and therefore would have less chance of seeing a young child may have influenced this result. Over a quarter of the senior respondents estimated the prevalence of ASD as about 0.01% or less, which would be consistent with the first report on a prevalence of autism of 0.04% in the mid 1960s [13]. However, a much higher prevalence of 1.16% for all ASD was reported recently [4]. Although the vignette demonstrating moderate to severe autistic symptoms might have led seniors to give the lower estimation, the same recent study reported a prevalence of childhood autism of 0.39% [4]. If the correct prevalence estimation in the present study is temporarily defined as about 0.1% for childhood autism and about 1% for all ASD, we cannot but conclude that the some seniors had misconceptions of ASD. Such misconceptions may lead seniors to deny that their descendants can be autistic, and such optimism might cause a delay in intervention. Providing new information for seniors is necessary to update their "common sense" beliefs, and will also aid younger parents who often have insufficient knowledge of childrearing and depend on the advice and support of seniors.

The results of this study should be interpreted with caution. First, the results might differ if the respondents had been directly asked about their knowledge and beliefs of "autism" instead of using a vignette. However, since other diagnostic terms are also used in Japan, a detailed case description based on international diagnostic criteria seems to be an appropriate method for sharing a specific clinical picture. Second, although the sample size of this study was larger than that of a similar previous study in England [7], a more detailed study based on a larger number of respondents is needed to confirm the present findings. Third, we did not ask for some demographic background data from the respondents. In particular, whether the respondent had a child may be important to consider when interpreting the results. Comprehensive regression analysis using such variables is necessary to clarify which factors influence public knowledge and beliefs of ASD. Fourth, mental health literacy for ASD without mental retardation (i.e., high-functioning ASD) should be studied in future.

Conclusion

Based on a nationwide survey, we clarified the public mental health literacy of ASD in Japan by sex and generation. Females showed more accurate knowledge in certain areas, possibly reflecting gender roles in society. Some young people are not likely to know of the impact of psychiatric treatment, and seniors appear to be unaware of the current broadened recognition of ASD. Continued efforts are required to disseminate accurate information in order to change inaccurate and outdated public perceptions, particularly among males. A confirmation study of larger scale and/or with different methodology is needed to accumulate knowledge about public mental health literacy of ASD in Japan and globally.

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Appendix 1

Vignette of autism spectrum disorders (ASD)

Person A is 33 years old. Person A's child is now 3 years old, but does not speak much. Also, the child does not communicate by pointing, body gestures, or facial expressions. For example, if the child wants to open a door, the child will grab an adult's hand to open the door.

The child is going to preschool, but does not seem interested in the teachers or other children. The child always plays alone with toy trains. When the preschool teacher tries to play with the child, the child tries to move away from the teacher.

Every morning the child steps on a manhole cover in front of the house before going to preschool. One morning a car was parked on the manhole, and the child could not step on the manhole cover. The child began to cry hysterically and refused to go to preschool.

Person A is very worried about the child's behaviors.

精神科デイ・ケア等実施施設の機能分化の状況

長沼洋一，立森久照，竹島　正

abstract

Psychiatric nurses' perceptions of mentally disordered offenders: an analysis using model cases

Junko Miyagi [1, 2], Nobuaki Morita [1], Yoji Nakatani [1]

Aims: We investigated psychiatric nurses' perceptions of mentally disordered offenders with a survey using model cases.

Subjects and Methods: We sent survey questionnaires to 954 randomly selected members of the Japanese Psychiatric Nurses Association. In addition to questions concerning respondents' experience of nursing mentally disordered offenders, we provided 6 different model cases with different diagnoses and offences, and asked respondents to answer questions pertaining to how they might perceive, and provide nursing care to, each case. The survey was conducted between May and September 2006, with a response rate of 48.0%.

Results : Perceptions correlated with the diagnosis and nature of the offence, with a tendency to interact sympathetically with cases of schizophrenia (assault, indecent assault) and depression (attempted infanticide). Less sympathy was shown for cases of substance abuse disorder (arson, home invasion) and personality disorder (rape). The greater the respondents' knowledge and training with the Medical Treatment and Supervision Act, and experience in nursing mentally disordered offenders, the less likely they were to envisage difficulty in dealing with the model cases.

Conclusions: Psychiatric nurses' perceptions of mentally disordered offenders correlated with the diagnosis and nature of the offence, suggesting the need for revision of nursing guidelines according to the nature of each case. Perceptions of each case also correlated with actual experience of nursing mentally disordered offenders and knowledge of the legal system, indicating a need for increased educational opportunities in the field of forensic psychiatric nursing.

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■原著論文

精神科デイ・ケア等実施施設の機能分化の状況

長沼洋一，立森久照，竹島　正

抄録：

目的：多様化しつつある精神科デイ・ケア等実施施設について，どのように機能分化がみられるか検討した。

方法：精神科デイ・ケア等を実施する精神科病院961カ所を対象とし，精神科デイ・ケア等の利用者の年齢階級別，疾患別の割合からクラスタ分析等により各精神科病院を分類した。

結果：7つの群に分類できた。①精神作用物質による精神障害の利用者が比較的多い群，②統合失調症および気分障害の診断の利用者が比較的多い群，③20歳未満の若年層を対象とする群，④器質性精神障害や，75歳以上の利用者が比較的多い群，⑤40歳から65歳の利用者が多く，また利用者の過半数が統合失調症である群，⑥20歳から40歳の利用者が多く，また利用者の半数近くが総合失調症である群，⑦統合失調症の利用者が大半を占める群に分けられた。

結論：各精神科病院において精神科デイ・ケア等が一定の機能分化をしていることを示している。

緒　言

平成16年9月に厚生労働省精神保健福祉対策本部より提示された「精神保健医療福祉の改革ビジョン」[8]では，精神医療施策の基本的な方向として，精神病床に係る基準病床数の算定式の見直しと，精神病床の機能分化と地域医療体制の整備

などが挙げられた。地域医療体制の整備の中では，「多様な利用形態にある精神科デイ・ケアの機能を，患者の症状やニーズに応じて機能の強化・分化を図る」とされた。

医療デイ（ナイト）ケアや訪問看護は，入院患者が地域復帰するにあたり，中間的な支援を提供するサービスと位置づけられてきた。精神科デイ・ケアの効果に関しては，欧米を中心にRCTデザインでの研究がなされているほか，日本でも前後デザインの研究や対照群との比較研究が報告されている。それらの結果，陰性症状や社会機能の改善において精神科デイ・ケアが通常の外来治療よりも高い効果を示すことや，精神科デイ・ケア利用者では短期的に再入院率の低下を示すことが，総説[2,7,13]されている。精神保健医療福祉の地域化を進めつつある現在，精神科デイ・ケア，ナイト・

