A. 研究目的

災害時の精神保健対応に関しては、時間経過に応じた各組織の動きや、組織間の連携等についての理解や文献はこれまでに少なかった。このため、H22 度の研究では、大型自然災害の対応の中から、精神保健対応に焦点をしぼり、郡部版および都市部版のクリティカルパスを作成した。本分担研究では、健康危機発生の各フェーズにおいて効果的な精神保健医療・ケアを保証する体制のモデルを提示することを目的に 22 年度に作成したクリティカルパスの修正と課題の整理をおこなった。

B. 研究方法

東日本大震災において、H22 年に作成した郡部版クリティカルパスを参考に、東日本大震災において岩手県精神保健福祉センターで精神保健福祉活動の調整業務を実際に行った。その対応結果と、当時の心のケアチームの診療録の集計解析、報告書や日誌等の資料レヴュー、研修とヒアリングに基づいて、クリティカルパスの修正をおこなった。

C. 結果

以下の経験と結果をもとに、クリティカルパスを修正作成した（表）。

I　岩手県の精神保健課題と東日本大震災による被害の概要

岩手県は、総人口は 1,385,041 人で、老年人口は 24.5%（全国 6 位）である。「厚生労働省 H20 年医師、歯科医師、薬剤師調査」の結果では、都道府県別 1㎢あたりの医師数は北海道についで 2 位である。精神保健指定医は 102 人（H20）で、盛岡市や内陸部に集中しており、広域、過疎化の進行、医療資源の不足という地域特性がある。地域の精神保健課題は自殺であり、H22 は、自殺死亡率（10 万対）32.2 でワースト 2 位であった。自殺対策のプロジェクトは、このような医師・医療資源不足を考慮して、住民活動や保健福祉活動によるものが中核となってきた。例としては、6 つの骨子（一次予防、二次予防、三次予防、職域へのとりくみ、精神疾患へのとりくみ、ネットワークづくり）からなる郡部の自殺対策包括プログラム「久慈モデル[1)]」があげられる。このプログラムは、県内 33 市町村のうち 28 市町村が実施してきた。

2011 年 3 月 11 日、東北地方の太平洋側に位置する三陸沖を震源としたマグニチュード 9.0 の地震により、岩手県内は最大震度 6 弱を観測した。この地震及び津波によって、岩手県では 2012 年 3 月 11 日現在、死者 4,671 人、行方不明者 1,249 人、家屋倒壊数 24,747 棟の被害を受けた。医療機関は、全壊（１９）、半壊（３８）した。避難所などへの避難は最大 54,429 人となった。被害額は沿岸資産の 47.3%にあたる 4 兆 2,760 億にのぼった。

II　調整の実際

岩手県精神保健福祉センターは、被災沿岸部からおよそ１００㎞離れた内陸部の盛岡市に位置している。全国 68 ある精神保健福祉センターの規模や役割は様々であるが、当センターは、相談機能のみで診療所機能を有しておらず、この他には行政業務と県の技術支援業務を担っている。今回の心のケアに関する調整活動は、精神科医、臨床

心理士、保健師、事務職、非常勤職員の中から８人が担当した。

１）フェーズ０～１

３月１６日には、岩手県災害医療支援ネットワーク会議が立ち上がり、支援チーム全体の管理が開始された。当センターは、３月１２日～１５日に、調査班による情報収集を行い、DMAT やチーム活動がスムーズに流れてきたことが確認できたため、同月１６日に窓口を開設し、対象被災地４保健医療圏（久慈、宮古、釜石、大船渡）のこころのケアチームの受け入れ調整を開始した。岩手医科大学チームの活動は 17 日に、県外こころのケアチームの支援活動は 23 日に開始となった。

当センターの調整手法は、（図１）の通りである。全ての心のケアチームには、当センターのＨＰを確認，電話での受付を通過し、オリエンテーションを受けていただいた後、被災地ケアにあたっていただいた。HP には、本クリティカルパスの他、被災地の精神保健医療情報シート、アクセス情報、生活情報、岩手県心のケアマニュアル等を掲載し、６月までは毎日、７月以降は週２回、８月以降週１回を目安に更新した。この他、ML の設置、３回のメディアカンファランスを行いながら調整にあたった。

２）フェーズ２

中期は、継続支援が決定した１０の心のケアチームの調整を続けた。活動記録の回収・集計も軌道にのり、被災地支援者やケアチームへのフィードバックが可能となった。

３）フェーズ３

（１） 心のケアチームから被災地への活動の引き継ぎ

24 年２月 15 日、岩手県は県央の盛岡市に心のケアセンターを設置し、岩手医科大学に運営を委託した。同年３月 28 日には、沿岸被災地４か所（釜石、大船渡、宮古、久慈）に地域心のケアセンターを開所した。心のケアチームが同定した延べ 9681 件の相談の中で、フォローが必要な者やハイリスク者への管理と対応は、岩手県精神保健福祉センターから、心のケアセンターに引き継いだ。その際に、全ての相談者の、心のケアチームが撤退し支援が終結した後の転帰を再度確認した。多くの相談者は相談が終結しているか、または地元の精神医療資源や医療資源等につながり、治療の場が移されていた。診療中断や不明の者は地域によって差があった。2012 年６月 30 日現在、心のケアセンターは、被災地全体で延べ 642 件の相談やアウトリーチを継続している。

