

を作成し、これを邦人援護担当領事に周知する。

B. 1 年目聞き取り調査の結果

主として北米地区外務省在外公館に勤務する医務官および邦人援護担当領事を対象に、海外で災害被災や犯罪被害等により精神不調をきたし援護された邦人事例について聞き取り調査を行った。あわせてケアギバーである医務官および邦人援護担当領事のメンタルヘルスについても聴取した。なお、邦人援護担当領事は、ほぼ 3 年間のサイクルで数カ所の在外公館、本省領事局の異動を繰り返しており、現職が北米勤務であっても、過去の任地での体験について聴取することができた。以下に援護業務経験の比較的長い領事 4 名からの聞き取り調査の概略とアンケート用紙に盛り込むべき質問項目を示す。

領事 A：警察庁からの出向として東南アジアに勤務。警察官の業務として死体検案の経験があるので邦人死亡案件への対応に大きな支障はないが、警察官は任務交代があるのに対して領事は一人に対応せざるをえないことが多く負担感はある。日本で知り合った東南アジア出身女性を追って来訪し、生活資金がなくなると追い出され困窮化する邦人が後を絶たない。公館に生活費援助を求めて来訪する邦人に対して、援助対象外であることを説明すると攻撃的な言動に転ずることがあり困惑することがある。他にも無理難題を要求する邦人がおり、対応法や気持ちの切替えの方法について知りたい。

領事 B：米国南西部で発生した交通事故加害邦人および被害邦人の援護を担当した。事件発生直後に長距離を運転して現場に向かい加害者と接触。その後、日本から到着した家族および遺族へ対応したが、あたかも担当領事が加害者であるかのような強い怒りと不満をぶつけられた。疲労と緊張の中、援護者として不全感を自覚したが何とか自分の感情をコントロールして誠実に援護業務を続けた。家族・遺族の攻撃的言動は徐々に治まったもののマスメディアの執拗な取材には閉口した。

領事 C：在ペルー日本大使公邸占拠事件において自らも人質となり、なおかつケアギバーとしての業務を遂行した。現在でもフラッシュバック、悪夢といったトラウマ関連症状が残存しているが、専門医による治療を受けたことがない。

領事 D：国によっては、麻薬や経済事件の罪が重く長期間の刑に服している邦人がいる。邦人援護担当領事は彼らとの面会や家族への連絡なども行うことがある。「縁を切った」「関わりたくない」「一切送金はしない」といった家族もおり、困窮邦人、邦人精神障害者、邦人犯罪者の一部は海外棄民ということが出来る。重刑を待つ邦人を長期にわたり見守ることはストレスである。

聞き取り調査を総括すると、邦人援護担当領事のメンタルヘルスに関する知識は、現場経験と個人的興味に依存しており、系統的な

学習の場が十分に用意されておらず強いステイグマを散見した。その結果、外務省邦人援護統計における「精神障害による援護」分類の根拠は不明確であり、過小計上の傾向が見られた。海外における大規模災害や事故においては、被災者遺族の心理的反応である援護者への非難、暴言、攻撃、マスメディアによる非人道的取材など共通する現象が発生し、邦人援護担当領事はそれらに対する怒り、不全感に苦悩しつつも多くは経験とともに受容していた。2年目のアンケート調査では、邦人援護担当領事の精神保健に関する知識、危機介入能力などについて調べ、対応ガイドライン作成の参考とし、さらにはより信頼度の高い邦人援護統計のよりどころとなる。

アンケート用紙質問項目草案（順不同）

- 対象者の属性：年齢、性別、現公館への勤続年数、通算の在外公館勤務年数、警察庁出向者か否か
- 精神障害または自殺への対応事例数
- 家族・遺族への告知体験
- 自らが被災者となった経験
- 災害被災や犯罪被害等により精神不調をきたした邦人援護に携わった経験
- マスメディアへの対応の経験
- 援護事例を精神障害として判定し援護する場合の拠り所
- 「精神障害による援護事例」かの判断に迷う理由
- 「精神障害による援護事例」かの判断に迷った場合の報告判断

- 精神障害事例に対するステイグマ
- トラウマ関連障害の知識とセルフケア能力
- 援護者としてのトラウマ関連障害への対応の知識
- その他

C. 研究成果

著書

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報告書

1. 東南アジア日本企業駐在員のメンタルヘルス - インドネシアでの調査より- 海外邦人医療基金調査報告書 (2011)
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1. Atsushi Sawa and Mitsuru Suzuki: Characteristics of psychiatric emergency services in Japan. 164th Annual Meeting, American Psychiatric Association, Honolulu 2011.5.14-18

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Ⅲ. 研究成果の刊行に関する一覧表

研究成果の刊行に関する一覧表

書籍

著者氏名	論文タイトル名	書籍全体の編集者名	書籍名	出版社名	出版地	出版年	ページ
加茂 登志子	配偶者間暴力	飛鳥井 望	心的外傷後ストレス障害 (PTSD)	最新医学社	東京	2011.10	150~158
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鈴木満	広域多発複合災害後の新しい地域精神医療の構築に向けて	外来精神医療	12 (1)		2012印刷中
Eri Takusari, Mitsuru Suzuki, Hiromi Karu Nakamura and Kotaro Otsuka	Mental Health, Suicidal Ideation, and Related Factors among Workers from Medium-sized Business Establishments in Northern Japan: Comparative Study of Sex Differences	Industrial health	49	452-463	2011
渡 路子	口蹄疫の全被災農家を対象とした電話スクリーニングの意義	保健師ジャーナル	68 (3)	220-225	2012
蒔田浩平、辻厚史、大和田孝二、壺岐佳浩、吉原啓介、掛水由洋、出口祐一郎、榎本豊、河野宏、黒木啓光、由地裕之	2010年に宮崎県で発生した口蹄疫により被災畜産農家が受けた精神的ストレス	畜産の研究	66 (1)	151-155	2012
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IV. 研究成果の刊行物

