Mental Health Literacy and on mental health system in each country.

2. Purpose of the Research on Mental Health Literacy

It was agreed to undertake joint research in both Australia and Japan aiming at 'Improving Community Attitudes to Mental Illness'.

The major purpose of the research, for the Australian researchers, was to find out whether there had been changes in mental health literacy, judged against the baseline of an earlier survey, and the effectiveness of campaign activities that had been undertaken.

On the other hand, the purpose for the Japanese researchers was to carry out a large-scale nation-wide survey for the first time to understand awareness of mental health and attitudes to mental illness by the general public and specialists. Although the need for correct education on mental health literacy was increasingly recognized in Japan, given the environment where various mental health issues were occurring in recent times, there was very little information available to support such efforts. There were some small-scale surveys; (i.e. surveys taken in local mental health centres or surveys taken within specific groups) and to some degree large-scale surveys, such as a part of the `Survey on Health and Welfare Trend' by the Ministry of Health, Labour and Welfare, and the surveys on `Schizophrenia' and `Awareness of Cases such as Personality Disorder' by the National Institute of Mental Health. However, the information gathered in these surveys proved to be insufficient to be generalised, because of the small number of communities involved, for any use by the national or local governments and because of lack of comparability of the questionnaires used.

In the report ('Future Mental Treatment') based on these survey results, completed the Affiliated Committee for Mental Disorders at the People with Disabilities Subcommittee of the Social Society Council the research team tried to provide basic information to understand the community's attitude to those with mental disorders at a time when it is proposed to discharge and rehabilitate 72,000 inpatients in mental hospitals who are categorised as "possible to be discharged when post discharge conditions are met".

On examining the comparison between the two countries, the researchers decided to clarify the differences in social and cultural understanding of mental health and mental illness and to study the future development in the related fields in each country.

The Australian research group was lead by Prof. Anthony F Jorm with the members including Dr Helen Christensen and Dr Kathleen M Griffths. The Japanese research group was lead by Prof. Yoshibumi Nakane with the members including Dr Hideyuki Nakane, Dr Kumiko Yoshioka and Dr Tadashi Takeshima. Dr Tekeshima aimed to understand and compare

the mental health and welfare system in Australia and Japan, with the idea that the community awareness of mental health and attitude to mental illness were strongly influenced by the mental health services provided in the area. He repeated visits to institutes and facilities related to mental health in Australia and interviewed their staff.

3. Summary of Mental Health Literacy Research

The Australia-Japan comparative study adopted, as a starting point for discussion, the Australian study that had been carried out previously. The interview questionnaires called `Australian-Japanese Survey Mental Health Literacy' were proposed by the Australian group and the Japanese group converted them into a Japanese version titled `the Japan-Australia Joint Comparative Survey Questionnaires Concerning Knowledge and Understanding of Mental Health' and furthermore converted them into self-completion survey style ` Survey Questionnaires concerning Knowledge and Understanding of Mental Health'. The questionnaires consisted of 120 questions including ID section (respondents' background information), recognition rates regarding the case vignettes (2 cases describing depression and two cases describeing schizophrenia), general understanding, emotional reaction to the cases (including prejudice and discrimination) and how the public could support them, respondents' mental and physical health, and knowledge regarding mental health. It required 30 minutes for an interview. Some alteration was made for self-completed questionnaire survey (which was used for the survey of specialists).

II Summary of Research Results of Mental Health Literacy

The Japanese research was carried out with the support of Scientific Research Project of Wellbeing of Mind funded by the Ministry of Health, Labour and Welfare (Japanese FY 2003 – 2006). The Australia's research was funded by the Federal Government Department of Health and Ageing, beyondblue and a National Health and Medical Research Council Program Grant.. Partial results are shown here. The details are shown in attachments.

1. Samples

In Japan, the survey involved a national sample of 2,000 adults aged between 20 and 60 in 2003. In Australia, the survey involved a national sample of 3,998 adults. Furthermore, the survey involving the specialists was carried out in Japan in 2004. The table 1 shows the details of the samples.

Table 1 SUBJECTS

Age Groups	18-19	20-29	30-39	40-49	50-59	60-69	70 +	
General Population (AUSTRALIA)	120	549	778	786	654	507	604	3,998
General Population (JAPAN)	-	400	400	400	400	400	-	2,000
Psychiatrists	-	2	25	45	40	45	-	157
General physicians	-	0	8	20	25	35	-	88
PSW	-	114	112	76	48	15	-	365
OT	-	183	108	34	5	4	-	334
Psychiatric Nurses	-	18	39	67	46	2	-	172
General Nurses	-	84	68	71	33	1	-	257
Total (JAPAN)	0	801	760	713	597	502	0	3,373

2. Methods

Household interviews were carried out using the questionnaires, based on the manual provided by the Australian group and translated into Japanese. The locations for the survey were examined at the Japanese researchers' meeting. The survey of the specialists (in Japan only) was carried out by posting the same questionnaires used for the public. The five colleges and one association cooperated in the survey by selecting the samples for the specialist survey. The response rate was 30%.

3. Outcome

(1) Recognition rates of the cases

Table 2 and Figure 1 show recognition rates in the cases of depression and schizophrenia by the public and the specialists.

Table 2 Recognition Rates Among Public by Type of vignette (%)

	Depression				Schizophrenia			
	Non-Suicidal		Suicidal		Early		Chronic	
	Japan	Australia	Japan	Australia	Japan	Australia	Japan	Australia
Depression	**22.6**	**65.3**	**35.0**	**77.3**	13.6	34.8	9.6	9.6
Schizophrenia	2.2	0.0	1.2	0.5	**17.2**	**41.2**	**33.4**	**36.1**
Nervous Problems	2.0	0.7	2.6	1.6	2.6	1.7	2.4	1.0
Psychological/Mental Problems	29.4	4.5	24.8	6.0	28.4	12.9	27.2	14.3
Mental Ilnes	9.2	3.0	10.2	5.5	21.6	23.0	12.8	35.8
Stress	25.0	16.6	19.8	10.9	5.0	3.1	3.8	2.8

Source: : 'Images of Mental Illness in Japan' Jpn Bull Soc Psychiat 15 (1)