（２） 精神保健活動の事業再開と継続

ハイリスク者への対応は上述したとおりだが、ポピュレーション対応を含めた地域保健活動については、H23 年 11 月に、震災以前に取り組んでいた自殺対策「久慈モデル」の再開状況の調査を開始した[2)]。この調査の中では、実施している 28 市町村のうち全市町村の取り組み再開の意思を確認した。当時問題点として多くあげられたのは、研究で住民に実施した精神保健スクリーニングのフォローが被災地に任されたが、ハイリスク者に全く対応しきれていないといった点であった。

当精神保健福祉センターの活動を振り返ると、優先業務である精神医療審査や自立支援医療審査件数は、平時と比して横ばい

であり、早期以降は活動継続が可能であった。H23年の精神保健福祉相談窓口の電話件数は、3524件であり、アルコール問題の相談が若干増加した。24年2月～3月には、沿岸部に心のケアセンターが開所したため、当センターでは4月以降は、非被災地である内陸部を中心とした市町村や関係機関への自殺対策に関する技術支援を再開した。しかしながら、通常業務の再開から5カ月（被災後1年5カ月）後も、それは平時と比して円滑になされなかった。例えば、これまでは久慈モデルを推進する為のワークショップは年に6回程度実施していたが、24年以降は1回の実施にとどまっている。そして各市町村や関係機関へ出向く働きかけは、アセスメントも十分にできていなかった。この事の背景については、①多領域の窓口における相談件数やプロジェクトの増加と、その関係者への精神保健技術支援のニーズの増加、②県外からの、調査やヒアリングや報告機会の増加、③支援者・救援者へのケアの機会の増加と産業保健領域との連携、等があげられ、従来業務やプロジェクトの再開と継続に影響した[3)]。新規に心のケアセンターは開設されたが、活動の体制が整うまでにはどうしても時間が必要となった。心のケアセンターはその規模も大きいため、予算ベースで考えれば十分に心のケア体制は整ったと理解され、それ以外の既存の精神保健医療体制へは新たに予算も人も配置されにくい。しかし、開設後数か月～1年の移行期間における、地域の精神保健の技術支援や調整、支援者・救援者ケアを、具体的に誰がどのように実施するのかは今後検討する必要がある。すなわち、いずれかの既存機関の事業継続計画の中に、予め盛り込んでいたほうが現実的に住民のニーズに対応でき、現場は混乱しない。また少なくとも中期までの連携会議の段階でそのような点は話し合う必要がある。

III. クリティカルパスの利用の実際

クリティカルパスシートは、災害初期から中期の混乱した調整場面において、多様な心のケアチームやボランティア団体、メディア間の「心のケア」の共有化の簡便なツールとして多用した。前述したように、当精神保健福祉センターHPに貼り付け、こころのケアチームには、確認の上被災地に入ってもらった他、全てのチームに実施したオリエンテーションで改めて説明し、全体理解の共有化を図った。

また、精神保健関係者に対する研修は、パスに基づいて行った。特に最終年度は、支援者32人に加えて、住民による自殺対策の担い手である傾聴ボランティア団体311人にも行った。支援者への研修後実施したアンケート結果では、32人中29人が理解できた、役に立ったと述べている。傾聴ボランティアの研修であげられた感想としては、「時期によって相談の内容や様相が変化する点は、被災地のボランティア活動の経験上気づいていたが、知識として整理して理解できた」等があった。

IV. 心のケアチーム診療記録の集計結果

2011年3月11日から2012年3月11日までに活動した心のケアチームの診療記録は概ね全て回収にでき、まとまった情報を得られた。全30の心のケアチームの活動により同定された9,681人の主訴の経過は図

２のとおりである。

クリティカルパスの各フェーズにおけるターゲットの症状と今回の結果を比較すると、不眠不安の訴えが初期から継続して多かった。アルコール問題や抑うつはこれまでの経験同様、フェーズ２以降に増加した。希死念慮、自責感、喪失感の訴えは初盆の2011年８月と2012年３月に増加が見られた。

D. 考察

クリティカルパスは、想定外の被災状況でも最低限必要な視点を提供しうるが、平時の精神保健活動の基盤が、イニシアティブモデルではなく、PDCAモデルにおけるプロセスの継続と繰り返しという視点を持つような行政体制においては、被災地域の平時の各精神保健医療プロジェクトの再建のために現実的に作成され、より定着し展開すると思われた。当然、元々精神保健福祉活動が殆ど行われていない地域においては、フェーズ３の「事業再開」も検討する必要はなく、あまり意味をなさないだろう。さらに、災害は、一つとして全く同じ状況はありえないからこそ、モデルとしての理解と蓄積は、今後の被災現場で現実的な調整機関や介入方法を考える上でのたたき台になるものと思われた。

E. 結論

東日本大震災の被災と実際の調整業務経験にもとづき、大型自然災害発生時の精神保健対応に関する郡部版のクリティカルパスの修正と作成をおこなった。今後の行政における援用上の課題を指摘した。

