

まとめ：地域の体系的な医療提供体制の整備の促進

- 精神疾患は慢性的な経過をたどる疾患
 - 医療の機能分化に伴い、連携が不可欠
 - 「重度精神障害」は入退院をくり返す（地域滞在割合を長くすることがゴールのひとつ）
- 基準病床数により「入院の量」に歯止め
 - 診断（統合失調症、認知症、他）、入院期間による分類？
- 求められる地域連携へのインセンティブ
 - 前回の改正時よりも連携モデルが出つつある
- 他科疾患への精神科医の関与を評価
 - 一般病院精神科の評価（リエゾン活動の促進）
 - 精神科診療所の機能と位置づけるという考え方もある（身体疾患のうつ病治療のために精神科診療へ紹介される事例あり）

4疾病5事業での可能性

- 4疾病
 - がん、脳卒中、急性心筋梗塞、糖尿病
 - 【可能性1】精神疾患を追加
- 5事業
 - 救急医療【可能性2】救急の中への位置づけ
 - 災害時における医療【可能性3】PTSD*対策
 - へき地医療、周産期医療、小児医療（小児救急医療を含む）
 - 【可能性4】精神科（救急）医療を追加
- ここでは可能性1, 2・4を検討

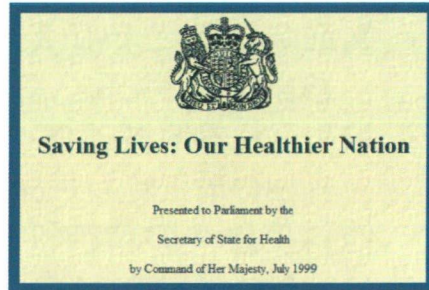
*PTSD: Post-Traumatic Stress Disorder

【可能性1】英国での先行事例

Saving Lives: Our Healthier Nation (UK, 1999-2010)

がん、冠動脈疾患・脳卒中、事故、**精神疾患**

- *Saving lives: Our Healthier Nation*: アクションプラン
- 最初の包括的な政府の計画
- 最優先領域における2010年までの達成可能なターゲット
 - **がん**
 - 75歳未満の死亡率を20%減少
 - **冠動脈疾患および脳卒中**
 - 75歳未満の死亡率を40%減少
 - **事故**
 - 死亡率を20%、重傷者を10%減少
 - **精神疾患**
 - 自殺と特定不能の傷害を20%減少



【コメント】「健康日本21」に近いが、規模の大きな事業が進められている。

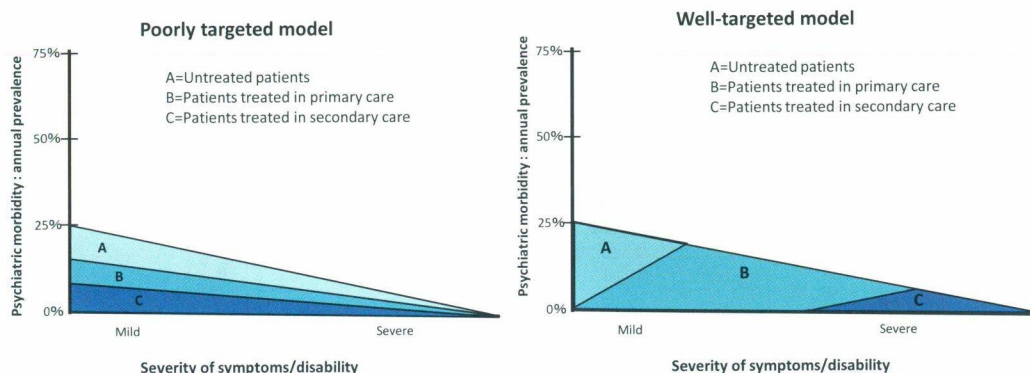
<http://www.archive.official-documents.co.uk/document/cm43/4386/4386.htm>

【可能性2・4】

救急・精神科救急：診療報酬

- 時間外加算
- 救急医療管理加算関連
 - 救命救急入院料への加算(平成20年改正)
 - 同様の方策を救命救急以外で検討
(例: 身体疾患患者の約2割は精神疾患を合併)
- 地域連携診療計画管理・退院時指導料関連
 - 精神科医連携加算(平成20年改正)
 - 精神科で「地域連携パス」の試みがある(資料参照)

参考：ターゲットの考え方



Thornicroft G & Tansella M. Better mental health care. Cambridge, 2009.

