychiatry represents the interests or pretended interests of sane ones, we may discover that, in fact, violence in psychiatry is pre-eminently the violence of psychiatry” (Cooper, 1967, 14, original emphasis). He opened an experimental therapeutic community called Kingsley Hall. In this community, “schizophrenia” was conceived as a voyage into the “inner space” and its “treatment” aimed to support the voyager, rather than attempting to “cure” them (Crossley, 1998). In 1961, the Minister of Health in the Macmillan government announced that mental hospitals were “doomed institutions”. The government planned to run them down and instructed the departments “to ensure that no money is spent on upgrading or reconditioning of mental hospitals which in ten or fifteen years are not going to be required”. “Belatedly, these anti-institutional sentiments were taken up by psychiatrists in continental Europe”. In particular, drastic deinstitutionalization took place in Italy (Scull, 2016, 369–370, 374).

These anti-psychiatric movements included ex-patients (Morrison, 2005, 66–68; Crossley, 2006, 144–146). McLean (2000) describes how various recipients of mental health services mobilized to transform the mental health system in the US, from the 1970s to the 1990s. She explains how the movement came to encompass ex-patients with ideological differences – a more radical group who identified as “survivors” and others who identified as “consumers” and accepted the medical model of mental illness. By comparing the identity politics in movements of persons with psychosocial disabilities with those of other movements Morrison (2005) argued that the consumer/survivor/ex-patients movements take a “complex position that requires differentiating the internal and external identity attributes”. This complexity is related to the harmful features of psychiatric diagnosis and treatment (Morrison, 2005, 165).

Crossley analyzed social movement organizations in the UK by referring to the resource mobilization theory of social movement. His subjects were not only the organizations of users and survivors but also various organizations in the mental health field. He described how organizations of users and survivors used or rejected psychiatric professionals, terms, or institutions (Crossley, 2006). Wallcraft et al. (2003) conducted a postal survey of service users and survivor groups to which they received 318 responses from across the UK. They found that “anger is still a common
factor, but, as the movement has grown, many people may join to find support and friendship rather than for political reasons”. Furthermore, they pointed out that there was a common agenda for the movement regarding how they should be treated in mental health systems or communities (Wallcraft et al., 2003, 1, 82–83).

Most of the research on movements in the US and the UK has explained how the movements have been influenced by and in turn influenced the mental health system. Their collective identities are explained as being based on a negative acceptance of diagnosis or arguments against the mental health system. When the number of psychiatric beds was reduced and the mental health policy was changed to accept the opinions of patients, the stance of the movements changed as well. This shift divided some organizations. Thus, decarceration from mental hospitals, as a result of a series of movements, is an important factor in explaining several aspects of user and survivor movements in the US and the UK. This study considers the experience of deinstitutionalization as an important feature of the movements of users and survivors and people with psychosocial disabilities in the Global North.

Global South
This article considers the situation in the Global South as an area that has not experienced deinstitutionalization in the same way as in the Global North. In the late 1990s, it became clear that there was “enormous suffering” associated with neuropsychiatric illnesses in low- and middle-income countries, where relevant healthcare resources were insufficient. To close gaps in support, the World Health Organization (WHO) developed a programme called the Mental Health Global Action Programme (mhGAP), which “encompassed a plan to equip primary care clinicians with training and skills in the care of patients with mental illness” (Becker and Kleinman, 2013, 66, 69). The mhGAP was endorsed by the 55th World Health Assembly in 2002. A series of actions with similar purpose followed, wherein WHO recognized that “mental, neurological, and substance use (MNS) disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality” (World Health Organization, 2008, 4). It was recognized that in several low – and lower –middle-income countries, resources for tackling the unmet needs of this patient group are insufficient, inequitably distributed, and inefficiently used, leading to a treatment gap (World Health Organization, 2008). Surveys have revealed that in high-income countries, people with psychosocial disabilities die 15 to 20 years earlier than people without. Excessive mortality due to mental health conditions is likely to be much higher in low-income countries. Therefore, the WHO adopted a Comprehensive Mental Health Action Plan (2013–2020) as a framework for scaling up access to services in low – and middle-income countries, alongside high-income countries (Votruba et al., 2014).