*Editorial***Great East Japan Earthquake and Early Mental-health-care Response**

ON 11 MARCH 2011, a devastating earthquake struck off the coast of Japan, causing blustering tsunami that swept over the northeast coast of the country. Many struggled to evacuate from their homes, schools and workplaces as 8–9-meter-tall tsunami rapidly reached the coast within half an hour after the earthquake (Emergency Disaster Response Headquarters). The officials reported a record-breaking magnitude of 9.0 (Mw), which made this earthquake the greatest earthquake in the country's history. It had not been long since the last massive earthquake had hit Kobe in 1995, killing 6434 people (Japan Meteorological Agency). The Japanese government immediately set up the Emergency Disaster Response Headquarters to initiate disaster relief. As many as 156 countries offered support through releasing emergency aid, and sending medical teams and relief workers (Emergency Disaster Response Headquarters). While the country was struggling with aftershocks, the impact of the earthquake and tsunami led to explosions and leaks of radioactive gas at the Fukushima Daiichi Nuclear Power Station. This nuclear crisis was categorized as being as severe as the accident in Chernobyl and has been considered as an international emergency. The Nuclear Emergency Response Headquarters has been taking measures to halt the worst nuclear crisis in the nation's history. The official death toll from the earthquake and tsunami has reached 14 998 as of 12 May 2011, and as many as 9761 people are still missing (the National Police Agency of Japan). Tens of thousands of residents within a radius of 30 km from the power station were legally enforced to evacuate from their communities, to be housed in temporary shelters (Emergency Disaster Response Headquarters).

MENTAL HEALTH COUNTERMEASURES**Initial response**

In contrast to the previous great earthquakes in Kobe¹ and Niigata,² where the damage was mostly restricted

to one prefecture and its local government organized the mental-health-care provision, the scope of the disaster this time was much larger and included three prefectures and one ordinance-designated city, so it was necessary to set up comprehensive mental-health-care planning to cover all the affected areas beyond the prefecture boundaries. The overall headquarter role was assumed by the Ministry of Health, Labor and Welfare (MHLW) in addition to spontaneous initiative roles taken by academic and clinical organizations of psychiatric and co-medical professions.

Some academic associations and institutes also took immediate countermeasures. Within 2 days of the initial seism, the Japanese Society for Psychiatry and Neurology (JSPN) set up a disaster response committee followed shortly by a mental-health-care disaster response operation center,³ gathering a number of academic, clinical and co-medical organizations, such as the Japanese Association of Psychiatric Hospitals, Japan Municipal Hospital Association, Japanese Association of Neuropsychiatric Clinics, Japan Association of Chairpersons of Departments of Psychiatry, Japanese Society of Traumatic Stress Studies, Japanese Association for Emergency Psychiatry, and others, which sent mental health teams or professional advisors to the afflicted sites; those organizations also set up committees of their own, some of which also sent mental-health-care teams and personnel to the affected sites. JSPN also declared the general policy of post-disaster mental health countermeasures,⁴ followed by updated information by the disaster response operation center.^{5–7}

On the third day, the National Center of Neurology and Psychiatry (NCNP) decided to launch an information website, to set up more than 20 guidelines or manuals that covered the overall policy of mental-health-care provision for the specific treatment of, for example, handicapped children or demented elderly patients. The site quickly came to be recognized as the most reliable and authoritative information

resource by the MHLW and other organizations involved in post-disaster mental health care.

General background

An urgent and crucial issue was to continue psychiatric service for those patients whose treatment was disrupted after the disaster due to transportation difficulty through ruined towns and villages, or the damage to mental clinics and hospitals themselves. The shortage of mental drugs was also a problem. The initial difficulty was that the supply of gas fuel was quite limited and the train network was almost stopped because the roads and railroads were ruined; also, aftershocks meant that secondary transportation accidents were a threat. For that reason, even local government staff could not easily go to the afflicted coastal areas, sometimes 200–300 km away from the local government capital. Telephone communications, including mobile phones, were also out of use. Despite tremendous efforts, these issues made it difficult to obtain exact information about the disaster sites, to supply the necessities of life and medical supplies, and, above all, the systematic rescue and care of victims.

It was also a worrying problem that the traumatic impact of the disaster would cause immediate severe distress, clinical or subclinical, resulting in the manifestation of acute delirium, panic, late post-traumatic stress disorder (PTSD), bereavement and depression.^{1,2} The perception of the great tremble, the impact of the tsunami, the loss of family members and friends as well as the witness of corpses would generate traumatic memories, followed by the persistent distress of living in shelters, mostly the gymnasiums of local schools, with hardly any privacy.⁷

Transportation of psychiatric inpatients

The transportation of inpatients from collapsed psychiatric hospitals was a matter of urgent concern. Three psychiatric hospitals in Miyagi prefecture and two in Fukushima lost their function due to the earthquake and tsunami and five psychiatric hospitals near the atomic plant in Fukushima did so a short time later for fear of suspected contamination with radioactivity. As a result, more than 1000 inpatients lost beds. On the second day after the disaster, 14 March, the MHLW surveyed the capacity of psychiatric hospitals for new admission in the non-afflicted prefectures around Tokyo and Tohoku. Within 10 days after

the disaster, transportation was almost completed to other hospitals within the same prefecture or in distant areas. In Japan, the number of inpatient beds is determined by the government, but the number of beds in nearby hospitals was not sufficient, so that the admission of patients beyond the permitted number was temporarily allowed by the MHLW and some hospitals were transferred to hospitals in distant and unaffected prefectures, such as Tokyo.