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F. 研究発表

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G. 知的所有権の取得状況
なし

表　大型自然災害時の精神保健対応クリティカルパス（岩手版）

フェーズ	フェーズ0 （救助が来るまで：数時間、数日） 各現場	フェーズ1 （救出・救助・救急：数日） 救護所、遺体安置所	フェーズ2 （医療保健：数週間） 避難所、自宅、医療機関	フェーズ3 （保健福祉：数か月） 仮設住宅
ターゲット	・精神不穏、不眠、不安	・精神障害者の状況悪化 ・悲嘆反応 ・スタッフの惨事ストレスによる急性反応	・服薬中断 ・適応障害、不安障害、PTSD等 ・アルコール関連障害 ・スタッフの疲労の問題の顕在	・うつ病、自殺、喪失感
ゴール	自助・互助による静穏化	ハイリスク者の同定、連携治療	ハイリスク者の同定、連携治療	ハイリスク者の同定、連携治療、チームから地域へのケース引き継ぎ
本部 （本庁、精神保健福祉センター等）	・情報収集と発信 ・精神保健活動方針の決定（精神科救急システム調整、ケアプランの確認等） ・人的支援（外部・内部）の派遣要請と調整			・活動の評価、継続支援の検討、活動報告会の開催 ・新規心のケアセンター等の設置準備とその活動開始までの調整活動機関の確定　・ヒアリングや報告対応
保健所	・精神保健福祉医療資源の被災状況や避難所などの保健体制の確認、ハイリスク者に関する情報収集、本部への人的支援の派遣要請と調整		・ケア会議、研修会、連携会議の企画 ・スタッフの心のケアチェック、産業保健領域との調整	・人的支援の終了時期検討 ・精神保健通常業務の継続と再開の評価・ヒアリングや報告対応・外部チームからのケース引き継ぎ
市町村	・精神保健福祉医療資源の被災状況や避難所などの保健体制の確認、ハイリスク者、要援護者に関する情報収集、本部への人的支援の派遣要請と調整		・ケア会議、連携会議の企画 ・スタッフの心のケアチェック、産業保健領域との調整	・人的支援の終了時期の検討 ・精神保健通常業務の継続と再開の評価・ヒアリングや報告対応・外部チームからのケース引き継ぎ
医療機関	・各機関における情報収集、連絡、精神保健活動方針の決定		・精神医療の実施 ・連携会議への参加 ・スタッフの心のケアの検討	・ヒアリングや報告対応
医療チームまたは心のケアチーム	・派遣準備	・ファーストエイドの実施、情報提供、精神科救急業務	・精神保健相談（訪問、窓口）、医療や情報提供の実施、ケア会議の参加	・地域保健や産業保健領域へのケースの引き継ぎ
保健チーム	・派遣準備	・ファーストエイドの実施、情報提供	・精神保健相談（訪問、窓口）、健康教育や情報提供の実施、ケア会議の参加	・地域保健や産業保健領域へのケースの引き継ぎ

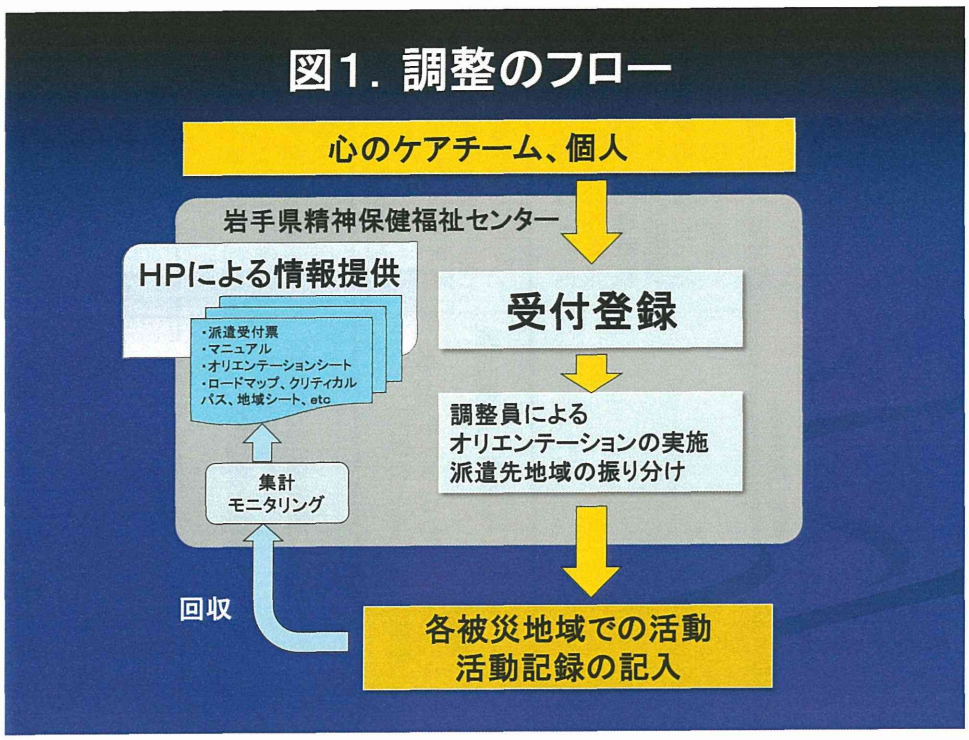
図1. 調整のフロー
心のケアチーム、個人
岩手県精神保健福祉センター
HPによる情報提供
・派遣受付票
・マニュアル
・オリエンテーションシート
・ロードマップ、クリティカルパス、地域シート、etc
受付登録
調整員による
オリエンテーションの実施
派遣先地域の振り分け
集計
モニタリング
回収
各被災地域での活動
活動記録の記入