East Asia
This study focuses on the social movements of people with psychosocial disabilities in East Asia. Therefore, it is necessary to discuss whether East Asian countries can/should be included in the Global North or South. We briefly look at the history of
psychiatry in Japan, South Korea, and Taiwan because the movements in these countries have been particularly active in the global social movements of people with psychosocial disabilities from East Asia. The knowledge and practices relating to psychiatry in East Asia largely reflect international trends, but have distinct East Asian features (Suzuki and Wang, 2022). To understand these features it is necessary to comprehend the significant social and political transformations that have taken place in the region since the nineteenth century.

In Japan, the Meiji Restoration in 1868 was instrumental in the emergence of a modern nation. The leaders of the Meiji government adopted Western medicines, which then came to be taught at universities. They made every effort to import Western systems, including those related to psychiatry and the institution of the asylum. In 1900, the Home Custody Act of Mental Patients was enacted. The purpose of the Act was to ensure public security, however, it resulted in the mandatory home detainment of patients in prison-like conditions. The Mental Hospital Law was enacted in 1919, recommending that all local governments should build at least one psychiatric hospital in each prefecture. However, only a few prefectures implemented this and home custody remained popular (Shinfuku, 2019, 180–181).

In 1950, after World War II, the Mental Hygiene Law was adopted. This prohibited home custody. A significant aspect of this law was that it was placed under the health sector, instead of the police sector. A further development saw a decrease in public provision and rise in private provision of psychiatric care:

The ratio of psychiatric beds per 10,000 people had been increased to 2.30 in 1951, 6.08 in 1956, and 11.27 in 1961. This increase was led by the private sector [...] The proportion of public psychiatric beds had been decreased yearly from 26.8% in 1955, 20.5% in 1960, and 15.1% in 1970. (Shinfuku, 2019, 183–184)

In the 1970s, there were news reports about many scandals at private psychiatric hospitals, where there was poor quality of care. The Mental Health Law was adopted in 1987 to ensure the quality of mental health services and this was amended in 1995 to include welfare services (Shinfuku, 2019, 186–187).

Between 1989 and 2018 the average length of stay within psychiatric institutions was decreased from 496 days to 274 days (Shinfuku, 2019). This figure is still extremely high when compared with that of other countries. As Shinfuku (2019, 190) observes: “Private psychiatric hospitals are reluctant to discharge the patients which are the source for their revenue”.

There has also been a shift in the demographic profile of in-patients in private psychiatric institutions. For example, the proportion of in-patients diagnosed with schizophrenia decreased, whilst the proportion of patients with Alzheimer’s disease and other forms of dementia sharply increased (Shinfuku, 2019, 189–190).

Western psychiatry in South Korea was introduced in the late nineteenth century by the Japanese colonial government. In the colonial period, the psychiatric hospital in Korea was exclusively for Japanese people. Japanese doctors monopolized faculty positions at the Medical College until Korea was liberated at the end of World War
II. The Department of Psychiatry was no exception. In addition, Western medicine reached Korea through missionary doctors, mainly of Protestant churches from the US, Canada, and Australia. Contrary to the biological approach of Japanese schools, the psychiatry of missionary doctors was patient-oriented and based on the psychosocial-spiritual model (Lee, 2004, 13–14).

During and after the Korean War (1950–1953), the majority of medical doctors were recruited to become military medical officers and learned American medicine (Lee, 2004, 15). Korea achieved rapid economic growth since the 1960s. Despite a rise in need, there was a decrease in mental health services/provision during the 1980s. As a result, many individuals with psychosocial disabilities received treatment in illegal private hospitals (i.e. unregistered medical facilities). Subsequently, an important moment was the enactment of the Mental Health Act in 1995, when the Korean mental health policy shifted from long-term hospitalization to community mental health services (Kahng and Kim, 2010).

In Taiwan, the Japanese rule began in 1895. Four institutions for “the mentally ill” and poor people were established by the [Japanese] Office of the Governor-General of Taiwan and Taiwanese philanthropists at the beginning of the twentieth century. The Enforcement Order for the Administrative Laws of the Empire of Japan to be applied in Taiwan was amended in 1935. This regulated the confinement of persons with psychosocial disabilities in hospitals and at home. However, no public psychiatric hospital was built. Instead, private hospitals were established in the 1930s, and were recognized as substitutes for public mental hospitals (Hashimoto, 2017, 45–46).