The below-mentioned on-site mental-health-care teams provided a temporary outpatient service for the patients of the collapsed hospitals or clinics, or for those who could not reach mental facilities due to damaged roads.

Supply of psychiatric drugs

The supply of psychiatric drugs risked running short, as the expressways were collapsed and railroads were destroyed everywhere. In response to an appeal from the afflicted local governments, drugs were conveyed by the MHLW, Japanese Associations of Psychiatric Hospitals. JSPN also played an advisory role in the effective distribution of drugs. Some pharmacological companies also donated drugs. The concern for the shortage of psychiatric drugs was most serious in antidepressant drugs or anticonvulsants, which in turn caused the restriction of the days of the prescription of those drugs in further areas, such as Tokyo. Some anticonvulsants are usually prescribed for up to 180 days, but for some time after the disaster, this was restricted to around 30 days.

Mental-health-care teams

The MHLW immediately scheduled and organized the dispatch of mental care response teams composed of psychiatrists, nurses, and/or psychologists, psycho-social workers, and clerks. The teams from national psychiatric hospitals, organizations such as the Japanese Association of Psychiatric Hospitals, the Japanese Association of Neuropsychiatric Clinics, and the Japan Association of Chairpersons of Departments of Psychiatry, were registered through the MHLW to the local governments, and their visiting schedule and working place were allocated in order to meet actual needs and to avoid overlapping of resources. In some cases, not teams but medical staff of a certain profession were sent, or voluntarily went, to those hospitals that were damaged or whose staff members were affected. The exception is the Red Cross, which is

allowed to send medical teams by Japanese law independently of the government's decision.

Even before the scheduling system came to work effectively, which actually took several days, some medical organizations spontaneously sent mental health teams, based upon their own information or personal communication with the directors of psychiatric departments of universities or hospitals of the afflicted sites. During the first 1 or 2 weeks, some of those teams entered the afflicted sites without notification to the local or national governments, but they soon came to be organized into the unanimous dispatching schema. Most teams came at first to the local government or the affiliated center of mental health and welfare, mandatorily founded to each prefecture, to receive an explanation of the ongoing mental health care and policy, and received mental-health-care manuals that contained the description of policy, assessment, and reporting procedures and forms, which goes in accordance with the national post-disaster mental health guideline issued in 2003. Otherwise they could download the guideline, manual and road map from the information website set up by the NCNP on 16 March. They were asked to send daily and weekly reports to the local government mental health office.

Within several days, the mental health teams dispatched via MHLW started their activity on the affected areas and the number of districts supported by those teams soon increased to be 30 in around 2 weeks, excluding the Red Cross teams and those who went there spontaneously without registration. The MHLW wished that from 1 month after the disaster, each team would hold responsibility for a certain district, but most teams voluntarily did so at an earlier phase, in that they spontaneously made routine teams to be sent successively, around every week, to provide continuous on-site mental care. They rounded among refugee shelters amidst various administrative and medical teams, and in the initial phase their major task was to continue treatment and medication for the patients who had already been treated by psychiatrists prior to the disaster. Some cases of acute stress disorder, panic attack, delirium or psychotic excitement were also reported, precipitated by the adjustment difficulty to a new refugee shelter. Such cases were even reported from the medical professionals who witnessed the ruined towns and injured dead bodies. Along with the time course, the reports of such fresh cases disappeared.

The treatment of people involved in the recovery process was also a critical issue and a focus of social concern.^{8–10} In most cases, such activity was composed of psycho-education, supportive counseling and temporary medication of distressing mental symptoms, on an outreach basis to the refugee camps. Subclinical distress and emotional upset were also seen, but the majority of the affected people did not show overt symptoms, although they occasionally uttered a deep sense of sorrow. This is a similar behavior to what had been observed after the Great Niigata Earthquake in 2005, which also occurred in traditional rural areas of Japan, where people are accustomed to a restrained manner of behavior and the expression of negative feelings in front of other people is strongly avoided. Such a restrained manner, however, is different from being mentally intact, and some reports from this disaster say that some people who lost their family members in the tsunami were composed during the daytime but sobbed outside the refugee camps at midnight.

Information provision

General policy

As mentioned above, the NCNP launched a website for adequate information provision. It contained the Japanese Guidelines on Post-disaster Mental Health Care, its manual, road map, and leaflets. In order to provide effective mental health care, it is crucial that professional mental-health-care providers share a common understanding of both the nature of disaster-related stress reactions and the rationale of intervention. From the bitter experience of Kobe where a flood of various types of information arrived from abroad or other areas of Japan, it was necessary to avoid confusion regarding the concept of mental health care in the acute phase, by establishing a standard guideline. The JSPN also joined the process of information provision by creating a mirror site of the NCNP information site.

Professional collaboration

JSPN's disaster response operations center also mediated collaboration with international societies, such as the World Psychiatric Association (WPA), by setting an international telephone meeting or by arranging presentations at such international meetings as the WPA. It also responded to an erroneous report from abroad, written by a person who came to

the disaster site immediately after the initial seism and jumped to the conclusion that Japan was ill-prepared to provide psychological care for victims, a statement that did not support but discouraged the care-givers, who would continue to live with the victims to take care of them. To make matters worse, the report emphasized that acute psychological intervention would prevent future post-traumatic symptoms, an idea no longer supported by any contemporary guidelines.