【参考：メンタルヘルス・マトリックス・モデル】

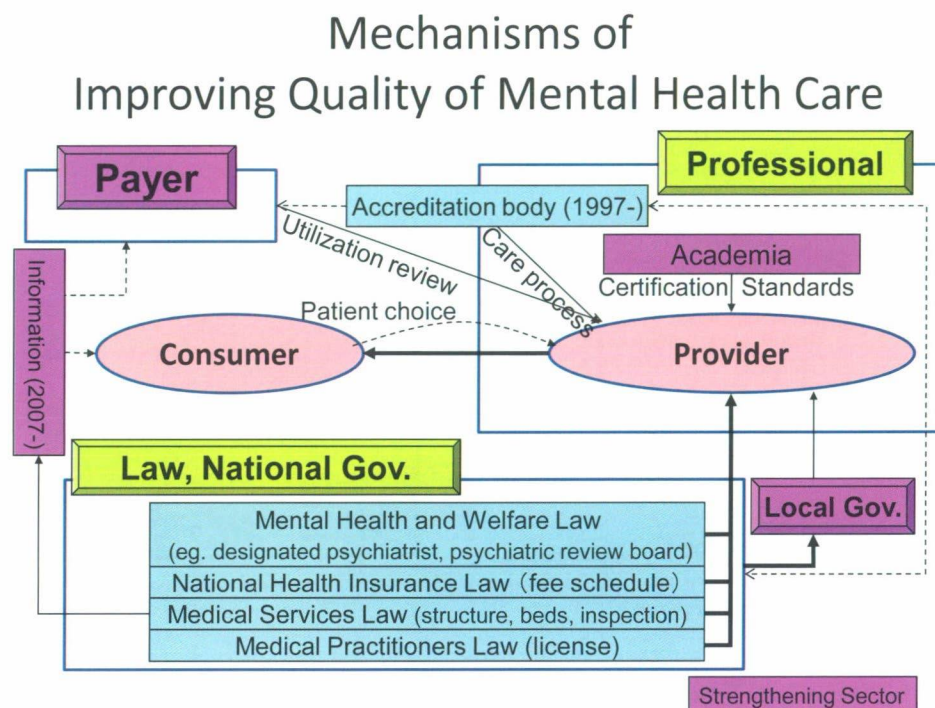
Mental Health Matrix*

Japan: Weak in (2) local level, and (3) outcome phase

	(A) Input phase	(B) Process phase	(c) Outcome phase
Definition	The resources which are put into the mental health care system	Activities which take place to deliver mental health services	Changes in functioning, in morbidity or in mortality
(1) National/Regional level	(1A) Expenditure and budget allocation, MH laws, governmental policy, staff training plan	(1B) Performance and activity indicators (eg. admission rate), clinical guidelines and treatment protocol, minimum standards of care	(1C) Suicide, homelessness, and imprisonment rates
(2) Local (Catchment area) level	(2A) balance of hospital and community services, assessment of needs	(2B) patterns of service use, audit procedures	(2C) suicide rate, outcomes aggregated at local level, physical morbidity
(3) Patient level	(3A) assessment of individual needs	(3B) subjective quality of treatments, continuity, care process	(3C) Symptom reduction, satisfaction, quality of life, disability

*Thornicroft G. & Tansella M, 1999.

【参考：医療の質を測定する仕組み】



【参考：米国における医療の質（パフォーマンス）の評価】

米国医学会

- Physician Consortium for performance improvement (PCI)
- 医療の質向上と患者安全の推進のために策定
- 42 領域で 261 の指標が策定
- Behavioral health 指標（合計 14 指標：測定期間中の割合）
 - 全大うつ病性障害のうち新たに DSM-IV の基準に該当した患者割合
 - 大うつ病性障害のうち自殺リスクを毎回評価した患者割合
 - 大うつ病性障害のうち重症度を評価した患者割合
 - 大うつ病性障害のうち適切な治療（別に定義）を受けた患者割合
 - 大うつ病性障害で抗うつ薬治療中断のある患者のうち、16 週間以上治療を継続して寛解した患者割合
 - 以下略（9 指標）

米国精神医学会（2002）

- 米国精神医学会タスクフォース
- 医療機関、保険会社、およびシステムの評価のためのフレームワークと指標例を開発

- 2002 年
- 4 領域 64 指標
- 指標の領域概要
 - アクセス（例：効果的な薬物療法と専門サービスへのアクセス）
 - 質（例：診断評価、薬物療法、心理社会的治療）
 - 治療ケアの認識（患者・家族・治療者の満足度）
 - patient, family, clinician
 - アウトカム（例：機能レベルや QOL の改善、症状の軽減安定）

米国保健福祉省の医療研究・品質局

- Agency for Healthcare Research and Quality (AHRQ)：標準医療の均てん化を担う政府機関
- 利用者・患者の観点からの医療の質の測定・報告・向上を目的に策定
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- 指標例：カウンセリングや治療がただちに必要であった場合に受けられていたか。

ナーシングホームの評価指標（メディケア・メディケイドサービスセンター）

- Centers for Medicare and Medicaid Services (CMS)
- Minimum Data Set (MDS)：メディケア受給のためにナーシングホームは測定が義務化
- 指標概要：2 領域 8 指標
 - 気分と行動パターン（Section E）：5 指標
 - 抑うつ・不安・悲嘆、気分の持続、気分の変化、行動上の症状、行動上の変化
 - 心理社会的 Well-Being (Section F)：3 指標
 - 参加の意識、人間関係、過去の役割

医師の質報告指標（メディケア・メディケイドサービスセンター）

- Centers for Medicare and Medicaid Services (CMS)
- Physician Quality Reporting Initiative (PQRI)：メディケアのドクターフィー等と連動する任意報告制度
- 指標概要：4 指標
 - 初発大うつ病患者の急性期での抗うつ薬処方（12 週間）の割合
 - 全大うつ病性障害のうち新たに DSM-IV の基準に該当した患者割合*
 - 大うつ病性障害のうち自殺リスクを毎回評価した患者割合*
 - 標準化された尺度によってうつ病・うつ状態を評価した割合

米国の第三者評価団体

- Joint Commission Performance Measurement Initiative
- 日本医療機能評価機構のカウンターパート

- National Hospital Quality Measure
- 7領域
 - アセスメント、治療計画と治療、希望とエンパワメント、患者主導ケア、患者安全、治療継続と移行、アウトカム
- 検討されている指標例
- 入院時のアセスメント、身体拘束時間、隔離時間、退院時の抗精神病薬多剤処方、正当化されている退院時の抗精神病薬多剤処方、退院後の継続ケア計画、転院・施設移行者への退院時ケア計画

全米医療の質保証委員会

- National Committee for Quality Assurance (NCNQ)
- The Health Plan Employer Data and Information Set (HEDIS) : 保険会社等のヘルスプランの評価指標
- 指標概要 : 5領域9指標
 - 抗うつ薬マネジメント : 12週間の治療継続等の3指標
 - 退院後のフォローアップ : 短期再入院率等の2指標
 - 利用度 (平均在院日数) : 1指標
 - 注意欠陥・多動性障害児のフォローアップ : 30日以内のフォローアップ等の2指標
 - アルコール・薬物依存サービス利用 : 1指標

【補足 : 米国以外での取り組み】

精神科におけるインディケータ (Australia)