The first Mental Health Act in Taiwan was enacted in 1990. Before 1990, people who were thought by the public or their family to exhibit mentally unstable and uncontrollable behavior were involuntarily admitted to mental care facilities or asylums without psychiatric evaluation upon the request of the family or police. (Wu et al., 2012, 419)

Since the advent of the Mental Health Act Amendment, the total number of hospitalizations under national health insurance increased from 114,451 in 2005 to 127,521 in 2014 (Hsiao and Wu, 2017, 45). Nevertheless, the number of patients with compulsory admission has significantly reduced. Hsu et al. (2017, 199) reported that although approximately 70,000 people consented to be hospitalized, only 0.96% of these individuals were compulsorily hospitalized. This figure, they state, is significantly lower than the figures for compulsory hospitalization in the United States and Europe.

According to the current OECD Data, Japan has the largest number of psychiatric beds per 1,000 habitats, compared to other OECD countries in 2021 or the latest data available,1 even though the number of psychiatric beds is not the most suitable index to determine the quality of psychiatric treatment. In addition, in South Korea, the average length of hospital stay is 237.8 days for a patient diagnosed with

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schizophrenia and 60.2 days for a patient diagnosed with mood (affective) disorders. South Korea’s numbers are the highest among the OECD countries (Go et al., 2020). Psychiatry in Japan and Korea overemphasizes institutionalization and does not have features of either the Global North or South. Taiwan has succeeded in significantly reducing involuntary treatment, however, the total number of in-patients has increased. Nevertheless, it shares institutionalized features, to some extent, with the Global North and South.

Method
This study examines how movements in East Asia have been active in the global movement of users and survivors of psychiatry and people with psychosocial disabilities. The study subjects are two global organizations – the World Network of Users and Survivors of Psychiatry (WNUSP) and Transforming Communities for Inclusion Global (TCI Global). Roughly speaking, the WNUSP is an organization led by the Global North and the TCI Global is an organization led by the Global South. The WNUSP was established in 1991 by people from Western countries. It gradually mobilized a range of members from broad geographical areas and with diverse opinions. It was initially established as the “World Federation of Psychiatric Users”. It changed to its present name in 1997 to clarify that they have members with different opinions (Ito, 2021). TCI Global was established in 2014 as an Asian organization. It expanded to become an Asia-Pacific organization in 2018 and a global organization in 2022. It was started as a project of Indian organizations managed by people with lived experiences. Its members are based in Asia, the Pacific, Africa, and Latin America, with a higher concentration in the Asia-Pacific region (TCI Global, 2023b).

To describe the histories of the WNUSP and the TCI Global, this study uses previous studies that have documented and focused on the movements of these organizations. The author participated in conferences and meetings of the TCI Global since 2015, primarily as an interpreter between Japanese and English. When information or materials received through participation are used, they will be noted in the footnotes. To protect privacy, the study will not use information which could identify individual activists without permission.

This paper describes and analyzes the history of both social movement organizations from the perspective of resource mobilization theory. Resource mobilization theory was an important development in social movement studies. It began by criticizing:

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\text{strong assumptions that shared grievances and generalized beliefs (loose ideologies) about the causes and possible means of reducing grievances are important preconditions for the emergence of a social movement in a collectivity. (McCarthy and Zald, 1977, 1214)}
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Instead of grievances and generalized beliefs, the theory focuses on “the aggregation of resources (money and labour)”, “minimal form of organization”, “involvement of individuals and organizations from outside the collectivity which a social movement represents”, “supply and demand model”, and “costs and
rewards [. . . that] are centrally affected by the structure of society and the activities of authorities” (McCarthy and Zald, 1977, 1214, 1216).

This article focuses on the resource mobilization of social movements, whereas previous studies of social movements of people with psychosocial disabilities in the Global North have focused on the arguments/ideas (even ideologies) of such movements. It explains the emergence and development of global social movements where it is considered difficult to share grievances and generalized beliefs due to very different social situations.