Research ethics

JSPN issued a statement¹¹ to promote the ethical awareness of researches, which was also a crucial concern. The boundaries between support and research can sometimes be obscured and some researches were actually planned and carried out without adequate ethical preparation. The Japanese National Ethical Guideline for epidemiological researches says that in emergency disaster cases, the dean of medical or other universities can give permission to research planning that meets the immediate needs of the victims without holding an ethical committee. Even such a simplified ethical procedure risks being ignored and could result in an abuse of victims through interviews about their distress, which they believe to be a support, but are actually aimed at research purposes.

Policy for acute mental health care

In post-disaster mental health care, humanitarian mental support tends to be confused with the psychiatric primary and secondary prevention of mental disorders, as is stated in the NCNP brochure, 'What is mental health care?' on the information website. Since the time of the great Kobe earthquake, we have experienced considerable confusion caused by the imported concept of psychological debriefing or any other acute psychological intervention focused on trauma. This concept not only said that it would be effective for preventing future post-traumatic symptoms but also nearly accused the local care-givers of not doing such an intervention and of leaving the victims in the malicious process of chronic agony. It is, of course, a precious human deed to sit aside victims and listen to their sufferings so far as it is desired by the victims themselves; however, it is a totally different story to unanimously encourage or force them to talk about terrible experiences and to

express deep sorrow and terror with risks of worsening their symptoms and preventing the natural recovery process, which is actually expected to occur in the majority of cases. The concept of the efficacy of early psychological intervention focused on trauma has been criticized and rebutted repeatedly; after the 9/11 terrorist attack the American Psychological Association issued a statement of warning against the technique of psychological debriefing.

Even when the psychological debriefing has been discarded as a credited early intervention, belief in the healing power of touching the trauma still prevails. An early international report¹² written by a temporary visitor positively reported an intervention carried out, also by a foreign visitor, with a child, who cried after his intervention. It revealed the risk that the child was just emotionally disturbed rather than being comforted by such a trauma-focused intervention by a visiting foreigner who was not accustomed to the manner of emotional expression in the local culture and where the intervention was not followed by sustainable psychological support in the community. The report is not only incorrect in its content, but also obstructs continuous mental care efforts on site.^{13,14} It would be an issue of further discussion why such a rash view is generated in the aftermath of a tremendous tragedy, with a split and inaccurate view of what is all good and bad.

The Japanese Guideline on Post-disaster Mental Health Care was published in 2004,¹⁵ in which an emphasis upon resilience and natural recovery process is clearly stated, and mental health professionals are requested to refrain from trauma-focused on-site intervention in the early phase. The guideline was disseminated by the MHLW to all the local area governments and has been used as an official standard guideline in post-disaster mental health care in Japan, including the disaster this time. After the tsunami disaster in Indonesia and Thailand, the guideline was translated into English, Indonesian and Thai. The outline of the guideline is attached as an appendix.

The Guideline stated that we should respect resilience and it is important to watch and wait for the spontaneous recovery process.¹⁵ Furthermore, psycho-education should be focused on the natural course of psychological response and how to cope with this, instead of threatening victims with the gloomy picture of their psychological outcome, while it is also important to offer an outreach service to help the vulnerable. Overall, the strategy of this guideline will be introduced in the following. The

guidelines from the National Institute of Clinical Excellence¹⁶ and Inter-Agency Standing Committee¹⁷ follow the same principle, however they were developed independently from Japanese experience, that watchful waiting is important, as is expressed in the NICE guideline.

Among Japanese mental health professionals, this view of psychological intervention in the acute phase has been widely prevailing, but it has not been disseminated into every corner of the activity. Some psychological professions and the media still emphasize the expression of traumatic memory as a useful way of preventive and healing intervention. The technique has been used even outside of the psychological profession: an organization tried to let affected children paint their psychological state and exhibited the paintings in order to show their power for recovery and to encourage the victims. The Association of Japanese Clinical Psychology issued a statement to warn against the popularized use of art therapy, stating that such therapy should not be done without a safe environment and that when paints are mixed they can generate horrible colors that can cause distress for children. There is a report by a clinical psychologist who witnessed such an activity in which a child became embarrassed, saying he could not understand why such an ominous color appeared in the sea that he painted.

Coherence of mental health professionals

As various organizations with different professional backgrounds, or even without professional expertise, tend to enter disaster sites to provide mental health care, it is crucial to keep a coherent purpose, the methodology of the care activity and to promote collaboration among different teams. For that purpose, sharing of information and the policy of mental-health-care provision is quite important, and medical-care teams need to reach a unanimous consensus on how to provide mental health care, in accordance with the Japanese Guideline on Post-disaster Mental Health Care, which was developed prior to the currently prevailing international guidelines, such as NICE or IASC, but shares the common basic policy for the management of psychological distress and for respecting resilience. Such sharing of information had to be renewed and maintained, receiving feedback from the onsite care activity.

The ongoing communication among different bodies was conducted by the crisis-response head-

quarters of the JSPN as mentioned above. The JSPN regularly held meetings inviting the representatives of the organizations that provide mental health support but also the directors of the mental health division of the afflicted prefectures and cities to update information of the effects of the disaster, the needs for mental health care and the overall situation of the people's recovery process.