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ケア，デイ・ナイト・ケア（以下，デイ・ケア等とする）の設置数は着実に増加を続けてきた。デイ・ケア等利用者の7割以上は統合失調症近縁の障害であるが，近年精神科診療所や精神保健福祉センターのデイ・ケア等では多彩な疾患の患者の利用が増加してきた。設置主体や利用者に合わせ，デイ・ケア等の多様な展開もみられる[12]。例えば，安西[1]は従来デイ・ケア等で対象とされてきた統合失調症患者については長期在院患者の退院後の医療継続と地域生活を支えるためのデイ・ケア等の役割が期待されているとした。加えて入院期間の短縮化の中で不安定さが残る退院患者のその後の治療を担当する医療型デイホスピタルのニーズが高まることが予想されると述べている。また，デイ・ケア等における対象の広がりを示すものとして，うつ病や不安障害患者を対象としたもの[6]，アルコール依存症[4,9]や薬物依存症[3]を対象としたもの，認知症を対象としたもの[11]，思春期の者を対象としたもの[5,10]が報告されている。

しかし多様化しつつあるデイ・ケア等についてわが国全体としての利用者の実態や機能分化の状況についてはほとんど報告されていない。そこで本研究では，厚生労働省 社会・援護局 障害保健福祉部精神・障害保健課によって，平成17年度6月30日付で実施された調査結果から，精神科病院の精神科デイ・ケア等の利用者の状況を分析し，各精神科病院において，どのような精神科デイ・ケア等が実施されており，機能分化がみられるか，疾患別・年齢別の観点から検討することを目的とした。

研究対象および研究方法

厚生労働省社会・援護局障害保健福祉部精神・障害保健課（平成18年からは障害福祉課との連名）では，毎年6月30日付で，都道府県・指定都市に精神科病院および精神科診療所の精神科デイ・ケア等の状況に関する情報などについて調査を依頼している（以下630調査とする）。また厚生労働科学研究費補助金（こころの健康科学研究事業）「精神保健医療福祉の改革ビジョンの成果に関する研

究」研究班によって，調査票の作成，調査結果の解析および研究成果の有効活用などの研究が行われている。本研究では，この調査の平成17年度630調査結果を用い二次的に分析した。

1）対象

630調査では，各精神科病院に対し，デイ・ケア等の状況として，平成17年6月1カ月間の精神科デイ・ケア，精神科ナイト・ケアおよび精神科デイ・ナイト・ケアの実施日数を尋ねている。本研究では，これらいずれかの実施日数が1日以上かつ平成17年6月30日または直前のサービス実施日の利用者数が0でない精神科病院961カ所を対象とした。

2）分析方法

630調査では，各精神科病院のデイ・ケア等について平成17年6月30日または直前のサービス実施日の利用者数を年齢階級別（20歳未満，20歳以上40歳未満，40歳以上65歳未満，65歳以上75歳未満および75歳以上）および国際疾病分類第10版（ICD-10）による疾患別に尋ねている。これらの数から各精神科病院のデイ・ケア等の利用者の疾患別の割合，年齢階級別の割合をそれぞれ算出した。次いで疾患別の割合において大多数を占める，「精神分裂病，分裂病型障害および妄想性障害（以下F2とする）」の割合の度数分布に基づいて第1四分位値である68.75％以下の群と68.75％より大きい群の2群に病院を群別した。さらに，F2の割合が68.75％以下の病院については，全利用者における疾患別の割合（F2の割合は除く）および年齢階級別（20歳未満，20歳以上40歳未満，40歳以上65歳未満，65歳以上75歳未満および75歳以上）の割合を用い，Ward法によるクラスタ分析を行った。

3）倫理面への配慮

本研究は，630調査の病院単位のデータを二次的に利用し，デイ・ケア施設等の利用者数等を集計，分析したものであり，個人を特定可能な情報は含まれていない。

表 1　対象病院の精神科デイ・ケア等の概要

	平均値	標準偏差
デイ・ケア（n ＝ 948）		
月間平均実施日数	21.4	3.7
月間延利用回数	510.7	434.1
利用実人員	49.2	42.2
ナイト・ケア（n ＝ 92）		
月間平均実施日数	18.5	6.4
月間延利用回数	136.8	133.2
利用実人員	15.4	14.6
デイ・ナイト・ケア（n ＝ 222）		
月間平均実施日数	20.1	5.9
月間延利用回数	492.1	469.4
利用実人員	33.6	26.9

結　果

　対象とした 961 病院のデイ・ケア等の実施状況について表 1 に示す。精神科デイ・ケアを実施していたのは 948 カ所，精神科ナイト・ケアを実施していたのは 92 カ所，精神科デイ・ナイト・ケアを実施していたのは 222 カ所であった。それぞれの平成 17 年 6 月 1 カ月間における平均実施日数は，それぞれ 21.4 日，18.5 日および 20.1 日であった。

　利用者の疾患が F2 である者の割合が 68.75％以下のデイ・ケア等について，全利用者における疾患別の割合（F2 の割合は除く）および年齢階級別（20 歳未満，65 歳以上 75 歳未満および 75 歳以上）の割合を用い，クラスタ分析を行った結果，デイ・ケア等を 6 群に分類した。これら 6 群およびクラスタ分析から除外した F2 の割合が 68.75％以上のデイ・ケア等の計 7 群について，各群のデイ・ケア等の利用者の疾患別の割合および年齢階級別の割合を表 2 に示す。

　グループ 1 は，18 カ所のデイ・ケア等が分類された。このグループ 1 は，疾患別では精神作用物質による精神および行動の障害（F1）の利用者の割合が平均 58.2％と過半数に達しており，年齢別では 40 歳以上 65 歳未満が平均 78.4％と大半を占

