11回日本トラウマティック・ストレス学会
シンポジウムC－4，福岡，2012.6.10.

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

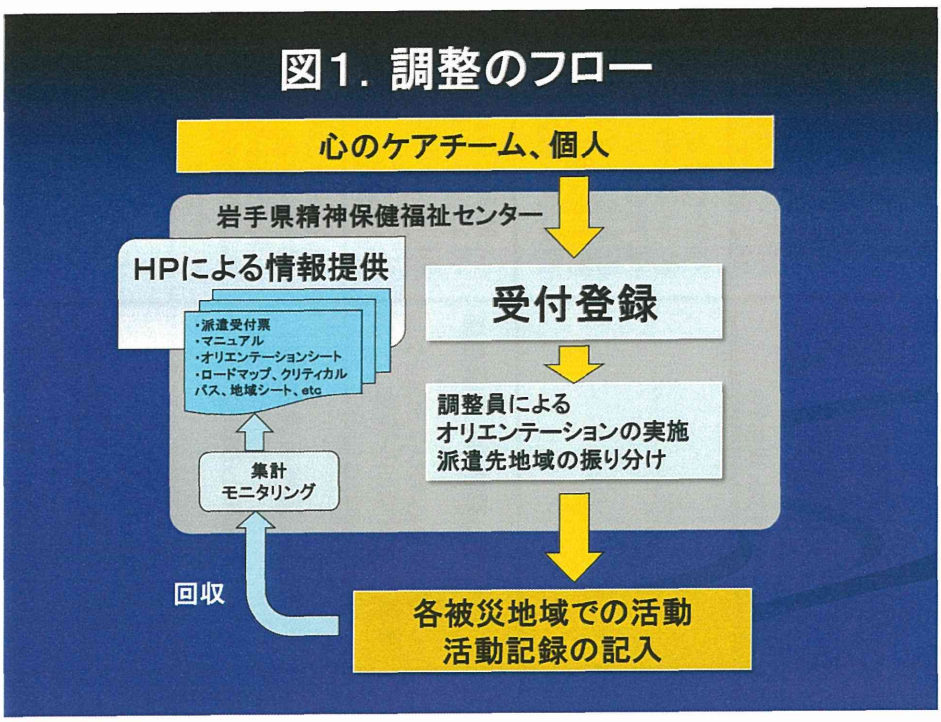
図1. 調整のフロー
心のケアチーム、個人
岩手県精神保健福祉センター
HPによる情報提供
・派遣受付票
・マニュアル
・オリエンテーションシート
・ロードマップ、クリティカルパス、地域シート、etc
受付登録
調整員による
オリエンテーションの実施
派遣先地域の振り分け
集計
モニタリング
回収
各被災地域での活動
活動記録の記入