Initially, activity had to be started amidst considerable confusion: due to the disruption of traffic and the inability to systematically access the afflicted coastal sites to evaluate the degree of psychological distress of the people and life burden, or the need for psychiatric services. So, the voice from the dispatched teams was a precious information resource, which was transmitted by the official documents via local governments to the national ministry, but the JSPN provided an occasion for direct and practical exchange of views, information and proposals. It provided interactive feedback from the scene of the disaster to the administrative offices regarding the principals. The meeting was held every 10–14 days, and adapted to the Skype system to communicate with the leading doctors and administrative directors in the afflicted sites, which was soon replaced by a television communication system.

The great difference from the previous disaster in Japan is that this time a number of opinion-makers in Japanese psychiatry came to be seriously concerned and devoted to the psychiatric care provided. Like most countries worldwide, psychological trauma has been an issue of only limited concern for the majority of psychiatrists in Japan, mainly because most psychiatrists have little chance to see victims of criminal offence, accidents, or disaster in their daily practice. This is partly because such incidents are rare and also because the victim would not receive psychiatric treatments for fear of insecurity of how they would actually be treated. PTSD and trauma-related mental responses were seriously discussed at the time of the Great Kobe Earthquake, but attracted professional concerns from a limited part of the country; Kobe was far from Tokyo and such a great disaster was supposed to occur only once every century. The debate over the robustness of the concept of PTSD also prevented some outstanding psychiatrists from getting involved in this field. This time, however, the site is nearer to Tokyo, and the anxiety about the pollution with radioactivity is so widely spread that no one around Tokyo can be a secure bystander.

Now the headquarters come to discuss a vision of how to renew the mental-health-care system in the affected areas. We should also remember that the suicide rates among those areas were the highest in Japan during the years before the disaster, and a number of reports on seasonal depression came from there. As some of the affected areas had been poorly equipped with mental health facilities and people's stigma against psychiatric disorders had been strong, a common phenomenon in local districts of Japan, a new system of community-based mental health care has to be established.

Summary

This report has described the outline of the initial mental-health-care responses on various levels. It has focused on the comprehensive strategies and policies that were intended to cover all the affected areas, and has not described the individual countermeasures and reactions in each prefecture and city. The psychological effects of the atomic plant accident in Fukushima has not been mentioned in detail, because the scope of the physiological effect of the accident has not been settled yet and the society is not necessarily ready to deal with the accident as a psychological matter rather than a sociopolitical one. As a number of psychiatric professionals are deeply concerned with the psychological and prolonged impact of the accident, including those who are in the Fukushima prefecture and conducting heroic efforts to care for the residents, the mental health activity in this area and the status of people's distress will be summarized elsewhere.

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APPENDIX

Guidelines for Local Mental Health Care Activities after a Disaster

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In the wake of recent natural disasters such as the Great Hanshin Earthquake Disaster (January 17, 1995) and disasters due to human crime or accident, the public as well as specialists in mental health in Japan have become keenly aware of the need for post-disaster psychological care, and a variety of practical work has been performed. In order to widely share what has been clarified through that experience, and link it to better programs in the future, we have drawn up these 'Guidelines for Local Mental Health Care Activities after a Disaster.' Posttraumatic stress and various other psychological reactions occur after a disaster, and it is vital to ensure not only accurate diagnosis, but also continued comprehensive provision of mental health care.

These guidelines are designed for the integration of all types of programs, with proposals based on accomplishing what is possible amid the chaos of a disaster situation. We have included with as much specificity as possible what has been learned in actual practice up to now about first contact, the importance of natural recovery from trauma, responding to multicultural contexts, and cooperation with volunteers and the press.

We hope that these guidelines will be widely used in disaster situations, and that the further experience of many caregivers will lead to their improvement in the future.

January 17, 2003

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Abbreviation of the Japanese National Guidelines for Local Mental Health Care Activities after a Disaster

Upon arrival at the disaster scene, the first requirement in providing mental-health-care activities is to support mental health centers in the afflicted communities so they can continue to carry out their mental health routines and treatments. In the case of Tohoku earthquakes, provision of medical assistance as well as medication supply took place immediately after the disaster in response to an interruption of medication delivery. In addition to supporting the local mental health centers, there are two main types of local mental-health-care activities targeting local residents affected by the disaster. The first type includes activities within the chain of general assistance programs which are designed to improve the mental health of the entire community as a group and to reduce the stress and mental trauma of the group. This type of activity consists mainly of ordinary assistance-givers and local mental health treatment staff going to the disaster area in outreach activities, delivery of disaster-related information, and psychology education for the general public. In addition, practical assistance for disaster recovery and life support in itself helps to improve the mental health of the community.

The second type includes prevention, early detection and treatment of particular mental disorders. The second type of activity consists mainly of screen-

ing individuals with mental disorders, encouraging people to come for consultations, providing psychology education for individuals, and making referrals to specialists. For the first 1–2 weeks or longer, the first type of activity will be the main focus. The health level of the community will be enhanced as relief workers enter the scene to meet and talk with survivors and victims and respond to their actual needs. The second type of activity should then follow and be directed toward alleviating states of confusion, excitement and disorientation, rather than making diagnoses.

Types of psychological burdens

There are three major types of psychological burdens following a disaster. *Mental trauma* is a condition in which the sympathetic nervous system stays overstimulated in response to a threat-to-life experience and is associated with the increased retrieval of traumatic memory. It can be characterized by heightened anxiety and fear, inability to take in the entire scene in front of one's eyes, and focusing of attention on the most fear-inducing stimulus. Acute memory of the disaster scenes and fears are deeply engraved in the mind. The second type includes emotional responses such as *Grief, Loss, Anger and Guilt*, and they may come to the fore after the initial disorientation and excitability have settled down. A person may be beset by a sense of heavy obligation for being the one who survived (survivor's guilt), grief following deaths of loved ones, or a feeling of having been unable to do the right thing. And at the same time, resentment at the fate that has befallen survivors may lead to anger toward relief workers or other people around them. *Social and Lifestyle Stress* is induced by a new living environment and can be characterized by physical or mental malaise, indefinite complaints, insomnia, and irritability. When a large group of displaced people live together, issues arise concerning privacy, the living space (food, toilets, garbage, duty assignments), and care for children, the elderly and the handicapped.