表 2　7 群に分類した精神科デイ・ケア等における，利用者の疾患別，年齢階級別，性別割合

		グループ1 n=18 平均値	標準偏差	最小値	最大値	グループ2 n=88 平均値	標準偏差	最小値	最大値	グループ3 n=8 平均値	標準偏差	最小値	最大値	グループ4 n=7 平均値	標準偏差	最小値	最大値	グループ5 n=90 平均値	標準偏差	最小値	最大値	グループ6 n=33 平均値	標準偏差	最小値	最大値	グループ7 n=722 平均値	標準偏差	最小値	最大値	合計 n=961 平均値	標準偏差	最小値	最大値
デイ・ケア等利用者疾患別（ICD-10）割合（%）	F0	0.3	1.2	0.0	5.0	3.0	5.9	0.0	28.6	0.0	0.0	0.0	0.0	58.3	19.9	40.0	100.0	3.1	4.7	0.0	20.0	5.6	9.6	0.0	30.0	1.1	2.5	0.0	25.0	2.0	6.3	0.0	100.0
	F1	58.2	24.7	20.0	100.0	4.4	5.7	0.0	22.2	0.0	0.0	0.0	0.0	5.2	8.2	0.0	20.0	9.4	9.4	0.0	38.0	2.8	6.0	0.0	25.0	2.3	4.0	0.0	27.7	4.3	9.8	0.0	100.0
	F2	32.1	21.2	0.0	66.7	55.9	14.7	0.0	68.8	17.9	15.6	0.0	68.8	22.3	18.4	0.0	28.6	57.9	13.0	0.0	68.8	49.7	20.1	0.0	68.8	83.6	8.7	69.0	100.0	75.9	17.9	0.0	100.0
	F3	5.6	9.1	0.0	33.3	25.4	19.1	0.0	100.0	0.0	0.0	0.0	0.0	10.1	10.1	0.0	29.4	13.6	12.5	0.0	56.5	15.0	14.7	0.0	62.5	6.3	6.0	0.0	30.0	9.0	10.8	0.0	100.0
	F4	1.0	2.8	0.0	11.5	4.4	5.5	0.0	25.0	22.6	25.3	0.0	50.0	3.2	4.2	0.0	9.8	6.6	13.8	0.0	80.0	9.3	14.6	0.0	50.0	2.1	3.7	0.0	25.0	3.0	6.6	0.0	80.0
	F5	0.0	0.0	0.0	0.0	0.1	0.9	0.0	7.7	8.3	14.4	0.0	25.0	0.8	2.0	0.0	5.3	0.6	1.7	0.0	9.8	0.1	0.8	0.0	4.8	0.1	0.8	0.0	10.8	0.2	1.2	0.0	25.0
	F6	1.6	3.4	0.0	18.0	1.3	3.0	0.0	16.7	0.0	0.0	0.0	0.0	0.8	2.0	0.0	5.3	2.3	5.7	0.0	33.3	4.6	7.4	0.0	25.0	1.1	2.7	0.0	20.0	1.3	3.5	0.0	33.3
	F7	0.3	1.0	0.0	4.0	2.5	4.1	0.0	18.2	23.4	37.5	0.0	66.7	0.0	0.0	0.0	0.0	2.6	5.3	0.0	27.3	5.1	14.7	0.0	83.3	1.4	3.1	0.0	83.3	1.8	4.8	0.0	83.3
	F8	0.0	0.0	0.0	0.0	0.4	1.5	0.0	10.2	16.7	28.9	0.0	50.0	0.0	0.0	0.0	0.0	0.2	0.9	0.0	5.9	0.7	2.3	0.0	10.0	0.2	1.3	0.0	20.0	0.3	2.0	0.0	50.0
	F9	0.0	0.0	0.0	0.0	2.2	3.7	0.0	16.7	5.6	9.6	0.0	33.3	0.0	0.0	0.0	0.0	0.4	3.5	0.0	33.3	3.5	9.9	0.0	50.0	0.3	1.4	0.0	50.0	0.4	2.6	0.0	50.0
	てんかん	0.0	0.0	0.0	0.0	0.2	1.0	0.0	8.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.5	4.5	0.0	25.0	2.8	7.1	0.0	33.3	1.0	2.3	0.0	15.0	1.3	3.1	0.0	33.3
	その他	0.9	2.8	0.0	8.7	0.2	1.0	0.0	8.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.9	2.4	0.0	11.9	0.7	3.5	0.0	20.0	0.5	2.2	0.0	24.4	0.5	2.2	0.0	24.4
デイ・ケア等利用者年齢階級別割合（%）	20歳未満	0.3	1.1	0.0	4.3	1.0	3.3	0.0	18.2	98.8	2.1	96.4	100.0	0.0	0.0	0.0	3.6	1.5	6.2	0.0	34.9	4.1	8.8	0.0	33.3	0.8	2.7	0.0	31.8	1.3	6.5	0.0	100.0
	20-40歳未満	13.0	11.9	0.0	44.0	39.2	9.8	19.4	66.7	1.2	2.1	0.0	6.7	3.4	5.5	0.0	14.7	16.2	8.9	0.0	36.4	68.5	15.1	38.5	100.0	33.6	21.0	0.0	100.0	33.0	21.1	0.0	100.0
	40-65歳未満	78.4	15.8	52.0	100.0	53.2	8.1	33.3	71.4	0.0	0.0	0.0	0.0	23.9	20.0	0.0	60.0	69.8	12.7	25.0	100.0	20.7	11.7	0.0	36.4	57.7	18.7	0.0	100.0	57.1	19.6	0.0	100.0
	65-75歳未満	7.3	7.4	0.0	26.4	5.5	5.7	0.0	25.6	0.0	0.0	0.0	0.0	14.6	8.8	0.0	26.3	10.5	11.2	0.0	68.8	5.3	8.4	0.0	31.3	7.2	7.9	0.0	42.9	7.3	8.2	0.0	68.8
	75歳以上	1.0	2.5	0.0	8.3	1.1	3.0	0.0	19.2	0.0	0.0	0.0	0.0	58.0	17.8	40.0	87.5	2.0	5.7	0.0	87.5	1.3	5.3	0.0	26.7	0.7	2.0	0.0	17.6	1.3	5.8	0.0	87.5
デイ・ケア等利用者性別割合（%）	男性	76.5	19.9	20.0	100.0	62.1	17.2	0.0	100.0	46.4	19.9	25.0	100.0	31.1	15.9	15.8	60.0	63.8	15.7	0.0	100.0	58.3	20.3	0.0	100.0	65.0	14.3	0.0	100.0	64.3	15.5	0.0	100.0
	女性	23.5	19.9	0.0	80.0	37.9	17.2	0.0	100.0	53.6	19.9	0.0	75.0	68.9	15.9	40.0	84.2	36.2	15.7	0.0	100.0	41.7	20.3	0.0	100.0	35.0	14.3	0.0	100.0	35.7	15.5	0.0	100.0

めている。

　グループ2には88カ所のデイ・ケア等が分類された。このグループ2ではF2の割合が平均55.9%と過半数に達しているが，気分障害（F3）の割合も平均25.4%と高い群である。

　グループ3には3カ所のデイ・ケア等が分類された。このグループ3は神経症圏（F4，F5）や発達障害圏（F7，F8，F9）やてんかんなど比較的若年発症の障害の利用者が多い群であり，年齢階級別の割合では20歳未満の利用者が平均98.8%と高くなっている。

　グループ4は7カ所のデイ・ケア等が分類された。このグループ4は症状性を含む器質性精神障害（F0）の割合が平均58.3%と高い群であり，同時に年齢階級別の割合で75歳以上の利用者の割合が平均58.0%と高かった。

　グループ5は90カ所のデイ・ケア等が分類された。このグループ5はF2が平均57.9%と過半数だが，F1，F3も平均1割程度みられるなど統合失調症を中心に多様な疾患に対応していると考えられる群であるが，年齢別では40歳以上65歳未満が平均69.8%に達していた。

　グループ6は33カ所のデイ・ケア等が分類された。このグループ6は，F2（平均49.7%）を中心にF3（平均15.0%）やF4（平均9.3%）の利用者がみられ，年齢別では20歳以上40歳未満が平均68.5%で大半を占めていた。

　F2が大半を占めるグループ7は722カ所のデイ・ケア等が分類された。年齢別では40歳以上65歳未満が57.7%と過半数に達していた。

考　察

　本研究の分析により，精神科デイ・ケア等の実施施設を7つの群に分類した。最も多いのは，診断が統合失調症圏の者を主たる利用者とする群であった。これらの施設は，日本の精神保健福祉施策の主要な対象が，長らく統合失調症患者を念頭においていたことに由来していると考えられる。すなわち伝統的な精神科デイ・ケアの役割を担っている施設であろう。その一方で，統合失調症圏