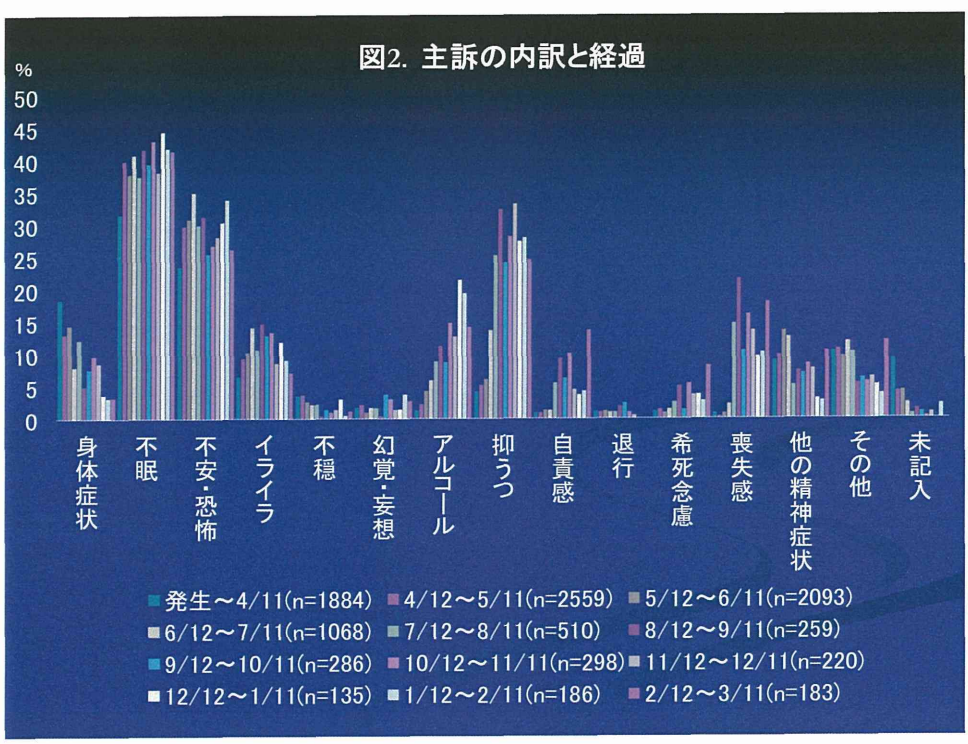
図2. 主訴の内訳と経過
%
50
45
40
35
30
25
20
15
10
5
0
身体症状
不眠
不安・恐怖
イライラ
不穏
幻覚・妄想
アルコール
抑うつ
自責感
退行
希死念慮
喪失感
他の精神症状
その他
未記入
発生～4/11(n=1884)
4/12～5/11(n=2559)
5/12～6/11(n=2093)
6/12～7/11(n=1068)
7/12～8/11(n=510)
8/12～9/11(n=259)
9/12～10/11(n=286)
10/12～11/11(n=298)
11/12～12/11(n=220)
12/12～1/11(n=135)
1/12～2/11(n=186)
2/12～3/11(n=183)

III. 研究成果の刊行に関する一覧表

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Ⅳ. 研究成果の刊行物

2 Mental health policy and services
Where we stand

Hiroto Ito

Introduction

A fundamental challenge in mental health policy is to establish a system that provides better mental health care. To accomplish this goal, it is necessary to improve access to mental health care and to provide quality services, while at the same time controlling costs. It is difficult, however, to establish a system that maintains a balance between access, costs and quality care. In addition, there are increasing calls for community care, rather than inpatient care, for persons with mental illness.

To date, Japan has developed many initiatives to address these issues. In 1961, when Japan was entering an era of high economic growth, the government implemented a universal health insurance system that provides free access to health care by allowing people to use health insurance at any medical facility.[1] The number of psychiatric hospital beds was concurrently increased so that persons with mental illness, who had not otherwise had access to psychiatric care, could receive appropriate treatment.

As 50 years have now passed since the universal health care system was introduced, certain institutional problems have begun to emerge. Although the need for a transition from inpatient care to community care was identified in the 1960s, no notable changes have been made, at least as far as the number of psychiatric beds is concerned. Because of the high economic growth achieved early on ahead of other Asian countries, Japan has been faced with issues relating to the universal health care system and an excess of psychiatric beds since the 1980s.

Japan's health policy has not received much international attention. Consequently, the large number of existing psychiatric beds has continued to be raised as an issue, despite the fact that Japan's mental health policy and services have changed considerably.[2,3]

In this chapter, current developments in mental health policies in Japan are reviewed for a better future.

Mental health needs

Health care for people with mental disorders

Figure 2.1 shows changes in the number of patients' visits over time according to the Patient Survey, which is conducted every three years by the Japan Ministry of Health, Labour and Welfare. The numbers of patients with cancer, acute myocardial infarction, stroke and diabetes have not changed so much, but that of mental disorders has increased since 2002, primarily due to the increase of outpatients with depression. About one million people are medically treated.