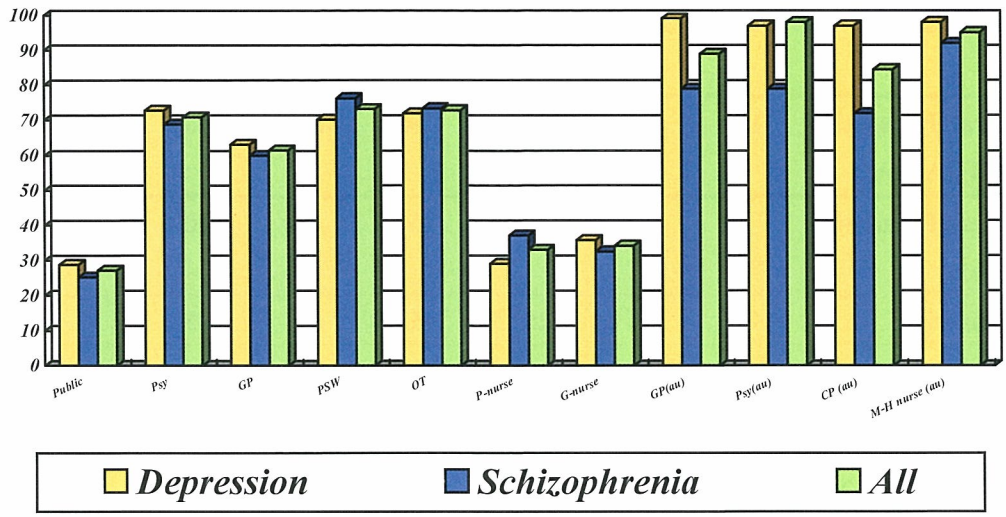

Figure 1: Percentage of respondents among general population and specialists by the type of vignette

Note: Public; General Population, Psy; Psychiatrists, GP; General physicians, P-nurses; Psychiatric nurses, G-nurse; General nurses, GP(au); Gp (Australian), Psy (au); Psychiatrists (Australian), CP (au); Clinical Psychologists (Australian), M-H Nurse (au); Mental Health Nurses (Australian)

Cf: The following references giving the data on Australian Specialists were given by Prof. Jorm.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Rodgers, B., Pollitt, P., Christensen, H. & Henderson, S. (1997). Helpfulness of interventions for mental disorders: Beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, 171, 233-237.

Caldwell, T.M. & Jorm, A.F. (2000). Mental health nurses' beliefs about interventions for schizophrenia and depression: A comparison with psychiatrists and the public. *Australian and New Zealand Journal of Psychiatry*, 34, 602-611.

(2) `Helpful' person, intervention, and information for each type of vignette (Comparison of Japan and Australia)

Table 3 shows the frequency of public respondents choosing each type of source as 'helpful' for the vignette

Table 3 Frequency of public respondents choosing each type of source as `helpful' for the vignette

	Depression				Schizophrenia			
	Non-Suicidal		Suicidal		Early		Chronic	
	Japan	**Australia**	Japan	**Australia**	Japan	**Australia**	Japan	**Australia**

Type of person								
GP	30.4	**87.3**	26.0	**84.1**	19.0	**76.7**	22.8	**76.3**
Pharmacist	6.8	35.4	6.6	33.2	4.2	23.6	4.2	28.1
Counsellor	85.8	82.2	87.6	85.5	87.0	85.0	88.6	83.1
Social worker	73.4	62.8	70.2	67.2	68.4	68.4	75.2	79.1
Phone counselling	42.4	63.5	49.8	66.2	35.6	56.6	29.6	47.5
Psychiatrist	**69.4**	**65.0**	**72.4**	**71.3**	**73.0**	**80.5**	**79.0**	**80.2**
Psychologist	56.6	66.9	51.2	69.7	56.2	73.6	65.2	74.9
Family	85.0	67.9	84.2	64.8	76.8	62.7	80.4	61.4
Close friends	84.8	78.2	83.2	77.1	70.4	73.0	70.2	72.0
Naturopath	11.2	34.9	14.8	31.8	8.4	23.7	9.0	19.4
Clergy	13.6	45.3	20.0	51.7	11.6	37.2	16.2	42.9
Deal with it alone	24.4	13.1	20.4	9.7	22.4	11.4	21.4	11.8
Medication								
Tonic/herbal medicine	20.2	**50.2**	16.4	**43.7**	10.6	31.3	12.4	33.2
Pain relievers	4.4	14.8	3.6	12.8	4.2	7.3	4.6	10.2
Antidepressants	**34.8**	**46.7**	**36.0**	**52.5**	38.6	49.9	39.8	42.6
Antibiotics	6.2	10.4	6.0	7.9	4.8	4.0	8.4	6.4
Sleeping pills	31.6	23.9	26.2	21.9	21.4	18.1	24.8	11.6
Antipsychotics	22.6	11.2	21.8	16.5	30.2	33.1	41.2	38.2
Tranquillizers	**38.4**	13.8	**37.0**	13.8	38.4	17.2	45.4	15.3
Intervention								
Physical activity	**69.4**	**92.0**	**73.4**	**92.5**	**73.4**	**87.4**	**70.6**	**79.6**
Books	60.0	79.3	59.4	79.8	57.6	79.6	46.8	74.7
Get out more	**67.0**	**87.0**	**72.0**	**90.3**	**67.2**	**87.1**	**61.6**	**76.5**
Learn relaxation	38.2	**83.6**	41.2	**85.3**	26.2	**77.1**	29.4	**68.7**
Quit drinking	10.0	56.0	14.2	59.8	18.6	66.1	17.2	53.4
Psychotherapy	49.0	44.1	48.2	50.4	53.8	59.1	67.0	62.3
Hypnosis	28.0	22.4	28.8	23.9	22.4	29.9	33.2	30.9
Psychiatric ward	13.6	16.4	12.0	20.2	22.0	31.9	30.0	37.8
ECT	2.2	5.9	1.4	**7.2**	1.4	6.4	1.4	6.5
Occasional drink	31.4	44.4	25.0	41.8	15.2	31.1	20.0	27.3
Special diet	5.6	48.3	6.0	45.6	4.4	**42.1**	4.4	**39.3**

Source: : `Images of Mental Illness in Japan' Jpn Bull Soc Psychiat 15 (1)

(3) Likely Cause of the Problem in the Vignette (Depression) (Public A-J Comparison)

Public thought the cause of depression as follows (Figure 2).

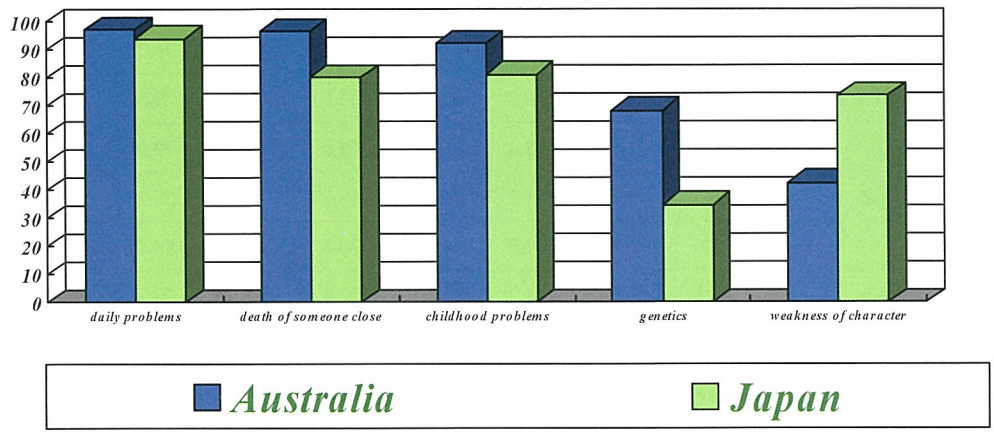

Figure 2 Belief of likely cause for the depressives

(4) Attitude to Each Type of Vignette (Prejudice and Discrimination by Community)