の診断である者を主たる利用者としているものの，それに次いで気分障害の診断である利用者が比較的多い群もみられた。これは近年注目されている気分障害の社会復帰支援に力を向けている精神科デイ・ケア等であるかもしれない。

　これ以外では，実施施設数は多くはないものの，器質性精神障害，精神作用物質による精神障害および発達障害もしくは若年を対象としていると思われる精神科デイ・ケア等の群が分類された。この解釈としては，これらのデイ・ケア等のみがそれぞれの対象を中心にしたものに機能分化して実施されていると考えるだけではなく，その精神科デイ・ケア等を設置している精神科病院自体が，病院機能の分化によって，アルコール依存や発達障害等の特定の患者対象を主として扱っている結果として生じたものも含まれていると考えるのが妥当であるように思われる。グループ毎に入院患者の疾患別の割合を求めたところ，例えばグループ1では全入院患者がF1である病院が2箇所，グループ3では入院患者の38.4%がF8である病院が1箇所，グループ4でも入院患者の99.5%がF0である病院が1箇所みられた。これらについては病院機能の分化が，実施しているデイ・ケア等の特徴に反映しているといえよう。もちろん，外来独自で機能分化をしたデイ・ケア等を実施している箇所も多くあるだろう。

　また，対象者の年齢別にも違いがみられ，20歳から40歳までの青年〜中年期を主な利用者としている精神科デイ・ケアと，40歳以上65歳未満の中高年期を主な利用者としている精神科デイ・ケアもみられた。このことは，ライフステージに応じた機能分化も行われていることを示していると考えられる。

　本研究は精神科病院単位で精神科デイ・ケア等の状況について尋ねている630調査を元に分析しているため，個別の精神科病院でどのようなコースやプログラムが実施されているかについては把握できない。例えばある精神科病院において，統合失調症の患者を主な対象とした精神科デイ・ケア等のコースと，気分障害の患者の復職支援のコースの両方が実施されていた場合，本研究では，

こういった内容を把握できない可能性が高い。また，630 調査では精神科デイ・ケア等の利用者について，精神科的診断別や性別，年齢階級別の状況を把握しているだけであるため，これ以外の機能に特化した，例えば精神科病院を退院直後の患者を対象とした精神科デイ・ケア等については当然ながら把握不能である。しかし，こうした限界は存在するものの，本研究により精神科デイ・ケア等は精神科病院においてもある程度の機能分化がされていることが示された。より詳細な精神科デイ・ケア等の機能分化の状況について把握するためには，精神科病院においてどのような内容で精神科デイ・ケア等が実施されているかを把握することが必要である。

結　論

平成 17 年度 630 調査において把握された精神科デイ・ケア等の利用者の属性等の分析から，精神科病院において実施されている精神科デイ・ケア等の機能について分類した結果，7 つの群に分類した。最も多いのは，診断が統合失調症圏の者を主たる利用者とする群であった。その一方で，統合失調症圏の診断である者を主たる利用者としているものの，それに次いで気分障害の診断である利用者が比較的多い群もみられた。また実施施設数は多くはないものの，器質性精神障害，精神作用物質による精神障害および発達障害もしくは若年を対象としていると思われる精神科デイ・ケア等の群が分類された。これらは各精神科病院において精神科デイ・ケア等実施施設が一定の機能分化をしていることを示している。

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abstract

Differentiation of functions in psychiatric day and/or night care facilities

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Objective: The aim of this study was to investigate the differentiation of the functions of day and/or night care services among psychiatric hospitals.

Methods: We performed a cluster analysis to the percentages of the age- and diagnosis-categories of the day and/or night care service users in 961 psychiatric hospitals.

Results: There emerged seven clusters of facilities. Each was characterized by following users with distinctive attributes: persons relatively common with mental and behavioral disorders due to psychoactive substance use; persons relatively common with schizophrenia and mood disorders; persons under age 20 in the great majority; persons relatively common with organic mental disorders or aged over 75 in relatively large proportions; persons between age 20 and 40 in the great majority, a small majority of them with schizophrenia; persons between 20 and 40, nearly half of them with schizophrenia; and persons with schizophrenia in the great majority.

Conclusions: The differentiation of the functions of day-care services among psychiatric hospitals appeared to have been developed to a certain level.

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ORIGINAL PAPER

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Prevalence and correlates of illicit and non-medical use of psychotropic drugs in Japan

Findings from the World Mental Health Japan Survey 2002–2004

■ **Abstract** *Purpose* To describe the prevalence of illicit and non-medical use of drugs, the age of first use, and their correlates in the general population of Japan, based on data collected between 2002 and 2004 as part of the World Mental Health (WMH) surveys. *Methods* Participants included were a subsample (n = 887) of the total 2,436 Japanese-speaking respondents aged ≥20 years, randomly sampled from residents in seven cities/municipalities in Japan. Face-to-face household surveys were conducted using the Japanese version of the fully structured WHO WMH Survey Initiative version of the Composite International Diagnostic Interview. *Results* Lifetime prevalence of marijuana and cocaine use, non-medical use of prescribed drugs such as tranquilizers, stimulants and analgesics, and use of other substances was 1.5, 0.3, 6.4 and 2.4%, respectively. Lifetime use of marijuana was significantly greater among men. Prescription drug abuse/misuse was significantly more common among the middle-aged (35–49 years) group and those who were married/cohabitating. The 12-month prevalence of marijuana and non-medical use was 0.3 and 1.9%, respectively. Age of first use was likely to be early adulthood. Non-medical use was significantly related to mood disorder, anxiety disorder, intermittent explosive disorder and alcohol abuse/dependence. *Conclusions* The present study confirmed lower prevalence of drug use in Japan than

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in other countries, such as the United States. However, the non-medical use of psychotropic drugs seems more common in Japan.

Introduction

A high population prevalence of illicit drug use has been reported worldwide, although the prevalence substantially differs from one country to another. Previous international comparison study [5] has shown that lifetime prevalence of the use of illicit drugs, such as cannabis and cocaine, was higher in the United States, followed by South American (such as Colombia, Mexico), European (such as Spain), and Pacific (such as New Zealand) countries, and extremely low in countries in the Middle East, Africa, and Asia. Similarly, the lifetime prevalence of extra-medical use of psychotropic drugs was high (45%) in the US [4] and also in Nigeria (the lifetime prevalence, 13.6 and 2.4% for sedatives and stimulants, respectively) [8] and in Israel (12-month prevalence, 6.9% for overall psychotropic drugs) [7]. It was relatively lower for Mexico (lifetime prevalence, 1.7% for tranquilizers) [12].

In general, the prevalence of overall drug use appears to be lower in Japan than in other countries. The prevalence of lifetime use of marijuana increased from 0.5% in 1995 to 1.1% in 2001 [17]. Rates of organic solvent use showed a small, non-significant increase from 1.7% in 1995 to 2.0% in 2001 [17]. Stimulant use leveled off at 0.3%, and rates of heroin, cocaine and LSD use showed no remarkable change between 1995 and 2001 [17]. Similarly, lower prevalence of drug abuse and dependence was observed in Japan, as well as those for the use of these drugs. Yamamoto [22] has reported that drug abuse in Japan was very low (1.3%) in 2001 compared to that in other countries and regions (41.7% in the US: Substance Abuse and Mental Health Service Administration, National Household Survey on Drug Abuse). The World Mental Health Japan (WMH-J) Survey 2002–2003 has also reported low prevalence rates of 12-month drug abuse/dependence (0.1%) [10].