Patients with schizophrenia were used to being hospitalised, and those who admitted in 1950–70 are now long-stay elderly patients. In recent years, however, the proportion of young long-stay patients has decreased, and newly admitted patients are discharged sooner. A new facility other than a hospital is required for this patient group in the community where physical care is also available.

In Japan, patients with dementia have been treated in psychiatry. Although patients suffering from dementia are common in general hospitals and geriatric facilities in reality, the dementia unit can be established in only psychiatry under the health care system. As the society is rapidly ageing in Japan, it affects more and more people, and a national strategy is urgently needed.

Mental health in the general population

Japan has had one of the world's highest suicide rates for years, and it remains above 30,000 for the thirteenth straight year. The suicide rate rose from 18.8 suicides

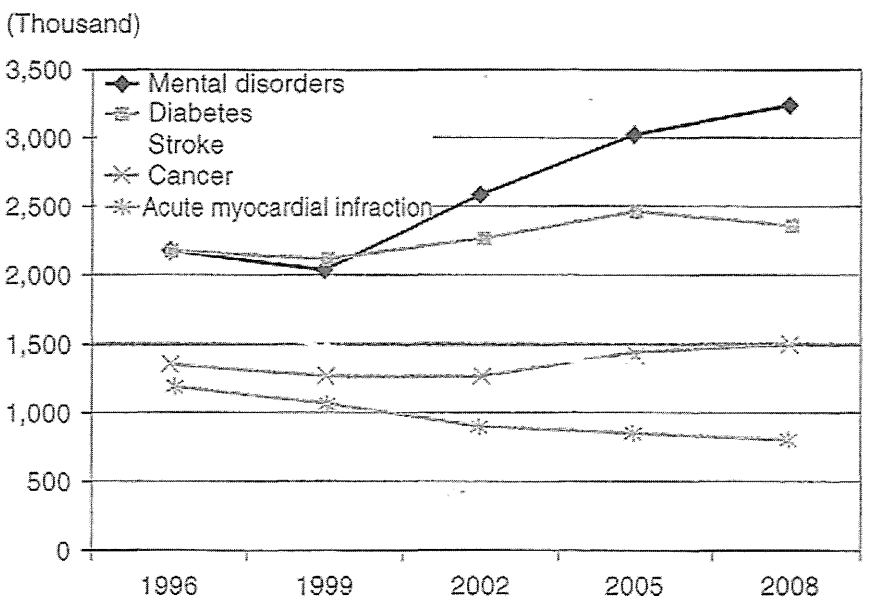

Figure 2.1 Number of patients.*

Note: * Patient Survey.

per 100,000 population in 1997 to 24.9 per 100,000 in 2010.[4] A prolonged recession seems to affect this trend. The National Police Agency suggested common reasons including health concerns, unemployment and financial difficulties. As suicide is a major issue in Japan, the Basic Act on Suicide Prevention was enacted in 2006. Multidimensional countermeasures are being implemented through both the high-risk group approach and population approach, but unfortunately the suicide rate does not appear to be declining as expected. The Japanese Medical Association developed and distributed the *Manual for Suicide Prevention for General Practitioners: Early Detection and Treatment of Depression* to educate physicians via training programmes. A nationwide suicide prevention study has accumulated data since 2005. The results will be reported soon. Further effective plans based on those results are needed.

On 11 March 2011, Japan experienced a devastating earthquake, the biggest one since 869, in east Japan. The subsequent tsunami with more than 30-metre waves killed nearly 16,000 people. More than 3,000 are still missing. Also, the Fukushima Nuclear Plants were seriously damaged by the tsunami. The three tragedies (earthquake, tsunami and radioactive contamination) simultaneously affected the mental health of the earthquake and tsunami survivors. Long-term care should be prepared for the affected people, especially children.

Mental health services

Acute psychiatric inpatient care

Case A: a 35-year-old man with schizophrenia. Onset occurred at the age of 20 when he was in his third year of university and he was involuntarily admitted to a psychiatric emergency unit. After 40 days, he was discharged to outpatient care and returned to university. The patient obtained a bachelor's degree, and worked part-time after repeating a year. He then started work at a small factory owned by his father. At age 28, the patient relapsed because he did not comply with his medication regimes, and he was voluntarily admitted to an acute psychiatric care unit for 20 days. Since then, the patient has been able to control his condition, and he visits the outpatient clinic twice a month and continues to hold down a job while taking medication.

The increase in the number of psychiatric beds, which started in the 1950s, came to an end in the late 1980s, when the beds were divided into acute psychiatric units and long-term care units. Then, in 1996, with a focus clearly on health insurance reimbursement, acute psychiatric care units were established under a provision that limited hospital stays to approximately three months, generating one and a half times higher reimbursement than that of general inpatient psychiatric units. Furthermore, in 2002, psychiatric emergency units were established in community hospitals with approximately three times higher reimbursement than that of general inpatient psychiatric units. In Japan, there are approximately 100 hospitals with a psychiatric emergency unit and approximately 200 hospitals with an acute

psychiatric unit. These two types of units are operated under a provision that limits the length of hospital stays and that more than 40 per cent of the patients be discharged into the community within a specified period.