Public responses to the question :` Do you think the type of person in the vignette is discriminated in the community?' (Figure 3, 4)

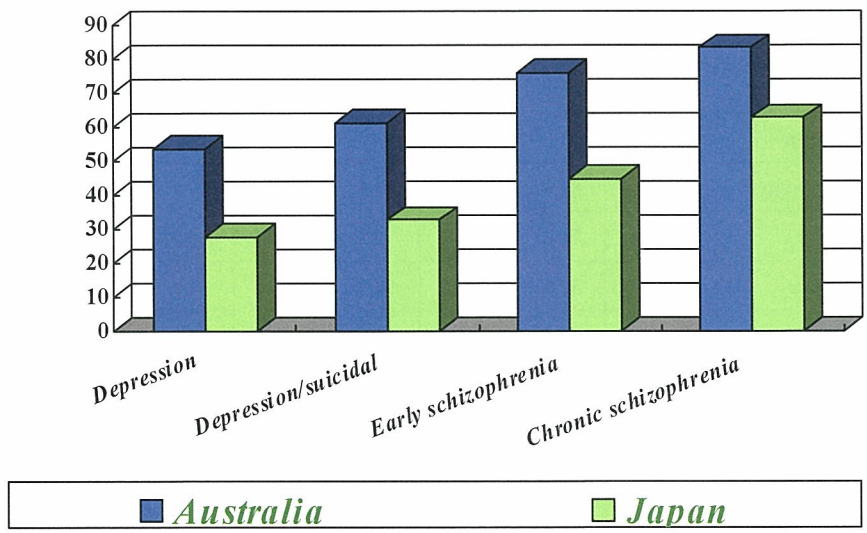

Figure 3 Percentage of Japanese and Australian respondents who think the person described in the vignette would be discriminated against by others in the community

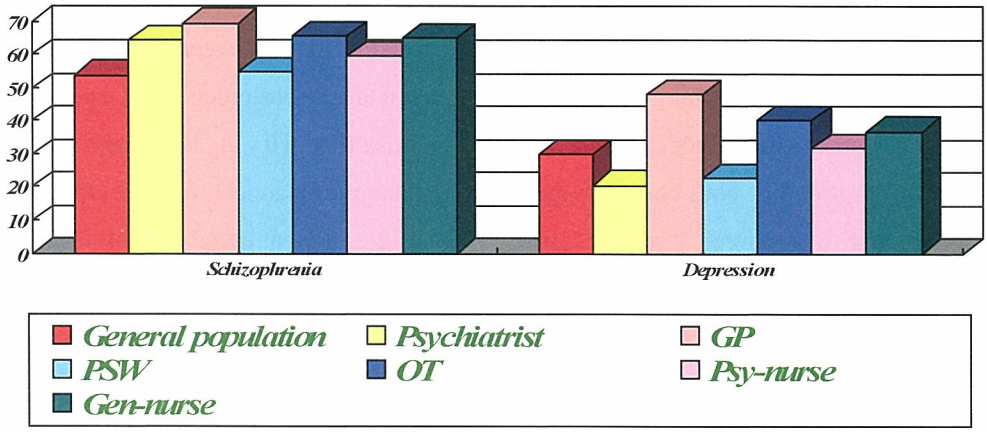

Figure 4 Comparison of respondents: 'Community discriminates against them'

In the final year of the research, the researchers collected material in Australia regarding the educational activities in Australia, and held a discussion with an aim of searching for the direction of draft guidelines, based on the outcome of the research, for the future education activities to support the community in Japan.

Conclusion

The results of the joint research are as follows;

(1) Among the public, it was clear that there were major differences between Australia and Japan in recognition of mental illness, in particular in the case of depression. The Japanese public had low recognition rates and do not sufficiently distinguish depression from other mental illnesses. Hence the need for improving recognition rates regarding mental disorders is apparent. It also was suggested that recognition of mental illness by the public varied between ages and different regions, showing that tailored approaches that suit different age groups are needed when provided information at a national level.

(2) Among specialists, it was clear that there were major differences in recognition of mental illness. (By contrast, very little difference was observed in Australia.)

In rating persons who are likely to be helpful, the following findings emerged;

- Counsellors were seen as more likely to be helpful than psychiatrists.
- The public were not sure about useful interventions and support for mental illness and many answered `don't know'.
- The Japanese sample showed lower degree of adequate judgement of useful persons, medicines and interventions, compared with the Australian sample. (ie. The necessity of providing accurate information is apparent.)
- In Australia, biological causes are appreciated as well as mental stress,

whereas in Japan self responsibility was blamed. (Provision of knowledge and information concerning causes for mental illness is necessary.)

It was suggested in both countries that psychiatric measures were not expected to be useful as treatment. (Suggesting the need to show the usefulness of psychiatric treatment.)

(3) There was some prejudice and discrimination towards mental illness among both public and specialists. However it became more apparent in cases of schizophrenia (suggesting the need to discuss education programmes for the specialists to further their understanding of mental disorders.)

(4) In both countries, a large number of respondents appreciate the usefulness of counsellors as potentially helpful persons, but the expectation of GPs was very small in Japan. (Suggesting the need to promote recognition through an education programme on the importance of GPs in Japan.)

(5) In the comparison of the degree of relationship between mental illness and suicide, it was much lower in Japan than in Australia. (It is necessary to enhance recognition concerning suicide issues.)

(6) There was a large gap in ideas towards mental illness between personal views (expressed as social way of thinking) and perceived views of other people. Co-existence of one's real view and one's public view was revealed. (Intervention is needed on the personal state of mind that does not want to admit ' prejudice and discrimination'.)

(7) In Japan, there was more rejection of contact with mental illness cases and a larger 'social distance' was apparent. (it is necessary to evaluate 'social distance' broadly.)

(8) Perceived discrimination towards people with mental illness was more apparent in Australia than in Japan. (Suggesting the importance of the public recognizing the occurrence of ' prejudice and discrimination).

III. Summary of Research on Mental Health System in Each Country

1. Purpose

Reforming mental health system is an urgent issue for both Australia and Japan. In Australia, National Mental Health Strategy has started in 1992. However, there still is a challenges to solve, and is currently undergoing the third phase of the National Mental Health Plan (2003-2008). In Japan, Ministry of Health, Labour and Welfare have submitted a report called "Reform Vision for Health, Medical Care and Mental Health Welfare" in 2004. In 2005, "Law to Support the Independence of People with Disabilities" has passed the legislation. So Japan is in the renovation process of the mental

health system. Situation between the two countries are different, and have different challenges, but some challenge can be shared.