Initial response (during the first month)

Still the nature of the area or the disaster could make the situation unusual, requiring special measures which match the actual circumstances. With regard to the anguish arising from actual damage, the best response is to take whatever practical measures are

obviously required. Issues of survival, bodily health and living arrangements must of course be speedily resolved as the precondition for starting to deal with anxiety or other psychological reactions. But since those steps alone will not be enough to alleviate all of the terror, worry or other reactions, it is important to keep mental health issues in mind while responding to the urgent practical problems.

One of the most important immediate responses is to carry out 'first contact.' First contact means meeting and talking with survivors as soon as possible after the event by visiting them at the disaster scene and evacuation centers. If it is delayed, people will be left in anxiety, despair and confusion. As a rule, the early responders making first contact should be people who have served the needs of the local population on previous occasions. While carrying out first contact, when possible, the responders should try to identify individuals who are under especially strong stress and provide basic mental health information, such as the availability of psychological services.

The experience of disaster does not necessarily lead to post-traumatic stress disorder (PTSD). In disaster situations the most commonly observed causes of PTSD are personal experience of fire, flooding or house collapse, the death or injury of a loved one, or seeing corpses. Since there are many other kinds of psychological reactions that may occur after a disaster, mental health treatment is not focused on early detection and treatment of PTSD. Rather, it is important always to maintain the basic approach of readiness to identify a broad range of psychological changes, and to respond as appropriate with diagnosis, evaluation or assistance. Assistance should be provided to minimize the survivor's responsibilities for care of others, so that the survivor finds security, peace of mind, and restful sleep as soon as possible.

As a rule, in counseling soon after the event, do not ask the survivor to recount the story and emotional impact of the disaster experience. This can be harmful. It was previously thought that using this technique (psychological debriefing) at an early stage could help to prevent the future onset of PTSD. But the technique is now discredited internationally and avoidance is clearly recommended. What is important is to build a network around the survivor of understanding people who can talk together about the actual suffering in the disaster and subsequent difficulties in moving forward.

Natural recovery from trauma

For most survivors, even if there is some temporary mental instability, they will naturally return to their normal selves. As a policy for mental health care for the community as a whole, it should be assumed that natural recovery will occur in most cases, and support can be provided for that process. In supporting the process of natural recovery, it is necessary to provide conditions that encourage natural recovery and to diminish factors that impede natural recovery.

Conditions that encourage natural recovery include practical support, such as providing bodily safety, providing protection from secondary events, maintaining living conditions and continuity of daily life, offering prospects for recovering economic footing, and providing protection from day-to-day stress. General support, such as providing information on damage and assistance, and responding to requests and questions in a prompt manner, can be helpful. Informing people about expected psychological changes following a disaster is an important part of psychological care. Suggestions for counseling can be made when needed.

Factors that impede natural recovery are intrusions that cause secondary trauma or threaten the stability of daily life. Some of the most common factors include delayed assistance in rebuilding deteriorated living conditions and loss of family members. Special attention should be paid to those who belong to any of the especially vulnerable groups (infants, the elderly, the handicapped, the sick or injured, people whose first language is not Japanese, and families of any of these groups). Socially isolated persons (single persons, people with nobody outside the family to talk to) should also be considered as vulnerable. Other common factors include being interviewed by the media against a person's will and having inspections by the police, public officials, insurance companies, etc.

Multicultural issues

Regardless of purposes of stay, most foreigners are considered as especially vulnerable to disaster because of their limited comprehension of the language spoken in the afflicted area. In general they cannot fully grasp public information, and are therefore liable to suffer secondary uncertainty anxiety. In addition, depending on their native

culture, foreigners are likely to have different patterns of reaction to a disaster. This may well lead to complications in the course of group activities and refugee shelter living, and mental-health-care supervisors will need some special understanding to rectify them. It would be helpful to have volunteers who can speak the native languages of the foreigners, but it is often impossible to have the right people on hand in the disaster setting. When there are multicultural needs, it may be possible to have linguists from outside the area prepare special messages for public information releases, or to request the media to prepare multilingual versions of disaster information broadcasts. Even though foreign-language versions may be less complete than the originals, the mere fact that information is provided in their native language will provide valuable reassurance to these survivors.

Mental health of relief workers

Relief workers can be fatigued from ongoing pressure of relief work. They may face limitations in performing a task in the ideal fashion. It is possible that a psychological conflict between the sense of mission and the limitations of reality will cause feelings of guilt or powerlessness. Amid the extensive damage and suffering, area residents often display emotional reactions such as anger and guilt. It is not unusual for survivors to release their anger toward relief workers who are in the vicinity. If the workers feel like the anger is personally directed toward them, they may come under considerable stress. In addition to the stress of carrying out duties, relief workers are quite likely, even more than most local residents, to be exposed to the sight of terrible damage, corpses and the like, which may result in PTSD or other trauma reactions. It should also be noted that some relief workers may be disaster victims themselves, and they are at risk of extra psychological tensions and exhaustion. Adjusting to a new place and being away from home may also cause considerable stress, especially if the assignment is for an indefinite period.