Community care provided by psychiatric hospitals

Case B: a 58-year-old man with schizophrenia; he developed the condition when he was 18 years old. Highly resistant to being seen by a psychiatrist, he remained untreated. At age 25, he was, at the behest of his family, admitted to a psychiatric hospital built nearby. At the time, patients were often long-term inpatients. He was hospitalised for 15 years. When the hospital director was succeeded by his son, the treatment policies were changed, and the new hospital director recommended that he should be discharged. Several facts became apparent regarding this long-term inpatient. He had no friends and his parents were elderly so he could not live with them. He had resided at the hospital for many years and was anxious about leaving, so he was discharged to a group home near the hospital. Upon discharge, he initially had periodic outpatient visits and used day care services, but he gradually became accustomed to communal life with patients who had been similarly discharged. Until recently, he helped out at a bread factory started by the hospital while receiving job assistance. He is currently working with a meal service run by the hospital to provide meals to elderly nearby. He delivers meals to the homes of the elderly by bicycle. Elderly clients appreciate the service and he finds the work worthwhile.

More than 80 per cent of Japan's psychiatric hospitals are privately run. Taking advantage of financial support for construction of psychiatric hospitals in the 1950s and 1960s, outpatient clinics built up psychiatric beds and subsequently became psychiatric hospitals. In the 1990s, these facilities were no longer able to increase the number of beds. In addition, revenue per day for treatment in a long-term care unit was equivalent to revenue per day for community care combining outpatient care and day care. To increase the number of admissions of new inpatients and utilise beds for acute inpatient care (which offered substantial medical fee reimbursements), hospitals began gradually discharging long-term inpatients. Discharged patients transfer to group homes built by psychiatric hospitals. However, patients who cannot be provided with a discharge destination, e.g. a group home, remain as long-term inpatients. Many of these individuals have already reached age 65, they have diminished activities of daily living (ADL), and they also have physical conditions as well. As things stand, these individuals still cannot be discharged.

Community care team

Case C: a 40-year-old male with schizophrenia has received nurse's home visits from a visiting nurse station for the past five years. The nurse visits him about twice a week. In addition to making sure that he takes his medication, the nurse advises

him on everyday activities. He is prescribed an antipsychotic by a clinic twice a month. When his condition worsens, he receives almost daily visits by the nurse, and at times he also sees the clinic's psychiatrist. Prior to receiving visiting care, he was hospitalised about three times a year, but in the last five years he has only had two short stays in hospital.

Amendments to the Mental Hygiene Act in 1965 required the establishment of publicly run community mental health centres, and public health centres were positioned as the first line of community mental health services. Home visit services were increased until the early 1990s. Due to financial difficulties faced by local government, provision of these public services has been scaled down since the late 1990s.

Home visit services are limited in public health centres and mental health and welfare centres. Since the late 1990s, care has primarily taken the form of visiting care for persons with mental illness who live in the community. Visiting care originally began as a service with reimbursed medical fees that involved home visits to the elderly, but this service is now provided by community service departments of psychiatric hospitals and persons with mental illness are now visited by nurses from independent visiting nurse stations. As of 2008, 47.7 per cent of visiting nurse stations conduct visits to persons with mental illness.

In recent years, clinics and outpatient departments of hospitals have combined home visits by nurses and visiting care by physicians to begin offering services that provide assertive community treatment (ACT).[5] ACT provides assertive and comprehensive community-based services by a multidisciplinary team to persons with severe and persistent mental disorders. The government recommends these services and in 2011 began creating model communities through financial assistance to communities and hospitals to enhance outreach services.

Outpatient clinics

Case D: a 35-year-old male working at a large firm felt depressed by his mistakes at work and was diagnosed with major depression by a psychiatric clinic. He took sick leave for three months. Initially, he visited the clinic, but at the recommendation of his primary physician he was admitted for a month to a stress care unit at a psychiatric hospital. When his condition stabilised, he was discharged. He participated in the clinic's return-to-work programme after discharge. He began with simple tasks two days a week in the day care office, which resembled the office setting where he worked. He gradually began participating more often and had the same starting and finishing times as he did at work. He became accustomed to the programme, so talks were held with a company physician and a psychologist involved in the return-to-work programme. He subsequently returned to work at his old company. He continues to visit the hospital twice a month.

Socioeconomic factors are impacting the mental health of employees. In the current economic downturn, more and more employees have mental problems, and

workplace mental health is a vital issue in Japan. Prevention, treatment and rehabilitation programmes can be provided in and out of the workplace. The employees can return to work in most of the large corporations and public organisations, however, those who work for medium-sized corporations often lose their jobs. Support services for such people are needed.

Dementia care

Case E: accompanied by family, a 75-year-old male was seen by the Centre for Dementia Care. Tests, including brain imaging, led to a diagnosis of dementia of the Alzheimer type. A year later, his spouse passed away; he became restless and began wandering. He began accusing his family of hiding his belongings and would forget to put out his cigarettes, so he was admitted to a dementia unit in a psychiatric hospital. His family was told by hospital staff that he would be hospitalised for a maximum of three months, so they began looking for discharge destinations immediately after his admission. However, many facilities for the elderly had a waiting list of over 100 people and he was turned away by numerous residential facilities and group homes since they could not accept patients with dementia and problem behaviour. Two months later, the family finally found a facility that would accept him.