1. 診断 (入院後短期間での診断確定)
2. 身体的所見
3. 処方パターン
4. 電気けいれん療法
5. 隔離の使用
6. 主要で重要なインシデント
7. 再入院
8. 死亡率
9. ケアのモニタリング
10. ケアの継続性

欧州地域保健指標プロジェクト

- European Commission
- European Community Health Indicator project (ECHI) : 現在進行中のプロジェクト
- 指標例 :

- 健康状態
 - 特定：自殺率、うつ病、不安障害、他
 - 一般：ストレス、障害、精神障害のための失業、他
- 個人・生物学的要因：社会的支援、孤立、他
- 健康システム
 - 予防・治療：予防プロジェクト、精神病床数、精神科医数、他
 - 利用度：退院数、長期在院患者数、外来患者数、向精神薬消費数、他
 - 社会・福祉サービス：精神障害者の障害年金・傷病手当
 - 医療費：精神科医療サービスの総医療費
 - 質指標：全国認定プログラムの実施

【参考：長期重症者数の推計】

後述の、平成 19 年度 厚生労働科学研究費補助金「精神医療の質的実態把握と最適化に関する総合研究」の分担研究「精神病床の利用状況に関する調査」報告書（分担研究者：松原三郎）

によると、「表 28. 日常生活能力の程度（能力障害評価）[問 19]」が、長期重症者数の実態に最も近い結果を示していると考えられる。

統合失調症患者で最重度の「能力障害 5」は対象となった全統合失調症患者の「10.7%」となっている。統合失調症の入院患者数は、「19.6 万人」（平成 17 年患者調査）であるので能力障害 5 の患者グループは、2.1 万人と推計される。能力障害 5 の患者グループはすべて入院していると仮定すると、人口 12,743 万人（平成 22 年 2 月 1 日推計）では、人口 10 万人あたり 16.5 人となる。

日米では地域精神保健の進捗に違いがあるが、Fisher らの論文によると、マサチューセッツ州が把握している 3 年以上の長期在院患者は 1990 年代後半に 330 名で、人口約 630 万人とすると、人口 10 万人あたり 5.2 人となる。

平成19年度厚生労働科学研究
精神医療の質的実態把握と最適化に関する総合研究

分担研究

「精神病床の利用状況に関する調査」

報告書

平成20年10月

分担研究者
松原 三郎

社団法人 日本精神科病院協会

回答は別紙の回答用紙にご記入ください。質問票が不足の場合は、恐れ入りますがコピーしてご利用ください。

問 18 対象者の現在の精神症状について、次のうちあてはまるものを1つ選択してください。

1. 症状がまったくないか、あるいはいくつかの軽い症状が認められるが日常生活の中ではほとんど目立たない程度である。
2. 精神症状は認められるが、安定化している。意思の伝達や現実検討も可能であり、院内の保護的環境ではリハビリ活動等に参加し、身辺も自立している。通常の対人関係は保っている。
3. 精神症状、人格水準の低下、認知症などにより意思の伝達や現実検討にいくらかの欠陥がみられるが、概ね安定しつつあるか、または固定化されている。逸脱行動は認められない。または軽度から中等度の残遺症状がある。対人関係で困難を感じることもある。
4. 精神症状、人格水準の低下、認知症などにより意思の伝達や判断に欠陥がある。行動は幻覚や妄想に相当影響されているが逸脱行動は認められない。あるいは中等度から重度の残遺症状(欠陥状態、無関心、無為、自閉など)、慢性的幻覚妄想などの精神症状が遷延している。または中等度のうつ状態、そう状態を含む。
5. 精神症状、人格水準の低下、認知症などにより意思の伝達に粗大な欠陥(ひどい誤解や無書症)がある。時に逸脱行動が見られることがある。または最低限の身辺の清潔維持が時に不可能であり、常に注意や見守りを必要とする。または重度のうつ状態、そう状態を含む。
6. 活発な精神症状、人格水準の著しい低下、重度の認知症などにより著しい逸脱行動(自殺企図、暴力行為など)が認められ、または最低限の身辺の清潔維持が持続的に不可能であり、常時厳重な注意や見守りを要する。または重大な自傷他害行為が予測され、厳重かつ持続的な注意を要する。しばしば隔離なども必要となる。

問 19 対象者の現在の日常生活能力の程度について、次のうちあてはまるものを1つ選択してください。(詳細は別紙-1「能力障害」評価表(P.14)をご参照ください)

1. 精神障害を認めるが、日常生活および社会生活は普通にできる。
2. 精神障害を認め、日常生活または社会生活に一定の制限を受ける。
3. 精神障害を認め、日常生活または社会生活に著しい制限を受けており、時に応じて援助を必要とする。
4. 精神障害を認め、日常生活または社会生活に著しい制限を受けており、常時援助を要する。
5. 精神障害を認め、身の回りのことはほとんどできない。

問 20 対象者が自身の病状についての洞察(病識)を有しているか、次のうちあてはまるものを1つ選択してください。

1. 十分にある
2. 不十分
3. ほとんどない

問 21 対象者が薬物療法の必要性を認識しているかどうか、次のうちあてはまるものを1つ選択してください。

1. 十分に認識している
2. 不十分ではあるが、嫌がらずに服薬している
3. 不十分で、服用を嫌がったり、拒否することがある
4. 処方されていない

回答は別紙の回答用紙にご記入ください。質問紙が不足の場合は、忘れ入り必ずコピーしてご利用ください。

別紙-1 (問 19 参考用)

「能力障害」評価表

精神障害者保健福祉手帳の能力障害の状態評価を利用し、判定に当たっては以下のことを考慮する。

- A) 日常生活あるいは社会生活において必要な「援助」とは助言、指導、介助などをいう。
- B) 保護的な環境（例えば入院しているような状態）でなく、例えばアパート等で単身生活を行った場合を想定して、その場合の生活能力の障害の状態を判定する。
- C) 判断は長期間の薬物治療下における状態で行うことを原則とする。