Before describing the histories of the two global organizations that are the focus here, the author briefly introduces the local movements of persons with psychosocial disabilities in East Asia. In Japan, groups of people with psychosocial disabilities, who were discharged from mental hospitals, began to emerge in the second half of the 1960s. Reformist professionals, who were influenced by the Western anti-psychiatry movements, supported these groups of in-patients and ex-patients. Some of the groups became independent from the professionals and established the Japan National Group of Mentally Disabled People (JNGMDP), the first national organization, in 1974. Since its foundation, the JNGMDP has argued against security measures. After the Utsunomiya Hospital Scandal of 1984 (when a patient was maltreated by male nursing staff and died at a private institution), the movement began to focus upon how forced hospitalizations were made possible and to critique the associated processes and practices. When the government amended the Mental Health Act in 2017 to include provisions that let police monitor people discharged from forced hospitalization the JNGMDP opposed the Bill, which was finally abolished (Kirihara, 2022).

In South Korea, a national organization called the Korean Alliance for Mental Illness (KAMI), was established in 2010. KAMI (2023, n.p.) describes itself as:

> an institution that was established based on the alliance between disabled people/patients themselves, their family members, friends, experts, human rights activities and the general public to help the mentally disabled people/patients and family members who are alienated in the respective societies due to the perception of mental illness to recover and to improve their life, and to eliminate our society’s discrimination against them. It is modeled after the NAMI of the US to engage in Education/Training, Advocacy, Support, and research initiatives.

Oh-yong Kweon, a founder and representative of KAMI, is a lawyer and person with psychosocial disabilities. KAMI has subsequently changed its name to the Korean Alliance for Mobilizing Inclusion (retaining the same acronym, but transforming its meaning).

The author was unable to find reliable information on the social movements of people with psychosocial disabilities, related to the global movements in Taiwan.

**Histories of the Global Movements**

**The WNUSP**
The World Federation for Mental Health (WFMH) is an organization for people interested in mental health, however, it has been led by Western psychiatrists.
In the 1980s, the office of the WFMH was based in the US. A programme of the National Institute of Mental Health acknowledged “the importance of funding patient-run programmes as a part of community support” (Chamberlin, 1990, 330). Morrison (2013) describes how the US movements, disagreements over seeking and accepting federal funds for mental health services reflected the growth of an important division between positions – between “reform” and “rejection” of psychiatry. Over time, the radical ex-patient position retreated into the background, and the reformist consumer position became dominant. There was a coming together of these different groups, however, when psychiatrists and “consumers” invited “users” and “survivors” of psychiatry as speakers at the World Congress of the WFMH. This set the stage to establish an international organization of people with lived experiences (Ito, 2021).

The first General Assembly of the WNUSP was held in 1991 in Mexico City at the same venue as the World Congress of the WFMH. There were seven participants in the first committee meeting – two from the US, two from New Zealand, and one each from the Netherlands, Japan, and Mexico. At the first conference, Mary O’Hagan from New Zealand was elected as the chair of the organization, and the World Network was established not only for reformists but also for abolitionists of psychiatry (O’Hagan, 2014, 207–208; Ito, 2021).

The WNUSP General Assembly continued to be held at the same venue as the biennial WFMH World Congress. The fifth assembly held in Santiago, Chile, in 1999, was the last to be held at that venue, because the WNUSP could not afford to hold the international conference. Thus, it used the participation of the WFMH’s World Congress to hold its General Assembly, saving the costs of transportation and accommodation. However, only people in the West were invited by the WFMH because it was led by Western psychiatrists. The WNUSP recognized this limitation and tried to obtain external funding (Ito, 2021). At the time, Japan was the only country from Asia that participated in the General Assembly of the WNUSP.

In 2000, the WNUSP held the “initial General Assembly” in Vancouver, Canada, although it was the sixth General Assembly when we count from the first in 1991. The naming was likely because this was the first assembly to be held on different dates and venues from the World Congress of the WFMH. It is worth mentioning that a Taiwanese organization joined as a further East Asian organization at this “initial” (Sixth) General Assembly (WNUSP, 2001; Ito, 2021).