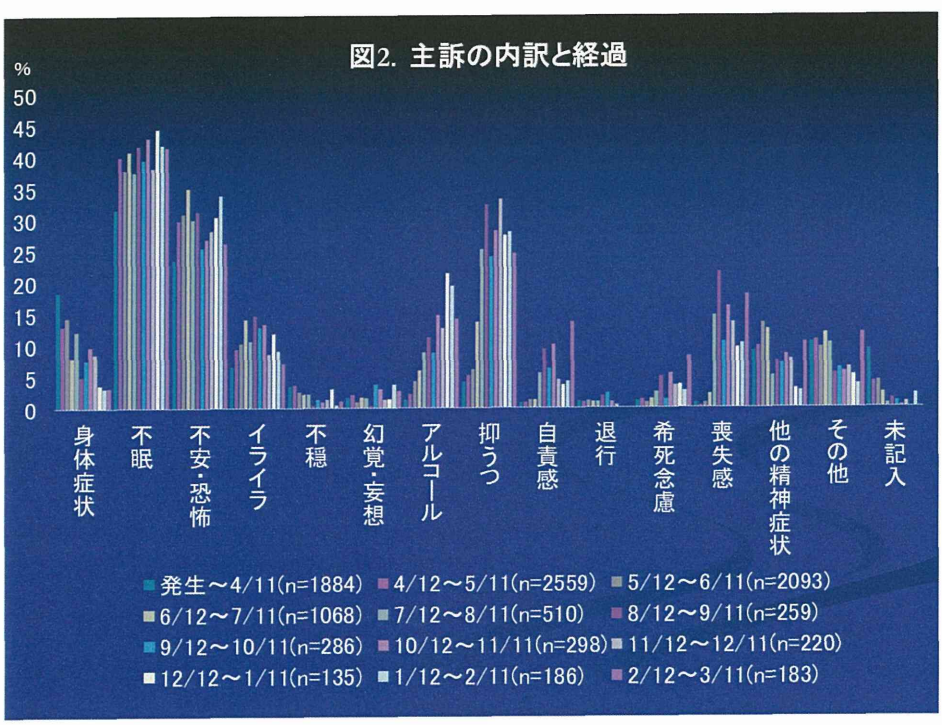
図2. 主訴の内訳と経過
%
50
45
40
35
30
25
20
15
10
5
0
身体症状
不眠
不安・恐怖
イライラ
不穏
幻覚・妄想
アルコール
抑うつ
自責感
退行
希死念慮
喪失感
他の精神症状
その他
未記入
発生～4/11(n=1884)
4/12～5/11(n=2559)
5/12～6/11(n=2093)
6/12～7/11(n=1068)
7/12～8/11(n=510)
8/12～9/11(n=259)
9/12～10/11(n=286)
10/12～11/11(n=298)
11/12～12/11(n=220)
12/12～1/11(n=135)
1/12～2/11(n=186)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

III. 研究成果の刊行に関する一覧表

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
Hiroto Ito	Mental health policy and services: where we stand	Ruth Taplin and Sandra J.Lawman	Mental Health Care in Japan	Routledge	London	2012	36-56

雑誌

発表者氏名	論文タイトル名	発表誌名	巻号	ページ	出版年
鈴木　友理子	東日本大震災後の地域精神保健医療	精神保健研究	58	21-26	2012
鈴木　友理子	震災被災者への精神保健医療支援	被害者学研究	22	58-66	2012

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

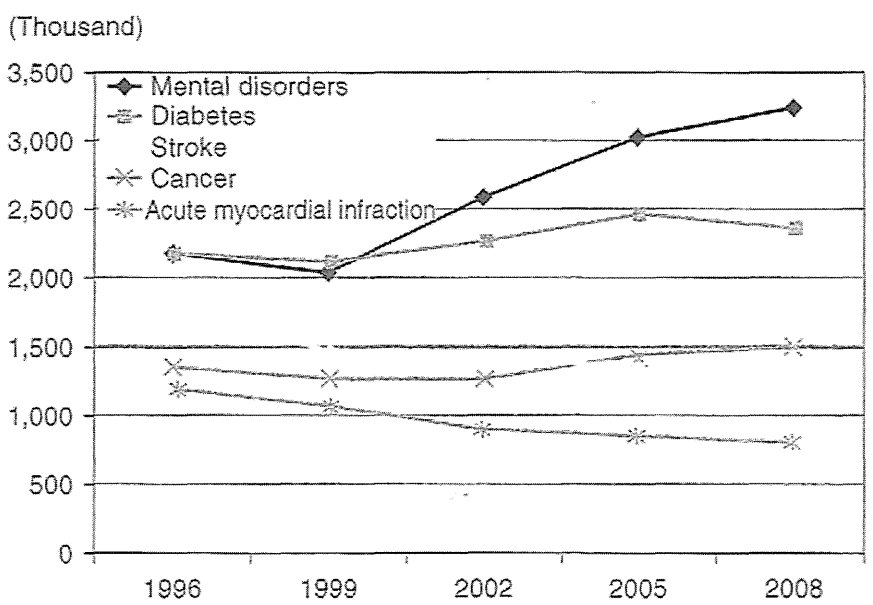

Figure 2.1 Number of patients.*

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.