In this research, Japanese researchers exchanged information with Australian researchers and officials, and visited mental health facilities, to learn about the current situation of mental health and welfare and about the mental health reform in both countries. By collecting information of mental health and comparing it, we derived implications which will be beneficial to the development of mental health in both countries.

2. Methods

The Japanese researchers visited Canberra, Melbourne, Sydney and Perth during 2003 to 2006. They interviewed people engaged in mental health matters such as the commonwealth government, state governments, clinicians and administrative staff at the hospital, and researchers etc. and visited various institutes and facilities such as such as forensic, acute, and children psychiatric unit, community mental health services, and NGOs etc. and exchanged information regarding mental health. The information collected from the interviews, brochures provided at the facilities, related documents and websites were carefully studied and sorted, for the purpose of producing the report. The Australian researchers also visited Japan on 2003 and 2006. From this information, we compared the history and the current situation of mental health system in each country. And from that result we derived implications for future mental health development.

3. Result

(1) Current situation in Japan

Recently, Japanese government has released mental health policies and laws relevant to mental health in rapid succession. This mental health system reform is aimed towards deinstitutionalization and community mental health.

In September 2004, the Ministry of Health, Labour and Welfare submitted the Reform Vision for Mental Health and Welfare Services. Its aim is to realize the transition "from institution-based medical treatment to community-based care." It was followed by the enactment of the law to support the independence of people with disability in October 2005, which contains the key elements of the reform vision. The revision of national fee schedule in 2006 also contained items which is relevant to community mental health.

This mental health and welfare system reform involves the three main themes. First is "educating the public" to achieve better understanding of mental disorders and patients among the public. Second is "reforming psychiatric treatment". Third is "strengthening community support systems" to secure the environment of the community for persons with mental disorder.

To achieve the objectives, definitive goals for the next 10 years have been set. The goal for public education is to raise public awareness about mental health to over 90%. In the area of psychiatric treatment, the target is to bring

down the "average residual rate of one year" to 24% or less, and to increase the discharge percentage of patients hospitalized for over 1 year to 29% or more. These are targets for each prefecture. By achieving these goals, Reform Vision aims to reduce the number of hospital beds by 70,000 within 10 years.

(2) Current situation in Australia

Australia's National Mental Health Strategy was implemented in 1992. It was initially meant to be a five-year- plan. However, it continued into the second and the third plans followed of 1998 to 2003 and 2003 to 2008, respectively. Psychiatric beds have been declining long before the strategy, so the main purpose of the strategy is to direct the way of the mental health services toward community mental health.

The major purposes of the strategies are; to promote mental health and prevention of mental disorders, to reduce the impact caused by disorders, and to secure the rights of those with mental disorders. The purposes were kept consistent throughout the three Strategies and the outcomes were continuously monitored.

The outcomes to date show;

(A) increased funds for mental health, in particular in the regional areas,

(B) reduced number of non-acute wards and a shift to community care

(C) monitoring of consumers' satisfaction

(D) increase in a number of hospitals where consumers are involved in planning and operation

The issues that Australia's mental health welfare is facing are;

(A) as the degree of implementation of the Strategy varies in each state, it has resulted in a gap between the states, particularly in the area of community care.

(B) there is a great deal of pressure to discharge a patient by hospital management without sufficient treatment being given, because of the too much reduction in number of beds.

(3)Difference of the health system between countries

There is a large deference in the health and mental health system between countries, and it was necessary to understand the difference before comparing the situation.

In Japan there is no GP, or a catchment area, so patients can go directly to whichever psychiatric hospital or clinic. Australian mental health system relies on catchment area based public services, whereas in Japan private sector plays an important role, and about 80% of hospitals and most clinics are private.

Japan has deferent payment system for medical and welfare. For medical part, Japan has a universal health insurance with co-payment, and it is based on the fee-for-service schedule. Both public and private are on the same schedule. For welfare part, users undertake a care needs assessment and depending on the level of the careneeds, service providers are paid subsidy from the government. In Australia, each state is responsible for the mental health service provision, and the fund are paid to each catchment area as a block funding.

(4) Implication to the Japanese system

When comparing the situation, current Japanese situation is similar to the beginning of the first phase of the Australian mental health strategy. Mental health reform in Japan has just started, and there are many things we can learn from Australia. Below are some important points we should learn and adopt.

・ Shift of the funding from the hospital to the community, by increasing the fund for community mental health.

In Australia, the percentage of the fund used for community mental health increased from 29.4% before the reform to 51.2% in ten years. Increase of the spending toward community is needed in Japan.

・ Enhancement of the community mental health services.

Community mental health services in Japan are growing, but Australia has more experience in those services, such as ambulatory services, care management and vocational rehabilitation and we should learn from that experience.

・ Specialization of the services

Specialization in services is late in Japan and needs more promotion in many areas. Australia has many specialized services, such as early intervention for psychosis, dual diagnosis, dual disability, child and adolescent, and personality disorders, etc.

・ Promotion and prevention of mental health

Promotion and prevention of mental health was one of the main aims of the strategy, and many programs, such as Mindmatters, which promotes mental health understanding and coping among high school students and Beyond Blue, which is a promotion and prevention program for depression and suicide have developed. Public comprehension of mental health is still low in Japan and we need a project to promote their understanding.

・ Monitoring service quality

Outcome of the reform is monitored in Australia, and service providers have a duty of reporting there outcome. Also the involvement of consumer to the service in planning and operation is active in Australia, and 68% of the mental health services involves consumer officially.

IV. What Japan Learned From the Joint Research

The Japanese group gained the following outcome from the joint research:

(1) The large-scale survey that was carried out, for the first time in such a scale in Japan, confirmed the characteristics of knowledge and attitude by Japanese people to mental health, and clarified the position of Japan by comparing the results with those of Australia.

(2) The Australian results showed that broader continuous educational activities were very effective in improving knowledge and attitude to mental health. It was confirmed that it was necessary to implement educational activities in

Japan.

(3) The differences of the administration system in both countries became apparent through collection of material and information regarding the national approach to mental health in Australia and numerous discussions involving researchers of both countries. Useful information was gained for a future development of educational activities in Japan, having clear key points regarding interpreting the results.

(4) It was re-confirmed that it was necessary to take account of what Japanese mental health administration system and society are like and Japanese people's mind, to develop fruitful educational activities in Japan.

V. Agreed Issues and Future Direction in Both Countries

Both Japan and Australia are facing some major issues such as a rapidly ageing society, changes in labour environment, increased demand caused by structural changes in illness and, in particular, rapid changes in mental health. Attention has been focused on the necessity for educational activities regarding mental health associated with social pathological phenomena, including death from overwork and suicide.

In this environment, the joint research between Japan and Australia has produced certain results by the facts that the researches clarified the related issues in both countries and also made international comparison possible. However, there still remains significant room for discussion on interpretation of the results.

Furthermore, it may be necessary to look at the mental health issues from the point of view of exchange/relationship program proposed.

1. Promoting relationship between the research economical efficiency by working out the social and economic burden.

Mental health in both countries could be advanced in the future by proposing and implementing ideas for trials of educational programs in both countries, taking account of the social and cultural background of each country.