The next General Assembly, held in 2004 in Vejle, Denmark, was a turning point in terms of participant diversity. There were 193 participants from 53 countries, including China, India, Japan, Nepal, and Pakistan. One of the participants from India was Bhargavi Davar (WNUSP, 2004) who became a board member of the WNUSP at this assembly. Her appointment is worth mentioning because, at the time of her entry into the board, she was asked if she was a user or survivor, in order to qualify as a member. She did not answer with a simple “yes” or “no”. She said that at that time, she “did not ‘know’ that we[they] were ‘users and survivors’ nor did we[they] ever imagine that we[they] were ‘disabled’ people” (Davar, 2015, 222).
Elsewhere, the author (Ito, 2021) has highlighted two reasons why people from Africa, Asia, and Latin America began participating from the 2004 General Assembly. First, drafting the Convention on the Rights of Persons with Disabilities (CRPD) began in the 2000s. Ad hoc committee meetings for the drafting were held in New York from 2002, and several disability rights movement activists from around the world visited New York for lobbying. Some governments included activists as members of governmental representatives for the meetings. In addition, many transnational and domestic workshops and seminars on disability rights and strategy meetings were held. These promoted exchanges within and among cross-disability movements, making it easier for people from these areas to know about the WNUSP. Conversely, it was difficult for people in Africa, Asia, and Latin America to obtain information on the WNUSP from domestic mental health professionals. Second, the Denmark government financially supported the General Assembly. That financial support came to WNUSP not through the WFMH, but through the Denmark organization of users and survivors. They prioritized participants in low- or middle-income countries. Therefore, the criteria for obtaining financial support were changed from whether they had connections to the WFMH or domestic psychiatric professionals to whether they lived in low- or middle-income countries.

The operating body of the WNUSP was unstable and changed according to the biannual General Assembly, from its establishment to the 2001 General Assembly. Between General Assemblies, members of the operating body often lost touch with each other. Whilst this was hard to achieve in reality, the WNUSP continued to attempt to operate through members from diverse areas. At the 1999 General Assembly, the WNUSP divided the world into four areas and reserved a seat on the operating body from each area (Ito, 2021).

Masaji Kowagezawa from Japan was a member of the operating body since its establishment, however, it was sometimes difficult for him to participate in the discussions. A possible reason was that he needed an interpreter when the discussion was conducted in English. This language barrier was often mentioned as a problem by him and other participants from non-English-speaking regions. When the WNUSP was unable to contact Koganezawa, he was replaced by another activist from Japan in 2002. The Asian seat in the operating body eventually became the seat from the Asia-Pacific region. It was occupied by members from Japan, New Zealand, and Australia. Davar subsequently became another board member from Asia (Ito, 2021). Following her involvement, Matrika Devkota from Nepal and Kweon from South Korea became board members from the Asian region.

The TCI Global
TCI Asia was established in 2014 as an organization, however it started as a project of the Bapu Trust. The Bapu Trust was established in 1999 in Pune, India, as an organization

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2. At the 2004 General Assembly, participants from Africa decided to establish an African continental organization and realized it the next year in Kampala, Uganda.
that created, piloted, and monitored community inclusion programmes. Davar was one of the two founders. The Bapu Trust has an urban mental health programme called the Seher (Dawn) programme. It focuses on psychosocial distress and improving well-being for persons with mental illness and psychosocial disabilities. They advocate for enabling environments and human rights-compliant policies and programmes. Their initial focus was upon the health system in India. Similar to other areas in the Global South, in the colonial period, institutions for the “insane” arrived in India from the UK, and the Indian government pushed to replace temple and indigenous healing spaces with “modern” treatments with claims to scientific rationality, such as psychiatry (Mills and Davar, 2016, 443–444).

The Bapu Trust gradually expanded its focus from India to other parts of Asia and held an event called the “Vision and Strategy for Transforming Communities for Inclusion of People with Psychosocial Disabilities” in Pune in May 2013. The participants included people with psychosocial disabilities from across Asia, including Nepal, the Philippines, China, Bangladesh, and India. According to Davar (2015, 223–224), the objectives of this event were:

> to explore the possibility of a common framework for policy advocacy in the Asian region; discuss questions of identity [...] and to plan for community mental health services [...] Finally, the conference aimed to foster links with cross-cutting disability and development discourses across the region.