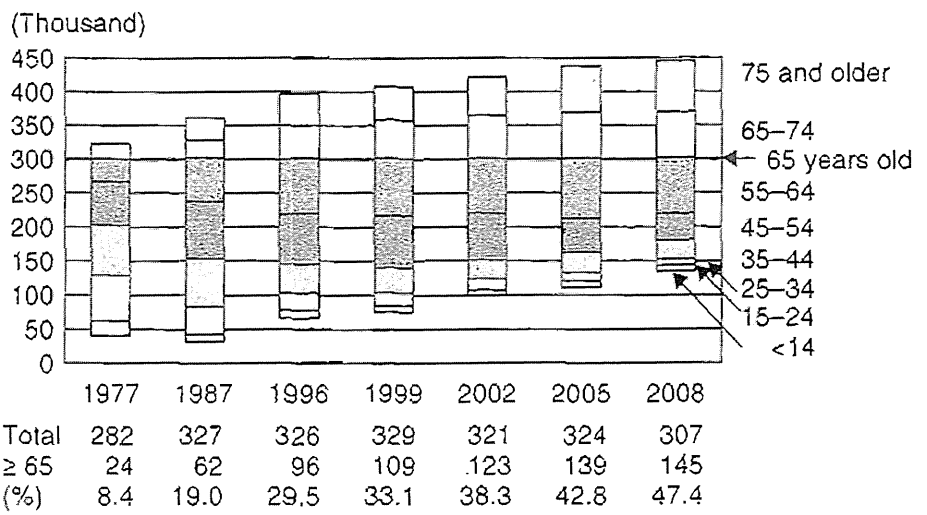

Figure 2.2 Number of inpatients by age group.

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.

Policy outcomes and payment system

Policy and outcomes

The fact that private, not public, hospitals are the major suppliers of psychiatric beds available in Japan, has its roots in the nation's unique mental health care policies. Because private hospitals are operated independently, even when an amendment is introduced to mental health and welfare policy at national level, it is up to individual hospitals to decide whether they adopt the amendment. In other words, central and local governments have limited control over private hospitals (Figure 2.3). As it is difficult to bring about drastic changes, a trial-and-error approach has been used to determine which policies effect favourable changes in psychiatric care. Let us review the positive and negative effects of past policies:

- In the 1950s to 1960s, because the development of prefectural hospitals did not progress as anticipated, the government allowed and provided financial aid for private hospitals with a reduced number of staff to be established and granted them the role of public hospitals. As a result, a large proportion of existing inpatient psychiatric beds in Japan has been owned by private psychiatric hospitals. When the staffing requirements for psychiatric care units were down-regulated, it soon became clear that it would be difficult to upgrade the new standard. Moreover, because of the policy – which focused on the improvement of private psychiatric hospitals – the increase in the number of psychiatric beds in general hospitals has either been halted or shows a decreasing trend due to low health insurance reimbursements.
- The increase in the number of psychiatric beds came to an end in 1985 when the Mental Hygiene Act was revised to limit the number of psychiatric beds available in each prefecture and to prevent a prefecture with an excess of beds from owning even more. The policy effectively stopped the number of beds from increasing, but did not reduce the number of existing beds. This is because, to a hospital, the number of beds it owns directly translates into the amount of profit it generates.
- In the 1990s, a health insurance reimbursement system for community care was developed by increasing the reimbursements for outpatient treatment and establishing a reimbursement system for day care. This policy also led to the establishment of psychiatric clinics and thus dramatically increased the number of outpatients. This policy contributed little to reducing the number of psychiatric beds, because psychiatric hospitals responded to the policy by only enhancing outpatient capabilities without downsizing the number of beds.
- In general, the government initiates a pilot project that reflects a prospective mental health policy for a limited period of time and provides financial incentives before officially implementing the entire policy. If the pilot project is successfully completed within a few years, it is converted into policy by standardising and scaling up the reimbursement system to meet the national level. Then, private hospitals begin a new insurance reimbursement service with the hope that the reform will have a successful outcome.