The proportion of older people is increasing at a rapid pace in Japan. The number of patients who have dementia but no facility to accept them is rapidly increasing and facilities will have to fill their empty beds with patients with dementia. This trend is already becoming apparent: inpatients age 65 and over accounted for 47 per cent of inpatients in 2008, and this number is predicted to increase further in the future. If this situation continues, medical expenses for persons with mental illness will turn into medical expenses for the elderly. This presents a major policy dilemma that is being debated even now.

Mental health system

Legislation

Mental health policies in Japan have been stipulated by general laws such as the Medical Care Act, Health Insurance Act and Mental Health and Welfare Act, which regulates psychiatric care such as involuntary admission, seclusion and restraint. Also, a forensic mental health law was enacted after the school massacre in 2001 in which many school children were killed and injured by a man with a long history of mental illness.

The government plays a key role in setting overall policy, implementing health services based on the legislation, and standardising health care fees in co-ordination with providers, consumers and payers.[6] Medical fees were revised every two years whilst the Mental Health and Welfare Act was amended every five years. Importantly, a roadmap for mental health reform, 'A Vision for Reform of the

Mental Health Care System', was released by the Minister of Health, Labour and Welfare in September 2004, addressing the direction of mental health and welfare policies up to 2014.[7] It has two aims that it hopes to achieve over the coming decade. First, at least 90 per cent of citizens will recognise that mental illness is a common disease that can affect anyone, similar to lifestyle-related diseases. Second, the focus of services will shift from hospitals to the community by shortening the length of stay, discharging long-stay patients and developing community services. This roadmap is a basis of the government's policy. Since 2004, revisions have been made in medical fees and the Mental Health and Welfare Act according to this roadmap.

Psychiatric beds

It was stated for the first time in 1950 in the Mental Hygiene Act that persons with mental illness have a right to medical care. Until that time, under the Mentally Disordered Persons Supervision and Protection Act, legislation provided protection more to society than to the persons with mental illness themselves. The Mental Hygiene Act was renamed through a series of amendments and is presently the Mental Health and Welfare Act. Because the establishment of public psychiatric hospitals in every prefecture did not move quickly, despite the recommendations for such institutions in the Mental Hygiene Act, the Medical Care Act was revised in 1958 to set a staff-to-beds ratio for psychiatric care units to half that for other clinical departments. The amendment enabled many private psychiatric clinics to upgrade their beds, which led in turn to an increase in the total number of psychiatric beds available. Today, Japan is unique in that 83 per cent (as of 2009) of existing psychiatric beds are provided by private hospitals. Private hospitals in Japan are non-profit organisations and are disallowed from distributing any profits. However, this policy resulted in an increase in the number of beds without a concurrent increase in the number of personnel, and this small staff-to-patient ratio put a halt to subsequent quality improvement of inpatient psychiatric care.

As a result of these policies, Japan is characterised by a large number of psychiatric beds per capita, compared not only to Asia but also the world. As Table 2.1 shows, there were 27 beds per 10,000 population in 2010. It should be noted, however, that the number of registered psychiatric beds has been gradually decreasing because of an upper limit put in place by the 1985 revision of the Medical Service Act.

Although not much has changed with regard to inpatient numbers, there have been changes in inpatient characteristics and bed utilisation. The number of acute care psychiatric beds is on the rise because the majority of inpatients in recent years are discharged within approximately two months, as described in Case B. However, patients who have been hospitalised for more than one year generally have long-term mental illness and are mostly elderly. As far as the number of acute care beds is concerned, the number per capita is close to that of South Korea.

Changes in the numbers of psychiatric inpatients in different age groups are shown in Figure 2.2. Although the total number of inpatients showed no change,

Table 2.1 Psychiatric beds in Asia

	Total number of psychiatric beds (per 10,000 population)
Brunei	1.2
Cambodia	0
China	1.06
Indonesia	0.4
Japan	28.4 (9.8*)
Laos	0.07
Malaysia	2.7
Mongolia	2.4
Myanmar	0.55
Philippines	0.9
Singapore	6.1
South Korea	13.8 (6.2*)
Thailand	1.4
Vietnam	0.63

Note: * Number of inpatients staying less than one year.

the number of inpatients older than 65 years increased, while those younger than 65 years decreased. This suggests that psychiatric care has been functionally divided into long-term care units for elderly persons with mental illness and acute care units for young adults with mental illness. Rather than focusing on the number of psychiatric beds available in Japan, current issues are emphasising the need to establish measures to treat long-stay patients.

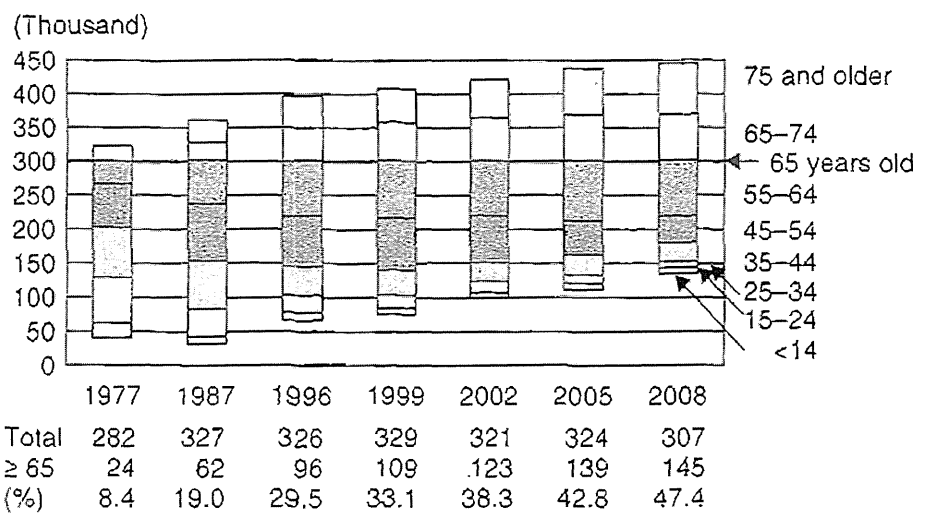

Figure 2.2 Number of inpatients by age group.