- 1 精神障害を認めるが、日常生活および社会生活は普通に出来る。
適切な食事摂取、身辺の清潔保持、金銭管理や買い物、通院や服薬、適切な対人交流、身辺の安全保持や危機対応、社会的手続きや公共施設の利用、趣味や娯楽あるいは文化的社会的活動への参加などが自発的に出来るあるいは適切に出来る。
精神障害を持たない人と同じように日常生活及び社会生活を送ることが出来る。
- 2 精神障害を認め、日常生活または社会生活に一定の制限を受ける。
1に記載のことが自発的あるいは概ね出来るが、一部援助を必要とする場合がある。
例えば、一人で外出できるが、過大なストレスがかかる状況が生じた場合に対処が困難である。
デイケアや授産施設、小規模作業所などに参加する者、あるいは保護的配慮のある事業所で、雇用契約による一般就労をしている者も含まれる。日常的な家事をこなすことは出来るが、状況や手順が変化したりすると困難が生じることがある。清潔保持は困難が少ない。対人交流は乏しくない。引きこもりがちではない。自発的な行動や、社会生活の中で発言が適切に出来ないことがある。行動のテンポはほぼ他の人に合わせる事ができる。普通のストレスでは症状の再燃や悪化が起きにくい。金銭管理は概ね出来る。社会生活の中で不適切な行動をとってしまうことは少ない。
- 3 精神障害を認め、日常生活または社会生活に著しい制限を受けており、時に応じて援助を必要とする。
1に記載のことが概ね出来るが、援助を必要とする場合が多い。
例えば、付き添われなくても自ら外出できるものの、ストレスがかかる状況が生じた場合に対処することが困難である。医療機関等に行くなどの習慣化された外出はできる。また、デイケアや授産施設、小規模作業所などに参加することができる。食事をバランスよく用意するなどの家事をこなすために、助言や援助を必要とする。清潔保持が自発的かつ適切にはできない。社会的な対人交流は乏しいが引きこもりは顕著ではない。自発的な行動に困難がある。日常生活の中で発言が適切にできないことがある。行動のテンポが他の人と隔たってしまうことがある。ストレスが大きいと症状の再燃や悪化を来しやすい。金銭管理ができない場合がある。社会生活の中でその場に合わない行動をとってしまうことがある。
- 4 精神障害を認め、日常生活または社会生活に著しい制限を受けており、常時援助を要する。
1に記載のことは常時援助がなければ出来ない。
例えば、親しい人との交流も乏しく引きこもりがちである。自発性が著しく乏しい。自発的な発言が少なく発言内容が不適切であったり不明瞭であったりする。日常生活において行動のテンポが他の人のペースと大きく隔たってしまう。些細な出来事で、病状の再燃や悪化を来しやすい。金銭管理は困難である。日常生活の中でその場に合わない行動をとってしまうがちである。
- 5 精神障害を認め、身の回りのことはほとんど出来ない。
1に記載のことは援助があってもほとんど出来ない。
例えば、入院患者においては、院内の生活に常時援助を必要とする。在宅患者においては、医療機関等への外出も自発的にできず、付き添いが必要である。家庭生活においても、適切な食事を用意したり、後片付けなどの家事や身辺の清潔保持も自発的には行えず、常時援助を必要とする。

2) 患者調査からの結果

表27. 精神症状[問18]

	自治体病院		大学附属病院		国立病院機構		公的病院		日精協		全体		(再掲)F20		(再掲)F0	
	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比
精神症状1	19	2.4%	8	7.0%	6	2.7%	6	0.0%	423	2.0%	456	2.0%	168	1.7%	59	1.7%
精神症状2	89	11.0%	25	25.2%	34	15.3%	8	0.0%	1,570	9.6%	1,722	9.7%	789	7.7%	136	3.9%
精神症状3	200	25.9%	27	23.5%	55	24.3%	19	26.5%	3,656	22.2%	3,978	22.5%	2,359	23.1%	646	15.7%
精神症状4	290	31.0%	33	28.7%	57	25.7%	15	28.8%	4,932	29.9%	5,237	29.0%	3,437	35.6%	703	20.2%
精神症状5	192	23.8%	13	11.3%	45	22.7%	13	25.0%	4,200	25.6%	4,470	25.3%	2,370	23.2%	1,226	35.3%
精神症状6	48	5.9%	5	4.3%	31	9.5%	5	9.6%	1,700	10.2%	1,779	10.1%	692	6.8%	810	23.3%
有効回答数	807	100.0%	115	100.0%	222	100.0%	52	100.0%	16,494	100.0%	17,690	100.0%	10,213	100.0%	3,478	100.0%
無効回答数	16	-	0	-	15	-	0	-	104	-	135	-	13	-	9	-
合計	823	-	115	-	237	-	52	-	16,598	-	17,825	-	10,226	-	3,487	-

表28. 日常生活能力の程度(能力障害評価)[問19]

	自治体病院		大学附属病院		国立病院機構		公的病院		日精協		全体		(再掲)F20		(再掲)F0	
	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比
能力障害1	35	4.3%	15	13.0%	15	6.3%	0	0.0%	625	3.3%	691	3.9%	288	2.8%	42	1.2%
能力障害2	146	18.1%	35	31.3%	57	16.7%	8	15.4%	2,203	13.9%	2,520	14.3%	1,354	13.6%	179	5.1%
能力障害3	277	34.3%	38	33.0%	80	36.0%	12	23.1%	3,011	19.8%	3,312	19.3%	2,057	20.5%	570	16.4%
能力障害4	251	22.3%	19	16.5%	80	27.6%	22	42.3%	5,598	34.0%	5,060	31.7%	3,859	37.8%	1,037	31.3%
能力障害5	88	10.9%	6	5.2%	30	13.5%	10	19.2%	3,080	18.6%	3,194	18.1%	1,093	10.7%	1,600	46.0%
有効回答数	807	100.0%	115	100.0%	222	100.0%	52	100.0%	16,487	100.0%	17,683	100.0%	10,213	100.0%	3,478	100.0%
無効回答数	16	-	0	-	15	-	0	-	111	-	142	-	15	-	9	-
合計	823	-	115	-	237	-	52	-	16,598	-	17,825	-	10,228	-	3,487	-