At the conference, the question of identity was a key topic. Some participants felt that the “user and survivor” identity was associated with a baggage of Western history. Others, especially participants from India and China, with strong experiences of oppression within the medical system, identified as a “user and survivor” but not as people with disabilities. As Davar (2015, 224–225) has explained: the concept of being “psychosocially disabled” is a “newly forming identity, inspired by the human rights vision of the UN CRPD”. Whilst it was difficult for some participants to be/feel included in the CRPD campaign, many people in the room did identify as people with psychosocial disabilities.

The group took its name from the previous year’s conference and was eventually formed as an Asian organization called “Transforming Communities for Inclusion of Persons with Psychosocial Disabilities – Asia” (TCI Asia), in Bangkok in November 2014 (TCI Global, 2023a). A press release emphasized the need to avoid homogenizing the Asian region, which is geographically, culturally and linguistically diverse and with complex social systems. At the Bangkok conference it became clear that the most obvious differences in terms of inclusion, were between countries with mental health legislations (Korea, Japan, China, India) and those without (Nepal, Philippines, Sri Lanka, Bangladesh, Indonesia, Thailand) was evident (TCI Asia, 2014).

Regarding the East Asian movements involved in TCI Global, KAMI hosted a five-day event in November 2015 in Incheon and invited members of TCI Asia. The event included an international symposium with the National Human Rights Commission of Korea, a conference with the Korean disability NGOs, and TCI Asia’s own conference. Therefore, invitees included members of TCI Asia, senior activists
in users’ and survivors’ movements outside Asia, lawyers, and activists of cross-disability movements, including the Korean Disability Forum. The author participated in this event from 17 to 19 November 2015 as an interpreter between the English-speaking participants and Japanese-speaking. In addition, the author later participated in several TCI events as an interpreter and met interpreters for other languages, including Chinese, Spanish, and sign language, especially after TCI became a global organization. Some of these, including the author, were amateur interpreters and members or allies of the movements.

After a large event in Korea, TCI Asia held several events – a three-day plenary conference in Bangkok in March 2016, a learning institute programme in India in November 2016, and a two-day strategy meeting in Bangkok in July 2017. The events in India included a three-day learning institute programme in Pune and a three-day INTAR (International Network Toward Alternatives and Recovery) conference in Lavasa. INTAR started in 2003 and is an international summit of world-renowned survivor leaders, psychiatrists, psychologists, family members, and other mental health professionals concerned with promoting non-coercive, non-medical alternatives to the traditional mental health system. One of the founding members is Peter Stastny, a dissident psychiatrist and leading psychiatric spokesperson for the patient self-help movement from Austria, who later moved to New York (Farber, 2012, 37–38). The organization has now revised its name to the International Network Towards Alternatives and Rights-Based Supports and adopted a rights-based approach aligned with the approach of the psychiatric survivors movement.

The JNGMDP hosted a three-day event in November 2017 in Osaka and invited members of TCI Asia. The participants were invited from South Korea, Sri Lanka, India, Indonesia, Pakistan, Hong Kong, China, Taiwan, and Thailand. Certain events with the theme of “peer support” were open to TCI members and other Japanese participants with professional consecutive interpretations.

During this period, TCI Asia established a management system for the organization and became independent of the Bapu Trust. An email titled, “TCI Asia membership invitation” was sent on 22 December 2017 to the mailing list of the “IDA CRPD Forum listserv”. It invited listserv members to become members of TCI Asia and spread the invitation to people with psychological disabilities or organizations working to promote their rights in the members’ network. The Steering

4. The author participated in these events as an interpreter between English and Japanese.
6. The author organized this event as a supporter and interpreter of the JNGMDP. The author reserved flight tickets for foreign participants, picked them up at the Kansai International Airport, and was involved in other logistical matters.
7. The IDA CRPD Forum listserv was set up by the IDA. “The IDA CRPD Forum listserv is the largest interactive online community dedicated to the implementation of the UN Convention on the Rights of Persons with Disabilities (CRPD), and the inclusion and promotion of the rights of persons with disabilities. This is an open and moderated Forum, with a diverse range of informed and influential perspectives, including up-to-date information, opportunities and discussion” (IDA, 2023).
Committee meetings began in January 2018 and were held several times. Around five to ten members had online meetings regarding several agendas. In addition, TCI Asia tried to register as an organization in Bangkok.