During the visit of Australian delegation in 2006, researchers involved in this project had a discussion about the continuity of the relationship after the completion of the Australia-Japan Health and Welfare Collaboration Project phase 2. They reached a conclusion that reform of mental health system is still an urgent issue for both countries, so it is necessary to continue this relationship between researchers. Below are the some institutes.

Promote relationship between researcher in the universities and institutes which have a history

of proposing mental health policies to the governments over the years. We should continue the transaction of researchers and promote the research into mental health reform. It will be especially beneficial to promote young researcher to join those activities, since it will furtherance the future collaboration.

2. Promote association which will contribute to the development of mental health in Asian countries

Melbourne University is currently leading a project called Asia-Pacific Community Mental Health Development Project. This project's main aim is to gather the information of each participating country about the situation they are in, and the best practices they are having for community mental health. To know the best practices in culturally relevant Asian countries will be beneficial for us to plan our community mental health system.

It is our hope to develop further the cooperative relationship based on the joint research, to advance measures to improve mental health, and to promote a commitment for mental health to the world.

日豪保健福祉協力

第二段階最終報告（草案）の要旨 ― 精神保健

Ⅰ．精神保健をテーマとする日豪保健福祉協力研究の概要

1. 緒 言

1998年度の日・豪共同研究の積極的推進、官民の専門家グループ会合の開催など6項目の合意をもとにスタートされた日豪保健福祉協力の共同研究は、2001年4月から第二段階として「精神保健」に入った。

まず、2001年11月に豪州側スタッフの訪日を受けて、「自殺防止」及び「地域の精神疾患への態度の改善」をテーマに2002年4月から実質的研究を行うことが合意された。そこで、2002年9月にオーストラリア・キャンベラで第1回両国研究者会議が開催され、具体的な今後の研究計画について討論された。研究交流の経過については、資料1に記す。

テーマの一つである自殺防止に関しては、両国で進行中の関連研究を包括したシンポジウムをオーストラリアで開催することとした。具体的には、両国で自殺に係る研究の専門家がシンポジストとなって研究成果を発表し防止策に関する討論を深めること、およびその成果はまとめて公表するとした。2006年??月に、自殺防止に関するシンポジウムの報告書が発刊されたので、詳細については同書（An Australian-Japanese Perspective on Suicide Prevention: Culture, Community and Care、Australian Government Department of Health & Ageing and Ministry of Health, Labour & Melfare Japan, 2006）を参照されたい。

一方、地域のMental Health Literacyに関しては、上記の第1回研究者会議において、オーストラリアにおける先行研究の成果を前提に詳細な研究計画の立案が討論された。同時に、研究者による施設の視察や情報交換により、両国の精神保健システムについての調査を行った。これは地域における精神保健の理解や精神障害への態度はその地域で提供されている精神保健サービスに強く影響されると考えたからである。そこで、ここではMental Health Literacyと両国の精神保健システムに焦点をあてて報告する。

2. Mental Health Literacy研究の目的

今回の共同研究は、日豪両国で「地域における精神疾患への態度の改善」を目的にした研究であることが合意された。

オーストラリアは、これまでの研究成果を背景に、今回の調査結果によって同国におけるMentall health literacyの年次推移を知り、更に同国でなされてきた普及啓発活動の有用性を知ることが大きな目的であった。

一方日本では、今回初めて全国展開の大規模調査を行い、地域住民や専門家における精神保健の意識ないし精神疾患への態度を広く把握することを目的とした。近年の精神保健上の様々な話題を前提に、その正確な普及啓発に関するニーズはきわめて増大してきているにもかかわらず、日本ではその背景となる情報は極めて少ないものであった。例えば、小規模な調査（例えば各地の精神保健福祉センターなどを中心とした調査や、特定の集団のみを実施した調査など）やある程度大がかりなものとして、厚生〔労働〕省による「保健福祉動向調査」の中の一部や国立精神衛生研究所での調査（精神分裂病〔統合失調症〕、人格障害などの症例についての意識調査）などはあった。しかし、国または地方自治体などの行政にとって有用となるほどに多数の地域住民を対象としていなかった点および調査票についての比較可能性の検討が不十分であり、一般化できる情報となり得なかったのである。今回の調査結果をもとに、社会保障審議会障害者部会精神障害分科会がまとめた報告書（今後の精神医療対策について）で「『受け入れ条件が整えば退院可能』な約72,000

の精神病院入院患者の退院・社会復帰を図ること」がうたわれるとき、地域住民の精神障害者への見方を知る上での基本情報を提供することを試みた。

また、両国間での比較検討において、精神保健および精神疾患に関する社会文化的理解の相違を明らかにし、関係分野の今後の展開について、それぞれに考察することにした。

今回の調査研究にあたって、豪州側研究班はチーフ Prof. Anthony F Jorm で、研究班メンバーDr. Helen Christensen、Dr. Kathleen M Griffiths、日本側研究班は代表者中根允文、分担研究者中根秀之、吉岡久美子、および竹島正であった。ただ、竹島正は、一般住民の精神保健の意識や精神疾患への態度は、その地域で実際に提供されている精神保健サービスに強い影響を受けるとの考えに立って、日豪両国における精神保健福祉制度の概要を把握し、比較検討することを試みた。そのために、彼は様々な資料交換をまず行い、次いで豪州での担当者との聞取り調査、関連施設訪問等を繰り返した。

3. Mental Health Literacy 研究の概略

日豪両国比較研究は、オーストラリアで継続的に行われてきた調査をたたき台にスタートすることとした。「Australian-Japanese Survey Mental Health Literacy」と題する面接調査票案が豪州側から提案され、これを「精神保健の知識と理解に関する日豪比較共同研究調査票」と題する日本語版とし、さらに調査仕様に改変した「精神保健の知識と理解に関する調査表」にした。調査表には、ID セクション（対象者の背景因子）、事例ビネット（うつ病 2 例、統合失調症 2 例）に関わる認識、一般的な理解、事例への情緒的反応性（偏見や差別を含めて）および一般市民としての支援のあり方、対象者自身の心身の健康状態、精神保健に関する知識などを問う約 120 項目からなる。面接調査であれば約 30 分を要した。アンケート方式（専門職を対象とする調査の時に使用）の場合には、また若干の修正を行った。

Ⅱ. Mental Health Literacy 研究成果の概要

日本における研究は、厚生労働省科学研究費補助金こころの健康科学研究事業（2003 年度～2006 年度）の支援を受けて実施された。オーストラリアでは、・・・からの研究費の基づいて実施された。ここでは、これまでの成果の一部を紹介する。詳しくは、別添資料を参照されたい。

日本では 2003 年度は一般人（2,000 人、20-60 歳）を対象に行った。豪州は、3,998 人であった。更に、2004 年度には精神保健に関わる専門職を対象にした調査が日本では行われた。それらの全てを含む対象者の詳細は、表 1 のとおりである。