表29. 病状への洞察(病型)[問20]

	自治体病院		大学附属病院		国立病院機構		公的病院		日精協		全体		(再掲)F20		(再掲)F0	
	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比
十分にある	99	12.3%	36	30.4%	32	14.3%	6	11.5%	1,182	7.2%	1,357	7.7%	453	4.4%	84	2.4%
不十分	353	43.9%	36	31.3%	100	44.5%	25	48.1%	6,044	40.4%	7,177	40.7%	4,516	44.4%	816	23.6%
ほとんどない	353	43.9%	25	21.7%	91	40.5%	21	40.4%	8,622	52.4%	9,112	51.6%	5,213	51.2%	2,567	74.0%
有効回答数	805	100.0%	115	100.0%	223	100.0%	52	100.0%	16,461	100.0%	17,646	100.0%	10,182	100.0%	3,467	100.0%
無効回答数	18	-	0	-	14	-	0	-	147	-	179	-	41	-	20	-
合計	823	-	115	-	237	-	52	-	16,608	-	17,825	-	10,223	-	3,487	-

表30. 薬物療法の必要性の認識[問21]

	自治体病院		大学附属病院		国立病院機構		公的病院		日精協		全体		(再掲)F20		(再掲)F0	
	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比	人数	構成比
十分に認識している	126	15.7%	49	39.0%	48	21.0%	7	13.0%	1,780	10.7%	1,882	11.3%	792	7.8%	146	4.2%
不十分で放棄	547	68.1%	51	53.5%	138	61.0%	38	73.1%	12,238	74.8%	13,082	73.9%	7,910	76.8%	2,665	77.1%
不十分で放棄しない	118	14.7%	6	5.3%	27	12.1%	8	11.5%	2,203	13.4%	2,380	13.4%	1,542	15.2%	464	13.4%
知らない	12	1.5%	2	1.8%	10	4.5%	1	1.9%	239	1.4%	250	1.4%	25	0.2%	182	5.2%
有効回答数	823	100.0%	114	100.0%	223	100.0%	52	100.0%	16,422	100.0%	17,814	100.0%	10,199	100.0%	3,457	100.0%
無効回答数	39	-	1	-	14	-	0	-	176	-	211	-	51	-	30	-
合計	862	-	115	-	237	-	52	-	16,598	-	18,025	-	10,250	-	3,487	-

Long-Stay Patients in State Psychiatric Hospitals at the End of the 20th Century

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Objectives: The purpose of this study was to assess the characteristics of long-stay patients in contemporary state psychiatric hospitals and to identify factors representing possible barriers to alternative placements for these patients. **Methods:** All patients in inpatient units of the Massachusetts Department of Mental Health who had been hospitalized for at least three years as of April 1, 1999, were assessed by their treatment teams with a standardized data collection instrument. Domains assessed included medical problems, need for nursing care, psychiatric diagnosis, and history of problematic behaviors. **Results:** The 330 individuals identified as long-stay patients had an array of medical problems and nursing care needs that likely would have been manageable in other long-term-care settings. A total of 276 patients had at least one significant medical problem. However, some patients exhibited behavioral problems that might have complicated such placements, especially when behavioral problems co-occurred with the need for medical supervision. A total of 228 patients had exhibited a significant problematic behavior in the previous 30 days. **Conclusions:** Although the number of long-stay patients in state psychiatric hospitals declined dramatically during the second half of the 20th century, a small group of patients still requires care in this setting. State psychiatric hospitals continue to occupy a significant niche in the mental health system. (*Psychiatric Services* 52:1051-1056, 2001)

At the end of the 20th century, mental health policy makers focused much of their attention on reducing the use and duration of inpatient psychiatric treatment. In many locales privatization, coupled with restrictions on hospitalization that had been brought about by managed care, significantly reduced the number and duration of inpatient

episodes. However, against this backdrop of change there remains a group of individuals who have severe mental illness and who require prolonged care and treatment in public psychiatric hospitals. These individuals pose a challenge to efforts undertaken in the past decade by many state mental health agencies to further reduce the number of beds in state hospitals.

This article describes the contemporary population of long-stay patients in state psychiatric hospitals in Massachusetts. We studied individuals who had been hospitalized for at least three years as of April 1, 1999—six years after the culmination of a significant effort to close state hospitals (1-3). We examined the needs and characteristics of these patients in several domains, considered the barriers to discharge and alternative placement, and evaluated the implications of these data for the long-term-care function of the mental health system and the role of state hospitals in fulfilling that function.

Background

The long-term care and treatment of persons who have severe mental illness became a core function of public psychiatric hospitals in the 19th century. By the mid-20th century the census of psychiatric patients in America's state hospitals on any given day exceeded half a million. The process that is popularly called deinstitutionalization, which began shortly thereafter and continued for the rest of the century, significantly reduced the state hospital population. Thus by the mid-1990s just over 72,000 patients resided in these facilities, which translates to a reduction of nearly 90 percent (4,5). Several factors contributed to this decline, including the availability of new pharmacologic treatments for mental illness and the reform of legal mechanisms for involuntary admission and retention in state hospitals. Of partic-

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ular importance to long-stay populations was the expanded availability of long-term-care settings—such as nursing homes—and the development of community-based residential programs for persons with mental illness, which enabled individuals who did not require acute treatment to be placed in noninstitutional settings (6–10).

Deinstitutionalization has been characterized as entailing two separate but related processes: the transfer of individuals from the hospital to the community and the transfer of the state psychiatric hospital's functions to alternative community-based settings (11). Viewed from this perspective, the long-term-care function and populations of state hospitals can be said to have "co-evolved" with other elements of the larger long-term-care system. For example, descriptions of the state psychiatric hospital population in the first half of the 20th century, before the advent of community-based care, suggest that there was a subpopulation of state hospital patients who had little, if any, clinical need for treatment in a psychiatric facility but who remained hospitalized because they required some nursing or custodial services and lacked the social or economic resources to obtain these services elsewhere (12–14).