TCI Asia gradually mobilized members from outside Asia, including from the Pacific, MINA, and African regions. Since the 2010s, the WNUSP has been relatively inactive and there has been almost no organization that can represent the global voice of users and survivors of psychiatry and people with psychosocial disabilities. TCI Asia is an active organization and has been invited to several international conferences on mental health or disability rights since 2014. For example, Yeni Rosa Damayanti, a chair of the Indonesian Mental Health Association, and Bhargavi Davar participated in the Consultation on Human Rights and Mental Health, titled “Identifying Strategies to Promote Human Rights in Mental Health” of the OHCHR in May 2018 in Geneva. TCI Asia recognized the possibility and necessity of being a global voice and became TCI Asia-Pacific during the 2018 Bali conference and TCI Global in the 2022 Bangkok conference.

After the plenary meeting in Bali, several conferences of TCI Asia-Pacific were held mainly in Bangkok before COVID-19. The TCI is now a global organization, however, most members are from Asia, the Pacific, and Africa. This is a major difference from the WNUSP because most WNUSP members were from Western Europe and North America, especially in the 1990s. Nevertheless, organizations from East Asia have been members of both global organizations since the beginning.

Discussion
We discuss the movements of users and survivors of psychiatry in the Global North. These movements, especially in the US and the UK, have been studied more than those in the South. Previous studies analyzed the movements by focusing on how they have or have not accepted diagnoses, knowledge, and practices in the mental health system.

Anti-psychiatry movements became active in the 1950s and 1960s, led by young psychiatrists. Some organizations of users and survivors of psychiatry became independent from anti-psychiatry movements in the 1970s and 1980s.

The stage was set for the establishment for the establishment of the WNUSP by the US psychiatrists and consumers of the WFMH. In the 1990s, the WNUSP held its General Assemblies at the same venue as the World Congress of the WFMH. Hence, the WNUSP, at least in the 1990s, had many features in common with movements in the Global North.

A Japanese organization was the first and only participant from Asia in the WNUSP General Assembly in the 1990s. It participated with an interpreter. For the Japanese

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8. Most other participants were professional organizations such as WHO- or UN-related organization such as UNAIDS or UNICEF. Other participants were activists, users, and survivors, such as Michael Njenga from the African Disability Forum from Kenya. (Accessed 25 January 2023, https://www.ohchr.org/sites/default/files/Documents/Issues/MentalHealth/ConceptNote.pdf)
member, however, it was difficult to play a leading role, and sometimes it became difficult to keep contact with the WNUSP. Other board members were unable to maintain contact with the WNUSP. For example, during the preparation for the 2001 “initial” General Assembly, two board members from Egypt lost contact. They came to the World Congress of the WFMH in 1997 with Egyptian psychiatrists and seemed not to know about the movements. Without the support from the psychiatrists, they could not or were not willing to contact the WNUSP (WNUSP, 2000; Ito, 2021, 275–277). Hence, mental health professionals played important roles in operating the WNUSP, including connecting members and providing logistical support, even though the WNUSP members were limited to users and survivors of psychiatry.

In addition to the Japanese organization, a Taiwanese organization participated in the 2000 General Assembly. The East Asian movements started to participate in the WNUSP before other Asian organizations. One reason was that movements or individuals with psychosocial disabilities had a stronger connection with mental health professionals who were influenced by Western psychiatrists. For example, the Japanese movements had a connection with reformist professionals.