However, even in Japan, the use of hypnotics and anxiolytics started to rise in the mid-1950s, and these drugs occupied the main position in non-medical use of prescribed drugs by 1975. The previous study has reported that prevalence of 12-month use of analgesics, anxiolytics and hypnotics was 35.5, 6.4 and 4.9%, respectively, including medical and non-medical use [6]. However, the survey did not provide the prevalence of non-medical use of prescribed drugs in Japan. It is speculated that the use and abuse of prescribed drugs might be increasing particularly among young people because of an easier access to such drugs through the new technology including the Internet [22]. The non-medical use of prescribed drugs may be increasing in the recent community population in Japan, which has not been studied well.

With respect to drug use in relation to mental disorders, the ICPE survey has reported that mental disorders such as mood disorders, anxiety disorders and conduct disorder/adult antisocial behavior are significantly associated with drug use [odds ratio (OR) 1.9–2.7, 1.1–2.5 and 3.2–7.8, respectively) [13]. Huang et al. [9] have also reported comorbidity of non-medical use of prescribed drugs and other mental disorders in the US community population. However, in Japan, the association between psychotropic drug use and mental disorders has only been investigated in clinical settings [14].

This is the first study reporting prevalence for drug use in the general population in Japan, based on data that were collected between 2002 and 2004 (WMH-J 2002–2004 Survey) as a part of the WMH surveys. The aims of this study were: (1) to present information about lifetime and 12-month prevalence and age of first use for marijuana, cocaine, non-medical prescription drugs and other drugs; and (2) to identify these user's sociodemographic characteristics and diagnostic correlates.

Methods

Subjects

World Mental Health Japan was an epidemiological survey of Japanese-speaking residents aged ≥20 years. Seven community populations in Japan were selected as study sites in 2002–2004. These sites included two cities (Okayama, population 660,000 and Nagasaki, population 450,000) and five rural municipalities (Kushikino, population 25,000; Fukiage, population 8,500; Ichiki, population 7,000; and Higashiichiki, population 14,000 in Kagoshima prefecture and Tamano, population 70,000 in Okayama prefecture). These sites were selected based on geographic variation, availability of site investigators, and cooperation of the local government. Mainly due to the last two factors, all survey sites were located in the western part of Japan for the 2002–2004 WMH-J. One subject from Tamano city, Okayama prefecture, did not meet the inclusion criteria, and excluded from this survey because he did not speak Japanese. The number of respondents was 2,436, and the total response rate was 58.4%.

An internal sampling strategy was used in all surveys to reduce respondent burden by dividing the interview into two parts. Part I included a core diagnostic assessment of all respondents (n = 2,436) that took an average of about 1 h to administer. Part II included questions about risk factors, consequences, other correlates, and additional disorders. Part II was administered only to 887 of the 2,436 Part I respondents, including all Part I respondents with one or more lifetime disorders plus a probability sub-sample of ~25% of other respondents. The interviews for the respondents who were not selected for Part II were terminated after Part I. Written consent was obtained from each respondent at each site.

The Human Subjects Committees of Okayama University (for the Okayama site), Japan NIMH (for the Kagoshima site), and Nagasaki University (for the Nagasaki site) approved the recruitment,

Table 1 Demographic characteristics of respondents from seven communities in Japan: Part II samples of the World Mental Health Survey Japan 2002–2004

Variables	Men ($n = 411$)		Women ($n = 476$)	
	n	%	n	%
Age (years)				
20–34	102	11.5	112	12.6
35–49	103	11.6	96	10.8
50–64	111	12.5	116	13.0
65+	95	10.7	153	17.3
Education (years)[a]				
0–11	110	13.1	146	17.3
12	124	14.7	144	17.1
13–15	62	7.3	103	12.2
16+	96	11.4	58	6.9
Marital status				
Married/cohabitating	281	31.6	291	32.9
Separated/widowed/divorced	36	4.0	107	12.1
Never married	95	10.7	78	8.8
Employment[b]				
Working	290	33.6	246	28.5
Student	13	1.5	9	1.0
Homemaker	2	0.2	154	17.8
Retired	76	8.8	32	3.7
Other	22	2.5	21	2.4
Household income				
Low	49	5.5	105	11.9
Low-average	105	11.8	180	20.2
High-average	204	23.0	165	18.6
High	54	6.0	26	2.9
Study area (urban/rural)				
Okayama (urban)	118	13.3	146	16.5
Nagasaki (urban)	32	3.6	34	3.9
Tamano (rural)	91	10.3	101	11.4
Kagoshima (rural)	170	19.1	195	22.0

Weighted number and percent for Part II samples
[a]Unknown = 50
[b]Unknown = 30

consent and field procedures. More detailed information on field procedures are described elsewhere [10]. The demographic characteristics of Part II respondents are shown in Table 1.

Measures

Assessment of illicit or non-medical use of psychotropic drugs

All respondents were asked about the illicit or non-medical use of psychotropic drugs (marijuana, cocaine, non-medical use of prescribed drugs, and other drugs) over their lifetime and for the 12 months preceding the survey. Face-to-face interviews were conducted using a standard booklet that listed psychotropic drugs in each category commonly used in Japan. To assess non-medical use of prescribed drugs, the following question was used: "Have you ever used tranquilizers, stimulants, pain killers, or other prescription drugs either without the recommendation of a health professional, or for any reason other than a health professional's instructions to do so?" The interviewers were instructed to include only drugs prescribed by physicians. The other drugs listed in the booklet were heroin, opium, glue, LSD, peyote, and others. Age at first use of drugs was also obtained using an improved set of questions prepared in the WMH Composite International Diagnostic Interview (WMH-CIDI): a respondent was first asked "Can you remember your *exact age* the very first time you had an episode

of drug use?"; if he/she said "yes", then he/she was asked to report the exact age; otherwise, the respondent was asked "*About* how old were you the first time?" in order to avoid an "I do not know" response [11].

Diagnosis of mental disorders

WMH-J diagnoses are based on the WMH-CIDI [11], a fully structured lay-administered diagnostic interview that generates both ICD-10 [20] and DSM-IV [2] diagnoses. DSM-IV criteria were used here. Diagnoses include: anxiety disorders [panic disorder, agoraphobia without panic disorder, specific phobia, social phobia, generalized anxiety disorder and post-traumatic stress disorder (PTSD)]; mood disorders (major depressive disorder, dysthymia, and bipolar I and II disorders); impulse–control disorder [intermittent explosive disorder (IED)]; and substance use disorders [alcohol abuse with/without alcohol dependence (AA), alcohol dependence with alcohol abuse (AD), drug abuse with/without drug dependence (DA), and drug dependence with drug abuse (DD)]. PTSD, AA, AD, DA and DD assessments were included in Part II, which was only asked for a random subsample of the respondents. All other disorders were included in Part I. Organic exclusion rules and hierarchy rules were used to make all diagnoses except for substance use disorders. The latter were diagnosed without hierarchy in recognition that abuse is often a stage in the progression to dependence.