The expansion of the nursing home industry and federal reimbursement for nursing home care, the development of community-based residential programs for persons with mental illness, and other programmatic innovations have provided alternative settings in which many of these individuals could be placed instead of being admitted to a state hospital (8). The availability of these alternative settings, particularly when coupled with appropriate supportive care, greatly facilitated the reduction of long-stay populations in state hospitals. Indeed, in an intensive court-ordered deinstitutionalization effort in western Massachusetts, the subpopulation of long-stay patients in psychiatric state hospitals was the easiest group to permanently deinstitutionalize (15,16).

During the second half of the 20th century, deinstitutionalization greatly reduced the size of the nation's state hospital population. However, the

pace at which this reduction proceeded diminished in the 1970s and 1980s. During that period the long-stay population, although it underwent considerable attrition, nevertheless continued to maintain a presence in state psychiatric hospitals. This population consisted of two groups: a dwindling number of "old long-stay" patients who were hospitalized before deinstitutionalization began and who remained despite it, and a cadre of "new long-stay" patients who began prolonged hospitalizations during the period despite efforts to prevent them (11). The 1990s witnessed re-

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■

newed efforts by many states to further downsize or to close many of their remaining state psychiatric hospitals (2,3) and to shift the locus of acute inpatient treatment to local general hospitals (17,18).

In Massachusetts, as elsewhere, these privatization efforts were accompanied by expansions in the availability of various kinds of community-based residential programs. However, as with similar efforts that had been attempted earlier, these interventions further reduced—but still did not eliminate—the long-stay population. The patients who remained were

those whose behavioral tendencies and other characteristics made them the most difficult to place in the existing array of community settings (19).

Methods

The setting for this study was the system of inpatient facilities maintained by the Massachusetts Department of Mental Health. The long-stay psychiatric patients who were the focus of the study are individuals who, according to the department, were receiving continuing treatment. Since July 1996 these services have constituted the mental health department's primary responsibility for providing inpatient services, given that the acute inpatient system has been mostly privatized. Patients who are served in the continuing-treatment system are those who were admitted for acute treatment to a Department of Mental Health facility before July 1996 without being discharged or were transferred for extended treatment from the acute psychiatric unit of a general hospital or private psychiatric specialty hospital after that date.

The medical directors of all eight Department of Mental Health inpatient facilities were asked to identify patients who were hospitalized as of April 1, 1999, and who met the preceding criteria. Because the study focused on the long-stay patient population, and because we determined that there was significant turnover in that population during the first three years of continuing treatment, only patients who had a length of stay of three years or more were included in the study. Patients who met these criteria were assessed in a variety of domains by the treatment team responsible for their care—arguably the group of individuals who were best qualified to make such assessments.

A structured data collection protocol was used systemwide. This protocol incorporated elements of several instruments with established validity and reliability that were designed for the assessment of persons with severe mental illness, including the New York Level of Care Survey (20), the Nurses Observation Scale for Inpatient Evaluation (21), and the Current Evaluation of Risk and Functioning-Revised (22). In addition, data on

Table 1
Demographic and diagnostic characteristics of 330 long-stay psychiatric patients in Massachusetts state hospitals¹

Characteristic	N	%
Sex		
Male	228	69
Female	102	31
Race		
Caucasian	285	88
African American	16	5
Hispanic	10	3
Other	14	4
Educational attainment		
Less than high school	125	41
High school or equivalent	116	38
Beyond high school	66	22
Primary diagnosis²		
Schizophrenia or other psychotic disorder	255	76
Mood disorder	34	10
Psychiatric disorder due to medical condition	23	7
Other disorder	17	5
Borderline intellectual functioning or mild mental retardation	26	8
Personality disorder		
Any	58	18
Antisocial	11	3
Borderline	15	5
Not otherwise specified	25	8
Other	7	2
Other axis II disorder	5	2
No axis II disorder	241	73
Additional co-occurring diagnosis		
Substance use disorder	99	30
Dementia	14	4

¹ Individuals for whom data were missing for a given variable were excluded from calculations of percentages.

² Some individuals were included in more than one diagnostic category.

patient history were systematically collected from patient records.

In addition to patients' demographic and diagnostic information, data were gathered on length of stay, medical conditions, current (previous 30 days) and lifetime problematic behavioral tendencies that co-occurred with their psychiatric symptoms, and current and lifetime psychosocial histories. The treatment teams provided their opinions about the supports and services that would be required by each patient if he or she were discharged. They also gave their assessments of each patient's readiness for discharge at the time of the assessment and, for patients who were assessed as not being ready, a

likely timetable for discharge. The instrument allowed multiple categories in all domains to be selected for each patient.

Results

Patient characteristics

A total of 330 patients met the inclusion criteria and were included in the study. The mean±SD age of the patients was 48.8±12 years, with a range of 21 to 93 years. They were predominantly between the ages of 31 and 60, although a substantial number of patients were 61 or older. The demographic and diagnostic characteristics of these patients are summarized in Table 1. These data show that the long-stay population in Massachusetts state psychiatric hospitals is disproportionately male and disproportionately Caucasian. Schizophrenia or another psychotic disorder was the primary diagnosis for about three-quarters of the patients assessed.

Although patients with mood disorders (depressive and bipolar disorders) were identified by the treatment teams and are commonly observed in state hospital populations and in acute treatment settings, these disorders accounted for only about 10 percent of diagnoses in the long-stay population. A diagnosis of co-occurring substance abuse was noted for about 30 percent of the patients. This proportion is lower than that observed in many populations of persons who have severe mental illness and may reflect the difficulty in identifying such a diagnosis among patients who have been hospitalized for extended periods and thus have been prevented from abusing substances.