Relief workers may tend to neglect their own health issues or, even when they recognize them, have too strong a sense of mission to take breaks or seek treatment. The following are some of the

countermeasures that can be helpful to relief workers. Although it may not be possible during the emergency phase just after the event, as soon as it is practical, the activity periods, relief schedules, responsibilities and job descriptions must be clarified for all mobilized relief workers. It is effective to teach relief workers that stress is nothing to be ashamed of, but instead must be recognized and adequately treated. It is important to give each relief worker a check-list of potential physical and mental irregularities, and when necessary to offer health counseling.

Postface

These principles mentioned above have been widely known to relevant authorities and organizations in Japan over the past decade and regarded as the basic principles of post-disaster mental-health-care activities. It appears that most of the mental-health-care teams have been following these basic principles in their relief efforts for the afflicted areas in Tohoku. Nowadays few believe that it is beneficial for the survivors to recount the emotional impact of the disaster experience soon after the event, but there are a few reported cases in which some relief workers of non-clinical backgrounds have used somewhat similar techniques. Further measures have to be taken to disseminate the knowledge to all relief workers regardless of their backgrounds, in order to deliver more effective post-disaster mental health care.

This study was funded by the Ministry of Health, Labor and Welfare. The original document is available at National Center of Neurology and Psychiatry.

Supporting Information

Additional Supporting information may be found in the online version of this article:

Guidelines for Local Mental Health Care Activities after a Disaster

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One main obstacle to being open to these questions is the pressure on epidemiologists, managers, and academics to collect data in a vertical fashion. Yet violence cannot be seen as detached from infectious disease, maternal mortality, drug addiction, or unemployment. The Family Health Strategy, cited in most of the Series papers, has been a vehicle by which many vertical actions have already been integrated, and the results have been well studied.³ What readers really need to know are the obstacles to going further in this regard.

The outcome of *The Lancet's* Series is a collection of excellent health data empty of relevant messages for taking decisions around health-policy organisation. There is a need to understand health in Brazil in terms of the best answers to health service problems.

We declare that we have no conflicts of interest.

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Post-disaster mental health care in Japan

International guidelines and principles for the promotion of psychosocial wellbeing and the prevention or treatment of mental health problems in humanitarian settings are often ignored, and Justin McCurry's World

Report on Japan (March 26, p 1061)¹ is an example.

McCurry does not seem to have sought input from relevant mental health authorities within Japan, and instead cites "experts" as stating that "thousands of victims will be in need of long-term trauma counselling" and that "children who have been caught up in disasters can develop behavioural and mental health problems unless they receive counselling at an early stage".

Such statements are not consistent with guidelines² or published data³ and thus send inaccurate messages. Guidelines recommend that children are best helped by reinforcing supportive family and community structures, and by restoring routines and culturally accepted activities; only a minority of children and adults will need specialised mental health services.^{2,4}

Japan has considerable experience and expertise in the field of mental health and psychosocial support. The Ministry of Health, Labor and Welfare quickly mobilised human resources and guidance including from the Japanese Society of Psychiatry and Neurology and the League of Psychiatric Departments of Universities. Japanese response and support systems (including mental health care) for this disaster will be reported soon elsewhere.

We are keen to learn from international experiences and appreciate the support from international actors. However, as the Inter-Agency Standing Committee guidelines² note, responses must be coordinated, evidence-based, culturally informed, and build on existing capacities.

We declare that we have no conflicts of interest.

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In his World Report,¹ Justin McCurry succinctly highlights the difficulties facing the surviving victims of the earthquake and super-tsunami in northeastern Japan on March 11. However, he misrepresents existing mental health-care provision in two respects.

First, his statement that "Japan's health system is ill prepared to address long-term mental health problems triggered by the disaster" does not accurately reflect the situation. Although existing provision is not perfect, valuable lessons about post-disaster mental health have been learned since the two previous major disasters at Kobe in 1995 and Niigata in 2006. In 2001, the National Center of Neurology and Psychiatry issued national guidelines for post-disaster mental health,² and several thousand caregivers have been trained in traumatic stress counselling over the past few years. The directors of most mental health centres have attended lecture courses in post-disaster mental health care. As a result, responses to the present disaster were very rapid, allowing prompt scheduling and dispatch of mental health-care teams to the devastated areas.

Second, we were concerned about the inclusion of comments from Stephen McDonald of Save the Children on the fear expressed by a child he had interviewed, and the assertion that lack of counselling in the early phase can lead to subsequent mental and behavioural problems. There is no evidence for this statement. As recommended in



Corbis

the guidelines produced by the UK's National Institute for Health and Clinical Excellence,³ human suffering should not be too readily medicalised, and resilience should be respected. There is a possibility that early and temporary counselling focused on traumatic memory or fear could generate harmful effects, and there is no evidence for its efficacy in preventing the symptoms of traumatic stress.^{4,5}

McCurry's concern for the plight of the disaster victims is, of course, well intentioned, but we believe that a better balanced and more comprehensive picture of mental health care in Japan would have been conveyed if opinions had been sought from Japanese health-care professionals.

We declare that we have no conflicts of interest.

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See Online for webappendix



Life, health, and community in a tsunami-affected town

Toshiro Ueta, a general practitioner in Otsuchi Town, Iwate prefecture, Japan, was examining his patients when a massive earthquake hit eastern Japan on March 11. He and his staff escaped immediately after the earthquake to

the roof of their four-store building, where they watched the town become submerged under water. After having spent a night there, they were rescued and taken to an evacuation shelter. Ueta acted immediately by arranging desks and providing free medical consultations.