1. 対象者

表 1 対象者

年齢群（歳）	18-19	20-29	30-39	40-49	50-59	60-69	70 +	
オーストラリア 一般人	120	549	778	786	654	507	604	3,998
日本　一般人	-	400	400	400	400	400	-	2,000
精神科医	-	2	25	45	40	45	-	157
一般開業医	-	0	8	20	25	35	-	88
精神保健福祉士	-	114	112	76	48	15	-	365
作業療法士	-	183	108	34	5	4	-	334
精神科看護師	-	18	39	67	46	2	-	172
一般看護師	-	84	68	71	33	1	-	257
日本・合計	0	801	760	713	597	502	0	3,373

2. 調査方法

上記の調査票を、一般住民対象の場合、対象者宅を訪問する面接調査によって行った。面接調査の実施方法は、豪州から提示されたマニュアルに基づくものとし、日本では翻訳して活用した。また、日本での調査地点は日本側研究者会議により検討した。次に、精神保健に関わる専門職への調査（日本）は、一般住民を対象とした調査票と同一のものを活用した郵送調査により実施した。同調査の対象者抽出にあたっては、彼らが所属する５学会１協会からの協力を得た。郵送を受けた専門スタッフにおける回収率は約30%である。

3. 結果

(1) 事例に対する認識度

一般人および専門職におけるうつ病・統合失調症事例への認識度は、表 2、図 1のとおりである。

Table 2　一般人におけるうつ病・統合失調症の認識度 (%)

	うつ病事例				統合失調症事例			
	希死念慮なし		希死念慮有り		早期		慢性	
	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ
うつ病	**22.6**	**65.3**	**35.0**	**77.3**	13.6	34.8	9.6	9.6
統合失調症	2.2	0.0	1.2	0.5	**17.2**	**41.2**	**33.4**	**36.1**
神経症性の問題	2.0	0.7	2.6	1.6	2.6	1.7	2.4	1.0
心理的な問題	29.4	4.5	24.8	6.0	28.4	12.9	27.2	14.3
こころの病気	9.2	3.0	10.2	5.5	21.6	23.0	12.8	35.8
ストレス	25.0	16.6	19.8	10.9	5.0	3.1	3.8	2.8

出典：「精神疾患に対する日本人のイメージ」日本社会精神医学会雑誌　15（1）

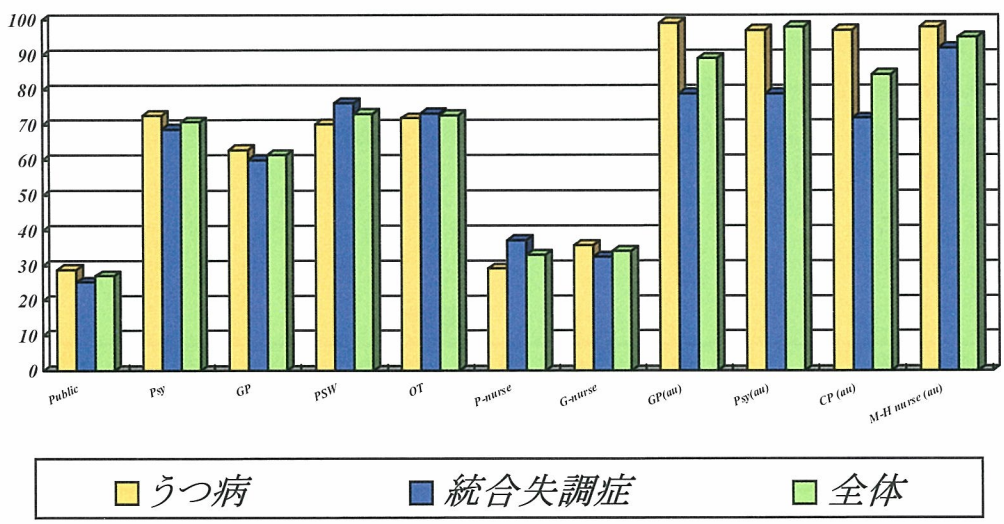

図 1 一般人と専門職におけるうつ病と統合失調症の認識度－日豪比較

注：Public：一般人、Psy：精神科医、GP：一般開業医、PSW：精神保健福祉士、OT：作業療法士、P-nurses：精神科看護士、G-nurses：一般看護師、GP (au)：一般開業医（豪州）、Psy (au)：精神科医（豪州）、CP (au)：臨床心理士（豪州）、M-H Nurse (au)：精神保健師（豪州）

Cf: The following references giving the data on Australian Specialists were given by Prof. Jorm.

Jorm, A.F., Korten, A.E., Jacomb, P.A., Rodgers, B., Pollitt, P., Christensen, H. & Henderson, S. (1997). Helpfulness of interventions for mental disorders: Beliefs of health professionals compared with the general public. *British Journal of Psychiatry*, 171, 233-237.

Caldwell, T.M. & Jorm, A.F. (2000). Mental health nurses' beliefs about interventions for schizophrenia and depression: A comparison with psychiatrists and the public. *Australian and New Zealand Journal of Psychiatry*, 34, 602-611.

(2) 事例に対して有用となる人的資源・治療手段・情報源（日豪比較）

事例にとって下記の人的資源・治療手段・情報源が有用と考える頻度（一般人の場合）は、表 3 のとおりである。

表 3 一般人における事例にとって有用となる人的資源・薬物・治療手段・情報源の頻度

	うつ病				統合失調症			
	希死念慮なし		希死念慮有り		早 期		慢 性	
	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ	日 本	ｵｰｽﾄﾗﾘｱ
人的資源								
一般開業医	30.4	**87.3**	26.0	**84.1**	19.0	**76.7**	22.8	**76.3**
薬剤師	6.8	35.4	6.6	33.2	4.2	23.6	4.2	28.1
カウンセラー	85.8	82.2	87.6	85.5	87.0	85.0	88.6	83.1
ソーシャルワーカー	73.4	62.8	70.2	67.2	68.4	68.4	75.2	79.1
電話相談サービス	42.4	63.5	49.8	66.2	35.6	56.6	29.6	47.5
精神科医	**69.4**	**65.0**	**72.4**	**71.3**	**73.0**	**80.5**	**79.0**	**80.2**
臨床心理士	56.6	66.9	51.2	69.7	56.2	73.6	65.2	74.9
家族	85.0	67.9	84.2	64.8	76.8	62.7	80.4	61.4
親友	84.8	78.2	83.2	77.1	70.4	73.0	70.2	72.0
自然療法家	11.2	34.9	14.8	31.8	8.4	23.7	9.0	19.4
聖職者	13.6	45.3	20.0	51.7	11.6	37.2	16.2	42.9
本人（の対処）	24.4	13.1	20.4	9.7	22.4	11.4	21.4	11.8
薬物								
強壮剤/漢方薬	20.2	**50.2**	16.4	**43.7**	10.6	31.3	12.4	33.2
鎮痛薬	4.4	14.8	3.6	12.8	4.2	7.3	4.6	10.2
抗うつ剤	**34.8**	**46.7**	**36.0**	**52.5**	38.6	49.9	39.8	42.6
抗生剤	6.2	10.4	6.0	7.9	4.8	4.0	8.4	6.4
睡眠薬	31.6	23.9	26.2	21.9	21.4	18.1	24.8	11.6
抗精神病薬	22.6	11.2	21.8	16.5	30.2	33.1	41.2	38.2
精神安定剤	**38.4**	13.8	**37.0**	13.8	38.4	17.2	45.4	15.3
治療手段								
身体の積極的活動	**69.4**	**92.0**	**73.4**	**92.5**	**73.4**	**87.4**	**70.6**	**79.6**
書籍から学ぶ	60.0	79.3	59.4	79.8	57.6	79.6	46.8	74.7
出歩くこと	**67.0**	**87.0**	**72.0**	**90.3**	**67.2**	**87.1**	**61.6**	**76.5**
リラックスの学習	38.2	**83.6**	41.2	**85.3**	26.2	**77.1**	29.4	**68.7**
全くの断酒	10.0	56.0	14.2	59.8	18.6	66.1	17.2	53.4
精神療法	49.0	44.1	48.2	50.4	53.8	59.1	67.0	62.3
催眠療法	28.0	22.4	28.8	23.9	22.4	29.9	33.2	30.9