Length of stay

Some individuals in our sample were "old long-stay" patients—that is, they had already experienced a long hospitalization at the start of the deinstitutionalization process. The median length of stay was just over seven years, but a substantial number of patients had been hospitalized for more than ten years at the time of assessment, including some patients with stays ranging from 20 to 30 years. One individual, among the state's last remaining old long-stay patients, had been hospitalized for 52 years (data not shown).

Table 2

Prevalence of selected medical problems among 330 long-stay psychiatric patients in Massachusetts state hospitals¹

Medical condition	N	%
Any disorder	276	84
Obesity	102	31
Chronic obstructive pulmonary disease or other serious respiratory problem	79	24
Dental problem	76	23
Hypertension	57	17
Gastrointestinal disorder	57	17
Arteriosclerotic heart disease or other circulatory disorder	56	17
Diabetes	45	14
Thyroid disease	41	12
Swallowing disorder	40	12
Seizure disorder	39	12
Tardive dyskinesia	38	12
Serious or other organic brain disorder	23	7
Urogenital disorder	21	6
Blindness or other visual disorder	20	6
Speech disorder	19	6
Deafness or hearing impairment	10	3
Hepatitis	11	3
Cancer of a major organ or system	9	3
Infectious disease other than hepatitis	5	2
Huntington's disease	2	1
Parkinson's disease	2	1
Other disorder	126	38

¹ Some individuals were included in more than one category.

Medical conditions

The treatment teams noted a substantial number of medical conditions among the assessed patients, including serious illnesses such as heart disease and cancer. The frequencies of various medical conditions are listed in Table 2. The most commonly observed medical condition was obesity, noted for about 30 percent of the patients. Respiratory disorders were also common; nearly a quarter of the patients were diagnosed as having chronic obstructive pulmonary disease or another serious respiratory problem. A substantial number of patients had more than one diagnosis; the mode was two, and one individual had ten diagnoses. Only 16 percent of the patients had no physical problems at the time of assessment.

Table 3
Current and past problematic behaviors among 330 long-stay psychiatric patients in Massachusetts state hospitals

Behavior	Previous 30 days		Lifetime	
	N	%	N	%
Unable to care for self	217	66	272	83
Dangerous to themselves or others	92	28	244	74
Had abnormal water intake	52	16	64	19
Committed physical assault	50	15	251	79
Refused medications	47	14	172	52
Had violent episodes	45	14	209	63
Talked about suicide	27	8	159	48
Talked about homicide	25	8	146	44
Injured self	18	5	142	43
Committed assault with a weapon	13	4	84	25
Destroyed property	11	3	154	47
Required suicide precautions	10	3	120	36
Committed sexual assault	8	2	59	18
Abused alcohol	5	2	174	53
Abused drugs	4	1	71	22
Attempted murder	4	1	149	45
Set a fire	3	1	64	19
Attempted suicide	3	1	134	41
Used a weapon against property	2	1	41	12
Attempted child molestation	0	—	25	8
Had no problematic behaviors	8	2	70	21

Problematic behaviors

The array of problematic behaviors observed in the 30 days before assessment—that is, while the patients were hospitalized—and problematic behaviors that patients were known to have displayed over the course of their lives, both in the hospital and in the community, are summarized in Table 3. These behaviors included the broad category of problems that led to their present hospitalization, such as poor self-care or dangerousness to self or others, as well as more specific behavioral tendencies that had caused difficulties in the hospital or in other environments. This latter category included characteristics that posed problems for hospital staff, such as assaultiveness; behaviors requiring close monitoring, such as abnormal water intake; and other behaviors that might represent threats to public safety, such as a propensity to engage in offensive or illegal sexual behaviors.

Behavioral problems and patients' needs

An important consideration in assessing the possibility of transferring long-stay patients from the state hospital to alternative settings is the need to bal-

ance "nursing home-like" functions with behavioral management. The scope of this problem is evident in the overlap of behavioral and medical problems observed in the 30 days before assessment. A total of 217 patients (66 percent) exhibited what staff described as poor self-care even while supervised, and 92 patients (28 percent) were considered to be a danger to themselves or others. Seventy-six patients (23 percent) were in both of these categories.

A similar analysis of lifetime behaviors provided an indication of the potential for placement outside an institutional setting. A total of 272 patients (83 percent) had a history of self-care that was sufficiently poor to raise staff concerns, and 244 (74 percent) were rated as having a history of being dangerous to others; 211 patients (64 percent) exhibited both of these behaviors.

Readiness for discharge

The treatment teams were asked to identify the kinds of settings to which each patient could be discharged, if any. Forty-six patients (14 percent) were deemed to be ready for discharge at the time of assessment, and an additional 36 patients (11 percent) were considered likely to be dis-

charged within six months. Settings that were deemed appropriate included nursing homes, community residential programs with various levels of staffing, and other miscellaneous settings.

Six months after the assessment, the Department of Mental Health client tracking system was queried for the number of patients who had been identified as being ready for discharge and who had actually been discharged. At six months only 19 patients (6 percent) had left the hospital. These 19 accounted for 23 percent of the individuals who had been rated by staff as being ready for discharge at the time of assessment or within the six-month time frame. Note that the assessments of readiness for discharge were based on the judgments of the patients' treatment teams. Clearly the members of these teams knew the patients best; however, the reliability and validity of the assessment process and the consistency of the process across sites or even across teams within sites has not been established. Moreover, such assessments clearly cannot account for changes in patients' clinical status or the availability of community placements over a six-month period.

Discussion

The data presented here describe a group of individuals who had experienced long stays in state psychiatric hospitals—stays that spanned decades in some cases—in an era when such hospitalizations are becoming less and less common. These data, along with observations by members of the treatment team, suggest that for many patients the factors that prevent or delay discharge are not confined to psychiatric symptoms. Indeed, for many individuals it is not their psychiatric illness alone but a combination of behavioral tendencies and clinical factors that necessitates continued hospitalization.