Next, we will discuss the movements of people with psychosocial disabilities in the Global South. TCI Asia chose “people with psychosocial disability” as its collective identity. This was its distinguishing factor from the WNUSP. Previous studies on the movements, mainly in the UK, revealed that some movements were reluctant to be part of the disability movement (Beresford, 2015; Plumb, 2015). Peter Beresford was involved in both the movements of users and survivors of psychiatry and disability movements in the UK. He focused on argument in the movements of users and survivors and described that “some [psychiatric] service users feared that the association of the social model of disability would add to the stigma they faced”, and “that the idea of ‘impairment’ underpinning the social model misrepresented the experience of mental health service users” (Beresford, 2015, 252). Similar discussion can be found at the European Network of (Ex-) Users and Survivors of Psychiatry, a Europe-wide organization established the same year as the WNUSP and maintaining a close relationship with it. When the European Disability Forum was established, there were tumultuous discussions about whether the European Network should become a founding member of the European Disability Forum. The European Network did eventually become a member (Ito, 2021).

The WNUSP became active in the cross-disability movement when drafting the CRPD both as a member and as one of the leaders, especially in discussions on decision-making (WNUSP, 2008). Many movements of people with psychosocial disabilities in Asian countries became active during or after the CRPD drafting. The TCI Asia members accepted having a psychosocial disability and found it better than user or survivor as their collective identity. Similar to other Asian movements, the reluctance to be part of the disability movements was not noted concerning the East Asian movements.

TCI Asia has members from East Asia. There were participants from China in the first conference before its establishment as an organization, and the organization of
South Korea held a TCI Workshop in 2015 and that of Japan in 2017. Only the Japanese movement was founded to participate in the WNUSP activities with an interpreter, although the language barrier to participation has been noted in other WNUSP activities. In contrast, Chinese and Spanish interpreters, in addition to Japanese, were involved in the TCI activities. This suggests that TCI may have been more accessible to non-English speakers, however, the author was able to correct more information about the interpretation of the TCI because she participated in the activities as an interpreter. By comparing the histories of the WNUSP and the TCI, it is revealed that the movements of East Asia have features of the movements in the Global North and South.

**Conclusion**

To date, studies on the movements of users and survivors of psychiatry and people with psychosocial disabilities have tended to focus on movements in/of the Global North, especially the UK and the US. These studies have explained these movements as resisting the mental health system. There is a need for further research into the movements elsewhere in the world.

This study adopted the CDS’s proposal to move beyond binary thinking: North/South and impairment/disability. It has focused on the movements of people with psychosocial disabilities in East Asia. In East Asia, many people with psychosocial disabilities have remained institutionalized, as in the Global South. Yet the degree of access to psychiatric treatment in East Asia is higher than in many low- and middle-income countries. Thus the situation in East Asia cannot be easily categorized as Global North or South.

Knowing the features of the mental health system, this study analyzes the movements of people with psychosocial disabilities in East Asia. It describes the participation of the East Asian movements in the global movements through the histories of two global organizations. The analysis has shown that East Asian movements have rarely been a part of Global North or South movements from their beginning. Rather, they joined later. In addition, they share commonalities with both movements. The feature of Global North movements is reliance on and strong connection with the movements of mental health professionals. The feature of the Global South movements is reliance on and strong connection with disability rights movements.

This study pointed out an implication of such features of the movements in East Asia for further research in the field of psychosocial disabilities. To date, the movements of people with psychosocial disabilities from beyond the Global North have been largely overlooked within academia. Movements in the South, including the TCI, have been gaining momentum in recent years. Their purpose is different from the Global Mental Health movements. Moreover, if the purpose of movements in the Global North is explained as resisting the mental health system, the purpose of movements in the Global South is different from the Global North. Several TCI Global members have not experienced oppression by a mental health system. How can we balance this difference in the movements’ purposes in terms of East Asian movements,
which have been members of both movements? Further examination of the movements in East Asia may find claims that are compatible with those of both the North and the South movements; and perhaps presenting a new, critical perspective.

From the CDS perspective, the Western ways of supporting people with disabilities cannot be applied to all regions. Nevertheless, to some extent, the achievements of the movements in one area can provide a positive influence on other areas. Since the East Asian movements can be explained to have characteristics of both the North and South movements, their analysis should indicate how we can bridge the gaps between the Global North and South, and movements of users and survivors of psychiatry and disability rights movements, especially in European countries.

REFERENCES