精神科への入院	13.6	16.4	12.0	20.2	22.0	31.9	30.0	37.8
電気けいれん療法	2.2	5.9	1.4	**7.2**	1.4	6.4	1.4	6.5
時々の飲酒	31.4	44.4	25.0	41.8	15.2	31.1	20.0	27.3
特別なダイエット	5.6	48.3	6.0	45.6	4.4	**42.1**	4.4	**39.3**

出典：「精神疾患に対する日本人のイメージ」日本社会精神医学会雑誌　15（1）

(3) 事例（うつ病）の原因（一般人の場合、日豪比較）

事例の原因について、うつ病では一般人は次のように考えていた (図 2) 。

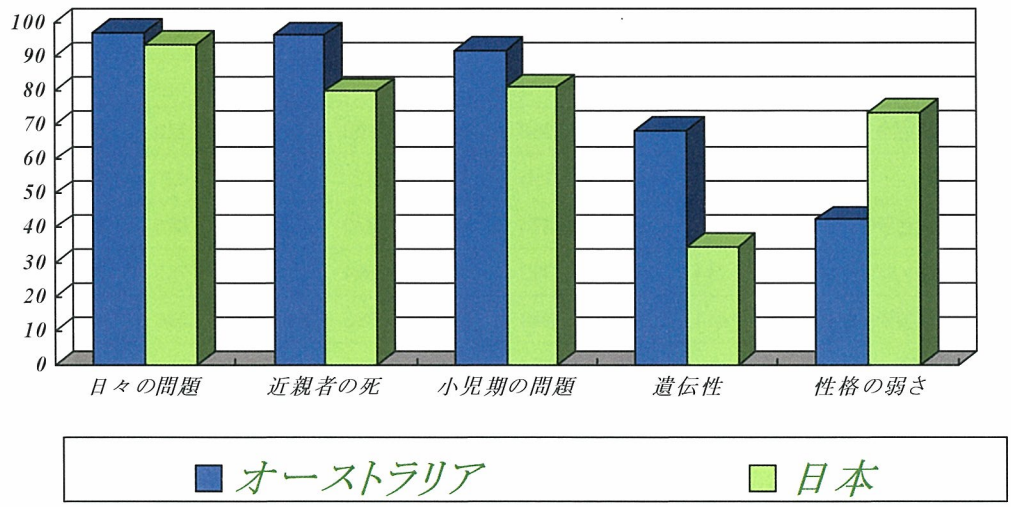

図 2　うつ病に考えられる原因—日豪比較

(4) 事例への態度 (地域社会からの偏見・差別)