Demographic variables

The demographic variables included age, gender, education, marital status, employment and household income per family member. Household income was classified into four categories: low (less than 50% of the median income), low-average (50–99% of the median income), high-average (100–149% of the median income), and high (150% or greater of the median income) [15].

Statistical analyses

Part II respondents were weighted by the inverse of their probability of selection to adjust for the differential sampling of cases and non-cases. In addition to this Part II weight, all samples were weighted to adjust for differential probabilities of selection and post-stratified to match the population distributions on the cross-classification of sex and age, for which the non-response weight in a given group with sex and age was the inverse of the response rate in this category. Weighting is described in more detail elsewhere [10].

Data were recorded on prevalence, age of first use, and diagnostic correlates of lifetime of drug use. Simple cross-tabulations were used to calculate prevalence, age of first use, and diagnostic correlates of lifetime of drug use. The χ^2 test was used to study sociodemographic correlates. Logistic regression analysis was used to study diagnostic correlates. Standard errors of descriptive statistics were estimated using the Taylor series method [19] implemented with the SUDAAN software system [16]. The logistic regression coefficients were transformed to OR and were reported with design-adjusted 95% confidence intervals (CI). Statistical significance was based on two-sided design-based tests evaluated at the 0.05 level of significance.

Results

Lifetime and 12-month prevalence of drug use

Table 2 presents prevalence of drugs use. The most prevalent lifetime use of drugs was non-medical use

Table 2 Lifetime and 12-month prevalence of drug use in the community population in Japan: Part II samples of the World Mental Health Survey Japan 2002–2004

Drugs	12-month use		Lifetime use		Age of first use		Unknown
	n[a]	%	n[a]	%	Median	Min–Max	
Marijuana	2	0.3	13	1.5	20	19–26	1
Cocaine	–	–	3	0.3	20	20–21	
Non-medical use	17	1.9	56	6.4	20	0–68	8
Other drugs	0	0.0	21	2.4	20	0–20	9

$N = 876$

The weighted number is rounded off to a positive number and percentages are rounded off to the first decimal place
[a]Weighted number and percent for Part II samples

(6.4%), followed by other drugs (2.4%), marijuana (1.5%) and cocaine (0.3%), and the most prevalent 12-month use of drugs was non-medical use (1.9%), followed by marijuana (0.3%). Age range at first use was: marijuana (19–26 years), cocaine (20–21 years), non-medical use (0–68 years) and other drugs (0–20 years).

Sociodemographic correlates of lifetime use of drugs

We examined associations between six sociodemographic variables and four types of drugs (Table 3). Lifetime use of marijuana was significantly more

common among men ($df = 1$, $P = 0.005$) and young respondents (20–34 years) ($df = 1$, $P = 0.001$, for the comparison between the youngest group and the all other age groups combined). Non-medical use of prescribed drugs was significantly more common among the middle-aged respondents (35–49 years) ($df = 3$, $P = 0.029$) and among those who were married/cohabitating ($df = 2$, $P = 0.019$).

Diagnostic correlates of lifetime use of drugs

The associations between lifetime prevalence of mental disorders and lifetime use of four types of

Table 3 Sociodemographic correlates of lifetime use of drugs in the community population in Japan: Part II samples of the World Mental Health Survey Japan 2002–2004

Variables	N[a]	Marijuana			Cocaine			Non-medical use			Other drugs		
		n[a]	%	P*	n[a]	%	P*	n[a]	%	P*	n[a]	%	P*
Gender													
Men	407	12	2.9	0.005	2	0.6	0.165	32	7.9	0.134	12	2.9	0.604
Women	469	2	0.4		0	0.1		24	5.0		9	2.0	
Age (years)													
20–34	207	10	4.6	–	3	1.3	–	15	7.1	0.029	11	5.2	0.280
35–49	197	2	1.0		0	0.0		21	10.5		3	1.7	
50–64	227	2	0.9		0	0.0		14	6.3		3	1.2	
65+	246	0	0.0		0	0.0		6	2.6		4	1.8	
Education (years)													
0–11	256	2	0.9	0.189	2	0.9	–	10	4.0	0.136	3	1.0	0.368
12	268	3	1.2		0	0.2		15	5.8		12	4.5	
13–15	165	0	0.3		0	0.0		11	6.7		4	2.7	
16+	154	5	3.2		0	0.0		17	10.8		2	1.4	
Marital status													
Married/cohabitating	563	8	1.4	0.156	2	0.4	–	45	8.0	0.019	15	2.7	–
Separated/widowed/divorced	142	0	0.2		0	0.0		5	3.5		0	0.0	
Never married	171	5	2.9		0	0.3		6	3.3		6	3.5	
Employment													
Working	536	12	2.3	–	3	0.5	–	43	8.0	0.102	15	2.9	–
Student	21	0	0.0		0	0.0		1	3.8		0	0.0	
Homemaker	156	1	0.8		0	0.0		5	3.2		6	3.7	
Retired	108	0	0.0		0	0.0		4	3.6		0	0.0	
Other	43	0	0.0		0	0.0		2	4.5		0	0.4	
Household income													
Low	154	2	1.1	0.958	0	0.3	–	7	4.8	0.648	8	5.4	0.220
Low-average	284	4	1.5		2	0.8		16	5.8		3	1.1	
High-average	363	6	1.6		0	0.0		25	6.9		7	1.8	
High	76	2	2.3		0	0.0		7	9.0		3	4.3	

*P for difference among categories (Chi-square test with Part II weight by SAS PROC SURVEYFREQ)
[a]Weighted number and percent for Part II samples. The weighted number is rounded off to a positive number and percentages are rounded off to the first decimal place
–, statistic could not be estimated because at least one category had no case

Regarding age of first use in this study, all drug users were found to have onset before their early twenties. The present study supports a previous observation that drug use commonly starts in adolescence and young adulthood [5, 8, 9, 12]. In addition, the present study observed an increase in lifetime use of marijuana among younger respondents, which is concordant with a pattern consistently seen in many other countries [5], suggesting a recent worldwide epidemic of marijuana use in the younger generation. On the other hand, the lifetime prevalence of non-medical use of prescribed drugs was higher in the group aged 35–49 years. An investigation in clinical settings in Japan also showed that the mean age for non-medical use of psychotropic drugs was ~40 years old [14]. Medina-Mora et al. [12] have reported that late onset of abuse or dependence is related more to non-medical use of prescribed psychotropic drugs in Mexico. It is suggested that the middle-aged population is at risk for the non-medical use of prescribed psychotropic drugs, possibly because that group is more likely to go to a doctor to obtain psychotropic drugs, such as sleeping pills, for psychosomatic complaints. It may be important to pay attention to the middle-aged population, by monitoring non-medical use of prescribed psychotropic drugs, in order to prevent this happening.