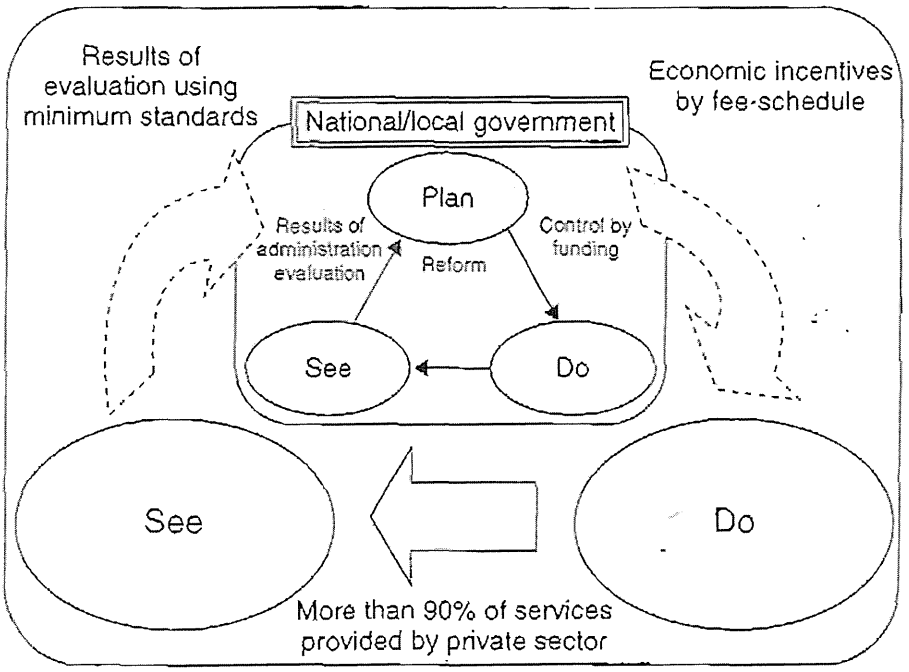

Figure 2.3 Mental health services in Japan.

- Interestingly, insurance reimbursement for psychiatric care at national/public and private hospitals is handled under the same system, and consequently similar behaviours are observed in these hospitals. Actually, the roles of national/public and private hospitals are not very different.

Insurance system

Japan has a universal health care insurance system, and residents are required to enrol in some kind of insurance plan. Health care insurances are classified as three types: employers' insurance including government-managed societies and mutual-aid associations for employees; national health insurance for the self-employed and unemployed; and insurance for the elderly. The cost of health insurance differs depending on the income of the insured. Although an individual needs to pay 10–30 per cent of the medical expenses incurred, there is a monthly upper limit to co-payment, and any payment above the limit will be taken from public funds. Public funds also cover all medical expenses incurred by a family receiving public assistance. Although the medical expenses of persons with intractable illness are covered entirely through the publicly insured programme, mental illness is not included under intractable diseases.

Even though several insurance providers are available, when health insurance is used to receive medical care, the service fee is reimbursed based on the price authorised for the service under the Health Insurance Act. In the case of hospitalisation, basic inpatient charges per diem are set at certain values and include essential hospital fees. The total cost for a single admission is calculated by multiplying the basic inpatient charge by the total number of hospital days and then adding treatment costs that are not included in the basic inpatient charge (e.g. costs for

prescription drugs and specialised psychiatric treatment). Outpatient services are covered on a fee-for-service basis. Authorised fees for health care services are revised every two years.

In 2003, the Diagnosis Procedure Combination/Per-Diem Payment System (DPC/PDPS) was introduced as a payment plan for acute inpatient care.[17] This system sets official per-diem payments for a combination of diagnosis and treatment and covers part of the treatment provided to inpatients at general hospitals. However, the system does not cover most psychiatric care. The reimbursements for the treatment of persons with mental illness are mainly covered by the following two methods.