「事例のような人は、地域の中で他の人から差別されると思うか」について、一般人は次のように回答した (図3,4)。

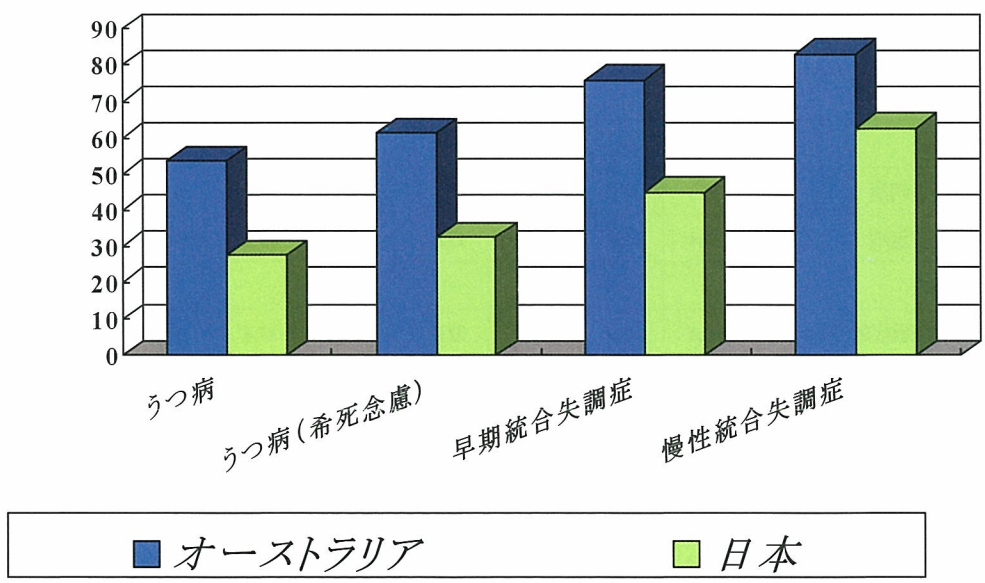

図 3 ヴィネット事例は社会から差別されると考えるか—日豪比較

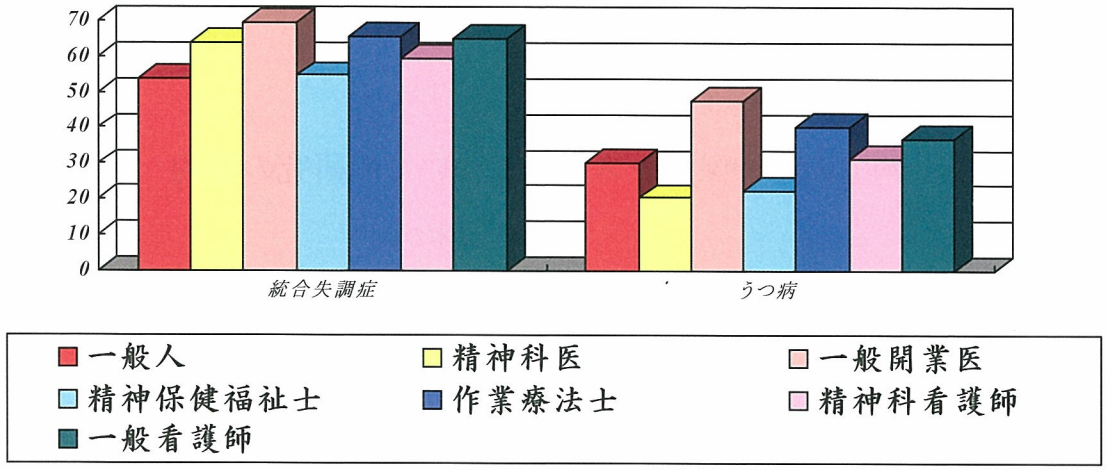

図 4 ヴィネット事例は社会から差別されると考えるか――一般人と専門職の国内比較

研究最終年度は、これまでの成果を基盤とした地域支援に関わる普及啓発のための具体的ガイドライン発案の指針をさぐるべく、豪州における普及啓発活動の展開を現地で資料収集を行い、且つ意見交換を行った。

4. まとめ

共同研究の結果は、以下のようにまとめられよう。

(1) 一般人における精神疾患の認識は、特にうつ病において日本で低く日豪両国間で大きく異なっていること、および他の精神疾患との識別が不十分であること（精神障害に関する認知度向上の必要性）が明らかになった。なお日本では、一般人における精神疾患の認識は、年齢別・地域別について異なること（各年代に対応したアプローチ、全国を網羅する情報提供の検討）も示唆された。

(2) 専門職にあっても、精神疾患に対する認識は大きく異なることが明らかになった（ただし、オーストラリアでは殆ど差を見ない）。人的資源として「カウンセラー」の有用性が精神科医以上に高く期待されていること、精神疾患の治療や支援にとって有用な方策は、一般人の中では曖昧で「分からない」の回答が多くなること、事例にとって有用な人的資源・薬物・治療手段として、豪州に比して日本では適切な判断が極めて少ないこと（精神保健の正確な情報提供の必要性）が明らかになった。豪州では生物学的病因論が心理ストレスと共に評価され、日本では自己責任的発想が目立つこと（精神障害の病因に関する知識や情報の提示）。治療手段として、両国で精神科的方策に高い期待が寄せられていないことが示唆された（精神医学的治療の有効性の呈示）。

(3) 精神疾患に対する偏見差別は一般人だけでなく専門職にあっても少なくないが、特に統合失調症では著しいことが明らかになった（精神障害の理解を深めるための専門職教育プログラムについて検討の必要性）。

(4) 人的資源としてカウンセラーの有用性は両国で高いが、一般医への期待が日本では極めて小さいことが明らかになった（日本における一般医の重要性の再認識と教育プログラムの必要性）。

(5) 精神疾患と自殺の関連を考える頻度は、豪州と比較したとき日本では明らかに低いことが明らかになった（自殺問題に関する認識を高めることの重要性）。

(6) 精神疾患に対する考えには個人的なものと社会的なものとの間に大きな差異があり、本音（社会的考えの形で表明）と建前の存在が窺えた（個人的には「偏見・差別」を認めたくないという心理への介入）。

(7) 日本では豪州以上に精神疾患事例との接触に拒否的であり、Social Distance（社会的距離）が大きいこと

が明らかになった（「社会的距離」の広範な評価の必要性）。

(8) 精神疾患事例に対する差別感は、日本より豪州において目立っていることが明らかになった（「偏見・差別」という認識の把握に関する理解の重要性）。

Ⅲ. 両国の精神保健システムについての研究の要約

1. 目 的

日本、オーストラリア（以下豪州）両国において精神保健システムの改革は喫緊の課題である。豪州においては 1992 年より National Mental Health Strategy として改革が始まり、現在第 3 次 National Mental Health Plan (2003-2008) を実施しているところである。また日本においても 2004 年に精神保健改革ビジョンが出され、2005 年に障害者自立支援法が成立するなど、過去に例のない精神保健システムの改革期が始まったところである。両国の状況、問題点など異なる点も多いが、一致する課題も多い。

本研究では日豪両国の研究者や専門家と情報交換を行い、精神保健施設を訪問することにより、両国の精神保健福祉の現状と、精神保健改革について検討した。集められた情報を元に、両国を比較することにより、相互の精神保健の発展への多くの示唆を得ることを目的とした。

2. 方法

2003-2006 年の間に豪州（メルボルン・キャンベラ・シドニー・パース）を訪問し、精神保健関係者（豪州政府、州政府、病院関係者、研究者等）と両国の精神保健システムについて情報交換するとともに、精神保健サービス（司法、急性期、児童等精神科病棟、地域精神保健サービス、NGO 等）を視察した。これらの訪問での情報交換、施設のパンフレット、関連文書、ウェブサイト等から得られた情報は、報告書作成のために注意深く検討した。また豪州側も 2003 年および 2006 年に日本を訪問している。これらの訪問および文献等からの情報により、両国の精神保健システムの歴史や、精神保健を取り巻くシステムの現況について概要を示し、両国を比較する。またその中より両国の今後の精神保健改革に資する情報を得る。

3. 結果

(1) 日本の状況

我が国では近年、精神保健に関連する政策や法律などを矢継ぎ早に提出している。この精神保健改革は脱施設化および地域精神保健の発展を目的としている。

平成 16 年 9 月に厚生労働省精神保健対策本部より出された、精神保健医療福祉の改革ビジョンは、基本方針を、「入院医療中心から地域生活中心へ」としており、我が国の精神保健医療福祉は、地域精神保健中心へと本格的に舵を切ることになった。その後、平成 17 年 10 月に障害者自立支援法が成立し、平成 18 年度診療報酬改定に地域生活への移行を促進する内容が多く盛り込まれるなど、過去に例のない改革期を迎えていると言える。

この精神保健医療福祉改革には 3 つのポイントはがある。一つ目は国民の理解の深化、二つ目は精神科医療の再編、三つ目は地域生活支援の強化である。これらのポイントを達成するため、今後 10 年の達成目標が数値で定められた。国民意識変革の達成目標は、国民の精神疾患についての認知度を 90%以上とすることとした。精神保健医療福祉体系の再編の達成目標は、各都道府県の平均残存率（1 年未満群）を 24%以下、各都道府県の退院率（1 年以上群）を 29%以上と定められた。これらの達成により、10 年以内に精神科病床の約 7 万床の減少を達成する。

(2) 豪州の状況

豪州においては、1992 年より National Mental Health Strategy として国家規模の精神保健の改革が始まっている。当初の計画では 5 カ年計画であったが、その後も第二次（1998-2003 年）、第三次（2003-2008 年）と継続して実施されている。精神科病床はこの改革以前にすでに減少傾向にあり、この戦略は精神科サービスのあり方を地域精神保健へと方向付けたものと言える。この戦略の大きな目的は、精神保健の推進と障害の予防、障害による影