Several patients had medical conditions that might have restricted the range of alternative settings in which they could have been placed. For example, patients who have diabetes or hypertension may require an enhanced level of supervision to ensure that they follow an appropriate med-

ication and dietary regimen. Patients who have impaired vision or hearing or who suffer from arthritis may be restricted in the kinds of physical settings in which they can be placed and may require some assistance in activities of daily living. Likewise, individuals who have difficulty swallowing, who have gastrointestinal disorders, or who are obese may need close dietary supervision. Clearly all of these services could be provided in nursing homes or comparable settings. However, as we have indicated, a co-occurring set of undesirable behavioral tendencies may make such placement difficult for some of these individuals. Thus these patients remain hospitalized.

Another group of patients had behavioral histories that suggested that their placement in a setting with less supervision might trigger a chain of events with undesirable consequences. For example, individuals who have exhibited severe substance abuse or medication noncompliance in previous episodes of community living may repeatedly engage in assaultive or other dangerous behaviors, even if supervised. Although such patients may appear to be clinically stable and to function reasonably well in the supervised environment of state hospitals, members of the treatment team must be cognizant of the course of events that might unfold after discharge and weigh the possible risks to patients and others when assessing readiness for discharge.

Our data also suggest that, in serving the continuing-treatment population, state hospitals are performing an important social function. As we have observed, a number of the patients had histories of dangerous behaviors, including sexual assaultiveness and child molestation. Some of these patients began their state hospital stays as forensic patients, having been referred by the courts to restore their competence to stand trial or having been committed civilly in lieu of criminal sanctions. Thus the criminal justice system, family members, or the community may oppose the release of some individuals to community settings.

Finally, our sample included a sub-

group of individuals whose hospital stays had been so long that the appropriateness of transferring them to an alternative setting may have been questionable. For example, it is unclear whether persons who have resided in a state hospital for two decades or more would benefit significantly from a change in residence at that point in their lives. Clearly the preferences of the individuals themselves must be weighed carefully in any decision about their transfer.



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adjustment."



Conclusions

In President John F. Kennedy's February 1963 message to Congress about mental health and mental retardation, he argued that "if we apply our medical knowledge and social insights fully, all but a small portion of the mentally ill can eventually achieve wholesome and constructive social adjustment" (23). The president was essentially correct in that belief: In the 37 years since he issued his mandate that a "bold new approach" be taken in the treatment of mental ill-

ness, many persons who once might have undergone long-term hospitalization have been spared that experience, thanks to innovations in pharmacologic, psychosocial, and other treatments. The data we have presented also confirm President Kennedy's belief that some individuals need to be hospitalized for extended periods.

At the end of the 20th century the long-advocated replacement of the state hospital by alternative settings and services has in many locales been nearly—if not fully—accomplished. In Massachusetts and in many other states the privatization of acute inpatient treatment and the expansion of community-based services have shifted many of the original functions of state hospitals to other settings. Mental health advocates and policy makers will continue to seek resources to further expand the community-based system and to further reduce reliance on state hospitals.

But therein lies a dilemma. Many of the patients identified in this study may be ready for discharge but may await the availability of services that will enable them to leave the hospital. For some of the patients who were assessed as not being ready for discharge and not likely to be ready in the foreseeable future, the reason may have been that the constellation of community services required to meet their needs in the community either does not exist or would be too costly to create.

In the case of one state hospital, almost the entire patient population, including patients who had been hospitalized for decades, was discharged over a period of about ten years. This outcome required that substantial resources be allocated to planning and creating a range of community placements appropriate to each patient's needs (14, 15). However, our data suggest that even if such resources were universally available, obstacles to discharge might nevertheless remain for some patients. The community's resistance to the discharge of individuals who have problematic behavioral histories is likely to persist, regardless of the resources available.

These factors, coupled with the pervasive stigma surrounding mental

illness (24), virtually ensure the perpetuation of at least a small long-stay population of psychiatric patients in state hospitals for the foreseeable future. That said, the "small portion" of individuals to whom President Kennedy alluded deserve the best possible care and an optimal environment in which to reside. In meeting the needs of these patients, state hospitals and their long-term-care function continue to occupy a unique and important niche in the system of care for persons who have severe mental illness. ♦

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- ♦ Evidence-based practices in child and adolescent mental health services
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精神科医療の目指すべき方向 および訪問看護・ケアマネジメントの 事業における位置づけ

萱間 真美

作業の前提

- 事業における基本方針「目指すべき方向」を検討会報告書、前回会議資料を基に作成した。
- 訪問看護は生活の場である地域で担う医療（未治療、治療中断を含む）の中で訪問看護およびケアマネジメントの機能（地域移行支援と継続的なケア）として位置づけ、医療機関に求められる機能の中で具体的記述を行った。

目指すべき方向(精神科医療の柱立て)

千葉県

- ・こころの健康づくりの推進
- ・精神医療対策の推進
- ・精神科救急医療の強化充実
- ・長期入院者地域移行の促進

目指すべき方向(精神科医療の柱立て)

東京都

- ・長期入院患者
- ・メンタルヘルス
- ・身体合併症医療
- ・認知症
- ・薬物関連問題
- ・小児精神科医療
- ・発達障害支援
- ・高次脳機能障害者支援

目指すべき方向(精神科医療の柱立て)

本試案

- **生活の場である地域で担う医療
(未治療、治療中断を含む)**
- 精神科救急医療の強化充実
- 身体合併症の予防と治療
- 認知症、発達障害、児童思春期、依存症

訪問看護およびケアマネジメントの機能 (地域移行支援と継続的なケア)

- 退院後の精神障害者の継続的受療等を支援すること
- 地域移行支援が必要な精神障害者とその家族に対し、適切な支援を提供すること
- 福祉サービス等について情報を提供すること
- 精神症状の急性増悪時に適切な医療を提供できること
- 身体合併症の予防および治療のための適切な援助を提供できること