Source: Patient Survey.

Human rights

Table 2.2 lists changes made to the law concerning the protection of human rights of persons with mental illness under inpatient care. It was only after 1950 that involuntary admission was limited to psychiatric hospitals. Although individual medical facilities were in charge of human rights protection in inpatient care, an incident at one hospital led to an amendment in 1987 to establish Psychiatric Review Boards in all prefectures. Under the law, psychiatric care units are required to install public telephones with the office phone number of the Review Board so that patients can freely make a phone call at any time. When a patient requests discharge or improved treatment, the Review Board responds by assigning third parties, including a lawyer, to investigate the case, makes a decision based on the findings and then reports the decision to the patient and hospital.

Monitoring of seclusion and restraint was mandated in 1998, and psychiatric care units are required to prepare monthly summary tables showing how seclusion and restraint procedures are being carried out. They are also required to hold monthly meetings of the committee for minimising seclusion and restraint to discuss the appropriateness of seclusion and restraint. The National Centre of Neurology and Psychiatry provides training programmes to minimise seclusion and restraint in an effort to improve the techniques used.

User involvement

Former patients called 'survivors' are speaking publicly at symposia, conferences and government panels on mental health policies.[8] In 2004, for the first time, as an official constituent member of the government committee, a user who had previously been involuntary admitted to a psychiatric hospital joined a meeting held by the Ministry of Health, Labour and Welfare. This was an unprecedented development in the history of Japan's health and welfare policy. This arrangement allows the opinions of third parties to be reflected in government committee's discussions. The Cabinet Office and other governmental offices plan to adopt a similar system whereby the users become constituent members.

Table 2.2 Changes to the law on protection of human rights of persons with mental illness

1900: Mentally Disordered Persons Supervision and Protection Act
1919: Mental Hospital Act
1950: Mental Hygiene Act
1965: amendment to the Mental Hygiene Act (establishment of community mental health centres)
1987: Mental Health Act (establishment of Psychiatric Review Boards)
1993: Disabled Persons' Fundamental Act
1998: Enhanced monitoring of seclusion and restraint
2003: Medical Observation Act
2009: amendment to the Mental Health and Welfare Act (concerning psychiatric emergency care)

It is also important to assist interested parties in organising themselves into groups. In Japan, a family advocacy group for persons with mental illness was founded after holding a workshop on this issue. The National Federation of Families for the Mentally Ill in Japan was also formed, but it was closed in 2007 due to financial problems. Now a newly formed similar organisation is working to reflect the voices of users and families in policy making.

Anti-stigma campaign

Educational programmes on depression have been available for over 30 years. In 1975, at the conclusion of one of their studies, the World Health Organization (WHO) established the International Committee for Prevention and Treatment of Depression (ICPTD) to educate general practitioners and health care professionals on the prevention and treatment of depression. Four years later, Japan launched the Japan Committee of Prevention and Treatment of Depression (JCPTD). JCPTD was later taken over by the World Psychiatric Association (WPA), and, as WPA/PTD (Prevention and Treatment of Depression), has been offering educational programmes – beyond the scope of depression – on the prevention and treatment of common mental illnesses.

Despite such educational activities, awareness of depression is not high in Japan. When a comparative study on the stigma of mental illness was conducted in Japan and Australia, 20–30 per cent of Japanese were aware of depression and schizophrenia to a similar extent, while 60–70 per cent of Australians were aware of depression.[9] In Australia, Beyondblue, a national organisation that addresses issues associated with depression, proactively performs educational activities on depression, and the success of its operations is thought to reflect the difference in awareness of depression between the two countries.[10]

Japan's Ministry of Health, Labour and Welfare, as the public administration body responsible for health care, finally began to address the issue of anti-stigma after announcing its intention to reform mental health and welfare policies in 2004.

An interesting attempt was observed in that the Japanese term 'schizophrenia' was renamed. Traditionally, psychiatrists were reluctant to inform their patients of a diagnosis of schizophrenia because the Japanese term *Seishin Bunretsu Byo* (disease of split and disorganised mind) had negative connotations.[11,12] The WPA initiated the 'Worldwide Programme to Fight Stigma and Discrimination Because of Schizophrenia' in 1996. As part of this activity and also in response to the request from the National Federation of Families for the Mentally Ill in Japan, in 2002 the Japanese Society of Psychiatry and Neurology decided to change the Japanese term schizophrenia to *Togo Shicchou Sho* (dysfunction of integration) to reduce stigmatisation against people with schizophrenia.[13,14] Renaming schizophrenia has been well accepted in Japan and Hong Kong.[15,16] Similar movements are seen in other East Asian countries where Chinese characters are used.