Nagasaki University medical relief team joined the efforts of Ueta from March 16. The shelter-based clinic provided everyday consultations to 70-90 patients who came from the shelter and its neighbourhood. The most common reasons for presentation were the need for repeat routine medications, upper respiratory-tract infections, and insomnia apparently related to the increasing stress.

One of the major features of this disaster was that it hit areas with a high level of population ageing. 27% of Iwate's population was 65 years of age or older in 2010.¹ Of 221 evacuees at the shelter on March 28, 84 (38%) were aged 65 years or older. Such an age structure was the reason behind the high need for routine medications. Many had chronic diseases—eg, hypertension, diabetes, and heart disease. The major challenges for the providers were to identify the medicines that patients had been taking. Pills and patient-held records were commonly lost with the tsunami. Pharmacists had a crucial role in the identification and selection of alternatives from the 100 or so types of available medicine.

A possible infectious disease outbreak was also a concern. Tap water and sewage systems were destroyed, and evacuees were advised to wrap their stools in newspaper and place them in a plastic bag. But when patients with acute gastroenteritis suggestive of norovirus infection were found, we facilitated improvement of hygiene measures, introduced chlorine-based disinfectants, and promoted accurate knowledge of virus transmission.

Despite very challenging conditions, people have worked tirelessly. What was extremely impressive was that evacuees at the shelter organised a

functional community. Representatives met every night to discuss the shelter's rules. People shared the chores of serving meals and cleaning the living spaces and toilets, and took routine physical exercise together.

External support and interventions should be made in collaboration with such local efforts in planning public health interventions and fostering a safety net in communities.

We declare that we have no conflicts of interest.

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- 1 Ministry of Internal Affairs and Communications. Declining birth rate and aging population. http://www.stat.go.jp/english/data/handbook/c02cont.htm#cha2_2 (accessed June 7, 2011).

Support for senior management at Great Ormond Street Hospital

The anonymous letter¹ you published online on July 1 does not, we believe, reflect the majority view of the senior staff at Great Ormond Street Hospital, London, UK. We have seen no evidence of bullying of staff who have raised concerns about clinical risk with management. It is regrettable that patient safety issues are being used as a political weapon, and that this will cause anxiety for our patients and their families.

We all support the Chief Executive and senior management of Great Ormond Street Hospital.

For the full list of signatories, see webappendix.

Jon Goldin, on behalf of 107 consultants and 52 other senior staff members
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- 1 Anon. GOSH consultants express alarm. *Lancet* 2011; **378**: 123.

The Great East Japan earthquake in 2011; toward sustainable mental health care system

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In face with a triple disaster of earthquake, tsunami and nuclear power plant accident, the degrees of which are historically hardly preceded, immediate mental health countermeasure was taken by the initiative of the national and local government together with academic and clinical organizations. Based on previous experience of natural disasters, more than 50 mental health care teams have been organized and dispatched to the affected areas, scheduled by the Ministry of Health, Labor and Welfare. When 6 months have passed, the acute and temporal support system should be replaced with more sustainable local networks with aims at promoting resilience, though community psychiatric service should be developed as well. Existing guidelines should be respected but actually it tended to be only partially recognized. In Fukushima prefecture, where nuclear plant accident occurred, its mental health impact is most concerned and long-term follow-up of the residents' health has been being planned.

Key words: Earthquakes, mental health, natural disasters, post-disaster intervention planning.

Outline of the disaster

At 14:46 local time on Friday, March 11, 2011, an unprecedented magnitude 9.0 earthquake occurred off the Pacific coast of northeastern Japan (the so-called Tohoku region), including Iwate, Miyagai and Fukushima prefectures, and the ordinance-designated city of Sendai, located within Miyagi prefecture. According to the Japan Meteorological Agency, the epicenter was located 130 km off the Oshika Peninsula and 24 km below sea level. A number of aftershocks followed, the largest one being of magnitude 7.7 occurring on the same day, followed by 6 quakes of magnitude 7 or more, 96 of magnitude 6 or more and 579 of magnitude 5 or more. Quakes of lesser magnitude occurred almost everywhere across the Japanese archipelago.

Historically, the affected areas had always been prone to major seismic events; the oldest record dates back to 879, when an earthquake with an estimated magnitude of 8.6 occurred, based on geological surveys. In recent years, magnitude 7–8 quakes also occurred in 1896, 1933 and 1968, all accompanied by tsunami. Therefore, it was assumed that local governments and inhabitants would have been well prepared for any tsunami disaster, having conducted escape training and building seawalls that were considered capable of withstanding waves several meters high.

The Meteorological Agency issued a tsunami warning as soon as 20 min after the initial major quake, but failed to appreciate its actual extent, which could not be measured adequately with ordinary equipment. The height of the tsunami was far beyond what had been anticipated, reaching 9.3 m in the Soma region of Fukushima and 8.5 m at Miyako city in Iwate prefecture, swallowing fields, houses and people. Some locals had placed such trust in the seawalls that they did not take immediate action to escape to higher ground. Others took refuge on the top floors of shore-front buildings in accordance with training instructions, but were engulfed by the tsunami.

Initial response

With regard to mental health countermeasures in the acute phase, the main issues of concern were the continuation of previous psychiatric services and the supply of necessary medical drugs, as well as the treatment of acute mental disorders such as panic, delirium or acute stress reaction. Such issues were complicated by extensive disruption of the infrastructure by heaps of debris, making it difficult to supply gasoline, fuel and vital supplies. For these reasons, even local government officials had considerable problems getting into the affected coastal areas 100–200 km away.

All these factors made the community psychiatric services very fragile. Some hospitals had collapsed, or sufficient staff could not commute to them, making it impossible to continue inpatient services, or for

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