There was a significantly greater lifetime prevalence of marijuana use among males than females in the present sample. This is consistent with previous findings that marijuana use was much more common in males than among females [4, 5, 8, 12]. For other drugs, a previous study of the general population in Japan showed that females were more likely to have taken analgesics, tranquilizers and hypnotics than males were [6]. In the present study, we found no significant, but slightly greater lifetime prevalence of cocaine, non-medical use of prescribed drugs, and other drugs among males. Our finding is consistent with those in the United States [4] and Nigeria [8], but contrary to the slightly higher prevalence of non-medical use of prescribed drugs among females in Mexico [12]. In general, drug use appears to be more prevalent among males than females in Japan, as well as in other countries [1, 5], although it has been reported that the male–female gap was closing in more recent cohorts [5]. Part of male domination in drug use is attributable to a possible association between violent or impulsive behaviors and drug use [13], which is also supported by the observed association between IED and non-medical use of psychotropic drug in the present study.

There are several limitations to this study. First, the prevalence and age of onset were based on a retrospective self-report assessment that was vulnerable to recall and other information bias (such as reluctance to disclose information). In addition, some respondents may have misunderstood the questions to report that they used the drugs for their whole life,

for whom we assigned zero age of onset. Such errors in self-reporting may have affected the findings. Second, this survey did not include adolescents and institutionalized individuals, or people living in metropolitan areas. We may have underestimated the prevalence of illicit drug use, which could have been higher if these excluded groups had been part of the sample. Third, a small sample size is an important limitation. The number of respondents may have been insufficient to allow the detection of a true and stable association.

Conclusion

The present study confirmed lower prevalence of drug use in Japan than in other countries, such as the United States. However, the non-medical use of psychotropic drugs seems more common in Japan.

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Table 4 Diagnostic correlates of lifetime use of drugs in the community population in Japan: Part II samples of the World Mental Health Survey Japan 2002–2004

Lifetime diagnosis[a]	N[b]	Marijuana				Cocaine				Non-medical use				Other drugs			
		n[b]	%	OR	(95% CI)	n[b]	%	OR	(95% CI)	n[b]	%	OR	(95% CI)	n[b]	%	OR	(95% CI)
Any mood disorder																	
Yes	60	1	2.3	1.60	(0.30–8.39)	0	0.8	2.76	(0.17–44.57)	9	14.7	2.82	(1.49–5.34)	1	2.1	0.90	(0.27–3.02)
No	816	12	1.5	1.0		2	0.3	1.0		47	5.7	1.0		20	2.4	1.0	
Any anxiety disorder																	
Yes	60	0	0.8	0.49	(0.06–4.01)	0	0.8	2.79	(0.17–45.19)	8	13.6	2.54	(1.34–4.82)	2	3.9	1.72	(0.44–6.75)
No	817	13	1.6	1.0		2	0.3	1.0		48	5.8	1.0		19	2.3	1.0	
IED																	
Yes	25	2	7.0	5.47	(0.64–46.71)	0	0.0	<0.001	(<0.001–<0.001)	5	18.7	3.62	(1.30–10.06)	2	7.0	3.25	(0.39–27.14)
No	851	12	1.4	1.0		3	0.3	1.0		51	6.0	1.0		19	2.3	1.0	
Alcohol abuse/dependence																	
Yes	42	3	6.4	5.26	(0.77–35.81)	0	0.0	<0.001	(<0.001–<0.001)	5	11.5	1.99	(0.86–4.62)	1	1.2	0.52	(0.09–3.08)
No	834	11	1.3	1.0		3	0.3	1.0		51	6.1	1.0		21	2.5	1.0	

[a]Lifetime prevalence of any mood, anxiety, IED, and alcohol abuse/dependence was 6.9, 6.8, 2.9 and 4.8%, respectively
[b]Weighted number and percent for Part II samples. The weighted number is rounded off to a positive number and percentages are rounded off to the first decimal place

drugs are shown in Table 4. Non-medical use of psychotropic drugs was significantly related to any mood disorder (OR = 2.82), any anxiety disorder (OR = 2.54), IED (OR = 3.62), and alcohol abuse/dependence (OR = 1.99) (all P < 0.05).

Discussion

The present study confirmed a low prevalence rate of drug use in Japan. The prevalence of use of marijuana (1.5%) and cocaine (0.3%) was lower in Japan than many comparable developed countries, such as the United States and European countries [5]. This is probably explained by the Japanese government having a strong policy for controlling the use of illicit and other psychotropic drugs [17]. However, a recent international comparison [5] has pointed out that punitive illegal drug policies do not necessarily correlate with low prevalence of illegal drug use, with the high prevalence in a country which has stringent policies, vis-à-vis (e.g., the US compared to the Netherlands). Other factors such as cultural and genetic ones may be also considered to understand the lower prevalence of illicit drug use in Japan.

On the other hand, we found a relatively high prevalence of non-medical use of prescribed psychotropic drugs, 6.4%, which was lower than that found in the United States (44.5%) [4] and Nigeria (13.6%) [8], but was higher than that in Mexico (1.7%) [12]. The cross-country patterns of non-medical use of prescribed psychotropic drugs seem different from that of illicit drugs, suggesting that a distinct factor underlies the prevalence differences among countries. Our findings showed that lifetime prevalence of mood disorders, anxiety disorders and IED was associated with a greater lifetime risk of non-medical use of prescribed drugs. Interestingly, the magnitude of comorbidity of drug use with mood and anxiety

disorders was similar to that reported previously in the United States [13]. People with these common mental disorders may more actively seek drugs not prescribed to them, but prescribed to family, friends, other people, in order to relief their symptoms. Also they may have more chances to obtain psychotropic drugs for non-medical purposes if they went to a doctor. Both lifetime and 12-month prevalence of these mental disorders in Japan were three times lower than in the US, and 1.5-times lower than in Mexico and most European countries, as reported in previous studies [10, 18]. Lower prevalence of these common mental disorders may partly explain the lower prevalence of non-medical use of prescribed drugs in Japan. Another factor which may underlie the country difference in the prevalence of non-medical use of prescribed psychotropic drugs may be availability of psychiatric care. For instance, Japan has three times greater number of psychiatrists (9.4 per 100,000 pop.) than dose Mexico (2.7 per 100,000 pop.); Accessibility to psychiatric care is also supported by the national health insurance system in Japan [21]. Psychiatrists and non-psychiatrist doctors tend to prescribe benzodiazepine hypnotics or anxiolytics more frequently in Japan [6]. This may be a reason that the prevalence of non-medical use of prescribed psychotropic drugs was higher in Japan than in Mexico. The high prevalence in the United States was also attributed to easy access to prescribed psychotropic drugs, without the supervision of a physician, e.g., via the internet [3], which may also explain the current increased prevalence in Japan. However, these factors do not fully explain the relatively higher prevalence in Nigeria, which has the low prevalence of mental disorders [18] and the small number of psychiatrists [21]. Further research is needed to explore the cross-country patterns of non-medical use of prescribed psychotropic drugs and the underlying factors.