Per-diem payment system for psychiatric inpatient care

Basic per-diem payments for psychiatric inpatient care differ depending on the type of unit they enter. Although a fee-for-services may be added to the basic payment, the basic inpatient charge accounts for most of inpatient medical expenses paid for by health insurance. The basic inpatient charge is relatively high for the use of an acute care unit or a unit specialising in complications, but small for a chronic care unit. Although dementia patients are admitted to special units, this is not the case with other kinds of mental illness. If persons with mental illness – whether that be schizophrenia or depression – are admitted to the same unit, they are charged the same inpatient fee.

Institutional standards are determined by the types of units operated. In 1994, long-term care units were established to improve inpatient care for patients with long-term mental illness. The establishment of acute care units in 1996 is particularly noteworthy. To be authorised as an acute unit, 40 per cent or more of inpatients must have stayed in the community for more than three months before admission, and another 40 per cent or more of the inpatients must have stayed in the community for more than three months after discharge. This requirement became a huge incentive to promote acute psychiatric care and shorter hospitalisations, and changed the insurance reimbursement evaluation system for psychiatric inpatient care into an evaluation system based on comprehensive units. In addition, emergency care units were established in 2002 with even higher insurance reimbursements and with the specific requirement that they cover more than 25 per cent of compulsory admitted persons with mental illness who are at a high risk of harming themselves or others in each medical district. In 2008, emergency care units for patients with comorbidity were newly established to treat the physical complications of psychiatric patients.

Fee-for-service system for psychiatric outpatient care

Outpatient care is basically provided on the basis of fee-for-services and is not classified by psychiatric diagnosis. From the standpoint of promoting community-oriented care rather than inpatient care, the reimbursements for outpatient care have been prioritised over those for long-term care. In addition to outpatient services,

psychiatric day care services aimed to improve social functioning were introduced into the system in 1974. A combination of outpatient care and day care services sometimes costs more than comprehensive long-term inpatient care. Given the evidence that acute day care treatment is effective,[18] the reimbursements for day care treatment within one year of discharge were increased in 2010. For a facility to receive insurance reimbursements for day care services, it is necessary for it to fulfil the personnel requirements stipulated for such facilities. However, it is up to individual facilities to decide the specifics of the programmes and services they provide. Day care service reimbursement covers return-to-work programmes for individuals with depression and early intervention for individuals with schizophrenia. In addition, the visiting nurse service has been operating since 1986, and a special programme was introduced in 2008 to prevent medication interruptions and minimise readmissions by examining patients' adherence to treatment and the presence of medication side-effects. Although medical reimbursement for psychotherapy has been available for some time, the reimbursement for cognitive behavioural therapy was introduced into the system only recently, in 2010.

Strategic directions for mental health

Liaison consultation psychiatry

Integrating the mental health system into the general health system is a challenge for Japan. Until now, psychiatric care has been regulated under the Disability Policy. This is because mental health and welfare is managed by the Department of Health and Welfare in the Ministry of Health, Labour and Welfare, which also functions as a branch for the Department of Health and Welfare for Persons with Disabilities. Following physical and intellectual disabilities, mental disabilities were first introduced into law in 1993 with the promulgation of the Disabled Persons' Fundamental Act.

The development of 'psychiatric care' has been historically independent from that of general health care, and consequently psychiatric hospitals outnumber general hospital psychiatric departments. Because psychiatry does not have a strong voice in the general health care system, the number of general hospital psychiatric departments, which generally have low revenues, is continuing to decrease. Integrating the mental health system into the general health system is therefore a major challenge, and the position of psychiatric care in the field of general medical care needs to be strengthened.

Since most psychiatric beds were historically provided by individual psychiatric hospitals, only a small proportion of psychiatric beds are owned by general hospital psychiatric departments. In addition, compared with other clinical departments, the medical reimbursements for psychiatric care are relatively low, which has led to the closure of some psychiatric departments in general hospitals.

Several attempts have been made to improve the medical reimbursement status for psychiatric care. The involvement of psychiatrists in palliative care was mandated in 2002, while additional fees were provided to the reimbursement for