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わが国における精神科デイケアの
現状と今後のあり方

安西　信雄

わが国における精神科デイケアの現状と今後のあり方

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Key Questions

Q1：日本における精神科デイケアの現状は？

Q2：多様なニーズに対応した精神科デイケアの機能分化とは？

Q3：地域ケアの展開の中での精神科デイケアの今後の役割は？

はじめに

精神科デイケア（以下デイケア）以外に社会復帰施設がなかった時代にはデイケアの役割は自明に思われ，期待感に裏打ちされて効果は厳しく問われなかった．現在は共同作業所の普及や生活支援センターの登場，さらにセルフヘルプを志向したソーシャルクラブも生まれる中で，医療機関にあるデイケアには，その役割の明確化と効果の証明が求められるようになっている．わが国の精神保健医療福祉が入院中心から地域ケア中心に移行していく中で，デイケアはどういう対象に，どういう役割を果たすべきか．本稿では医療機関にあるデイケアに焦点を当て，現状と今後のあり方を検討した．

精神科治療の目標の変化とデイケア

近年，各種の精神疾患における治療目標が，精神症状の改善から，生活の質や就労・就学等の社会生活上の課題の達成に重点が移行しつつある（あるいは関心が拡大しつつある）ようにみえる．たとえば，うつ病では復職を支援するリワーク事業が盛んに実施されるようになり，統合失調症においても障害者枠を使った就労支援も実施されている．統合失調症では再発予防や寛解，社会的機能水準があらためて注目され，回復（リカバリー）が重視されるようになっている．

Lieberman ら[1]による統合失調症の経過の模式図（図）は，長期経過を踏まえた包括的な視点を代表するものである．ここで統合失調症は人生にわたる「複雑な脳機能障害」の経過を示すが，前駆期，進行期，慢性または残遺期の3つの時期ごとに対応が組み立てられる．前駆期や早期の心理社会的介入や抗精神病薬療法は症状を改善するとともに，その後の再発を防止する．進行期には寛解の維持と再発防止が，生活機能の低下を防ぐ鍵を握る．たとえ再発を繰り返し，慢性または残遺期になっても，適切な治療を行えば認知機能や職業的機能の回復（リカバリー）が可能とされる．こうした前向きな見解が述べられるのは，近年の非定型抗精神病薬の登場による抗精神病薬療法の進歩と，心理社会的治療の進歩に負うところが大きい．

統合失調症や遷延した気分障害，重症の神経症等の精神障害においては，それぞれの疾患に特徴的な精神症状が治まったあとも，対人関係がうまくいかず引きこもりに陥ったり，社会生活上の不器用さが残ったりするために就労や社会参加が妨げられることが多い．生活障害[2]と呼ばれるこれらの要因は，社会適応を妨げるだけでなく再発や悪化の要因ともなる．生活障害は治療者との一対一の関係を中心とする外来治療では改善が難しく，治療的に構成された集団への参加の経験を通

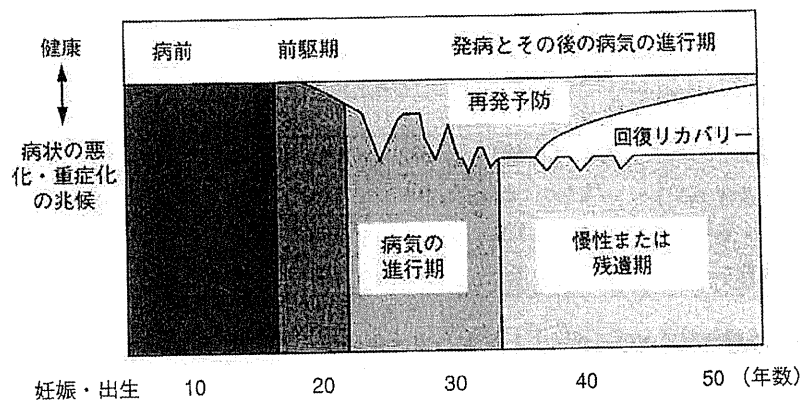[*]あんざい のぶお：国立精神・神経センター病院，医師　〒187-8551 東京都小平市小川東町4-1-1

図 統合失調症の経過と治療による改善の可能性（文献1より引用）
統合失調症患者の経過は，人生にわたる複雑な脳機能障害としての経過を示す．早期の心理社会的介入および抗精神病薬療法は症状を軽減させ，その後の再発を防止する．適切な治療により完全寛解を持続させることができれば，病気の進行を防ぎ，症状の持続や生活機能の低下を防ぐことができる．その後の慢性または残遺症状の段階でも，適切な治療を行えば認知機能や職業的機能の回復（リカバリー）に至ることができる．

して改善が得られる場合が多い．

それでは再発防止や生活機能が重視される状況で，デイケアがあらためて注目されているかといえば，現実は必ずしもそうではない．むしろ，デイケアに厳しい目が向けられているところに問題がある．

池淵[3]はデイケアを「在宅の慢性精神障害者に対して，外来治療では十分提供できない医学的・心理社会的治療を，週数日・1日数時間以上包括的に実施する場」と定義した．わが国ではデイケアという言葉が医療機関のものも，医療の枠外の保健所やソーシャルクラブも含めた幅広い意味で使われているが，上記の定義は医療機関にあるデイケアを医療の枠外にあるものと明確に区別して，その治療的機能を高めていこうとする考えによるものである[4,5]．

診療報酬への位置づけがわが国におけるデイケア普及の原動力となったことはいうまでもないが，そこでは次のように規定されている．「精神科デイ・ケアは精神科通院医療の一形態であり，精神障害者等に対し昼間の一定時間（6時間程度），医師の指示及び十分な指導・監督のもとに一定の医療チーム（作業療法士，看護婦（師），精神科ソーシャルワーカー，臨床心理技術者等）によって行われる．その内容は，集団精神療法，作業療法，レクリエーション活動，創作活動，生活指導，療養指導等であり，通常の外来診療に併用して計画的かつ定例的に行う」とされ，さらに「このデイ・ケアの治療対象は，精神分裂病等の重いものから精神神経症程度の軽いものまで幅広く適応され，入院治療ほどではないが，今までの通院医療よりも積極的で濃厚な治療を行うことができる」とされている．これらに続き，大規模なもの，小規模なもの，精神科ナイト・ケア，精神科デイ・ナイト・ケアの施設基準が定められている[6]．

このように診療報酬においてデイケアは「通院医療よりも積極的で濃厚な治療」とされているが「入院治療ほどではない」という限定がつけられ，デイケアのスタッフは，小規模デイケア（1日30人まで）では精神科医1名＋従事者（専従）2名，1日50人までの大規模デイケアでは精神科医1名＋従事者3人，1日70人までの大規模デイケアでは精神科医1名＋従事者4名とされている．精神科医以外の従事者数を基準にケースロード（従事者当たりの担当患者数）を計算すると，1名の従事者当たり15〜17.5人の患者を毎日担当することになる．池淵ら[4]は米国の部分入院協会（AAPH）が標準とするスタッフ数を紹介しているが，そこでは急性期のデイホスピタルは1：4，リハを主眼とするデイケアは1：6，維持療法を目