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平成23-25年度総合研究報告書
研究代表者　伊藤　弘人

Ⅲ.　研究成果の刊行に関する一覧

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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
Ito H	Mental health policy and services. Where we stand.	Sandra J. Lawman	Mental Health Care In Japan	Routledge	ｲｷﾞﾘｽ	2012	36-56

雑　誌

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泉田信行 野田寿恵 杉山直也 平田豊明 伊藤弘人	隔離室入室期間に投入される人的資源に関する研究．コストおよび行動制限最小化の視点から．	精神医学	54 (8)	801-809	2012
野田寿恵 安齋達彦 杉山直也 平田豊明 伊藤弘人	精神保健福祉資料（630 調査）を用いた隔離・身体拘束施行者数の分析．	精神医学	54 (3)	317-323	2012
野田寿恵 佐藤真希子 杉山直也　他	患者および看護師が評価する精神科病棟の風土．エッセン精神科病棟風土評価スキーマ日本語版(EssenCES-JPN)を用いた検討	（投稿準備中）			
野田寿恵 佐藤真希子 杉山直也　他	精神科看護師がいだく入院患者の攻撃性への態度と対処手法への臨床姿勢の関連	（投稿中）			
石井美緒	米国の隔離・身体拘束最小化方策=「コア戦略」とは（1）トラウマインフォームドケア．	精神看護	17 (1)	92-93	2014
佐藤真希子	米国の隔離・身体拘束最小化方策=「コア戦略」とは (2) セイフティプラン．	精神看護	17 (2)	65-67	2014
三宅美智	米国の隔離・身体拘束最小化方策=「コア戦略」とは (3) コンシューマー．	精神看護	17 (3)	70-71	2014

MENTAL HEALTH CARE IN JAPAN

Edited by Ruth Taplin and Sandra J. Lawman

Routledge

Mental Health Care in Japan

Mental health, including widespread depression, a high suicide rate and institutionalisation, is a major problem in Japan. At the same time, the mental health care system in Japan has historically been more restrictive than elsewhere in the world. This book looks at the challenges of mental health care in Japan, including problems such as the institutionalisation of long-term patients in mental hospitals. The book discusses the latest legislation to deal with mental health care, and explores the various ideas and practices concerning rehabilitation into the workforce, the community and service user groups that empower the mentally ill. It goes on to look at the social stigma attached to the mentally ill in Japan and Britain, which touches upon the issue of counselling those with post traumatic stress after the recent earthquake.

Ruth Taplin is Director of the Centre for Japanese and East Asian Studies, London, and is Editor of the *Interdisciplinary Journal of Economics and Business Law* (www.ijebl.co.uk).

Sandra J. Lawman is an Associate for the Shaftesbury Partnership.

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Mental Health Care in Japan

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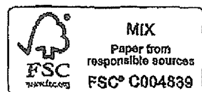

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2 Mental health policy and services

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

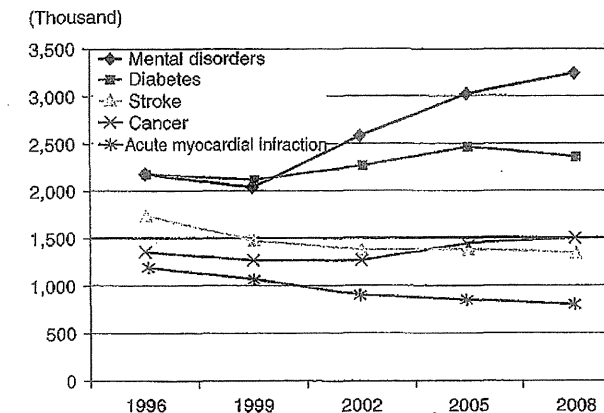

Figure 2.1 Number of patients.*

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.

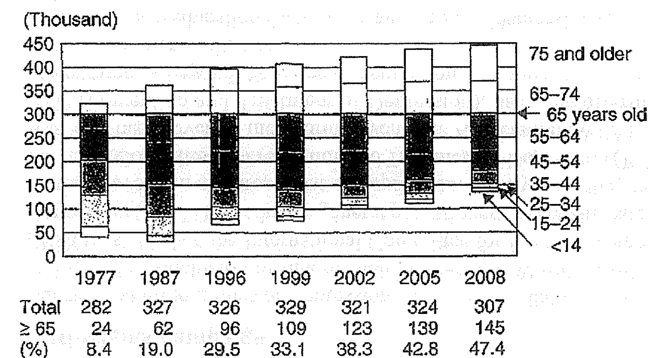

Figure 2.2 Number of inpatients by age group.

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.

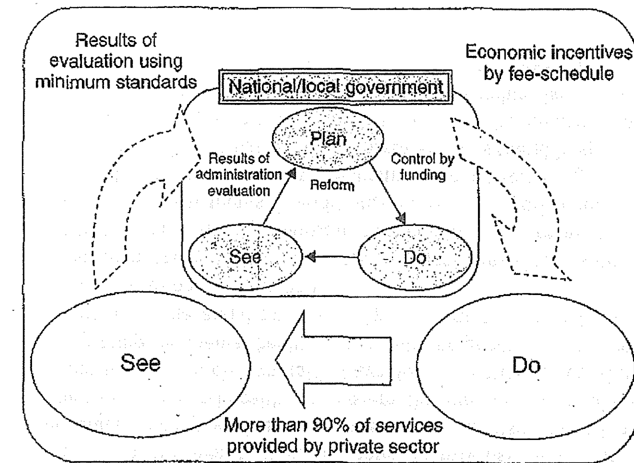

Figure 2.3 Mental health services in Japan.

- 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

treatment provided by designated psychiatrists to persons who attempt suicide transported to general emergency departments in 2008. Also in the same year, additional fees were provided to the reimbursement for referrals by primary care physicians to psychiatrists of patients with depression.

From the standpoint of positioning in a general care system, it is a huge step forward to have mental illness ranked as a high-priority disease in prefectural medical care plans. Starting in April 2013, each prefecture will plan future health care for mental illness as a high priority in addition to cancer, acute myocardial infarction, stroke and diabetes.

Identification of those who need care

According to a study conducted in the United States, 28.5 per cent of the total population has been diagnosed with some type of mental illness.[19] As it is impractical to publicly support mental health services for nearly 30 per cent of the population, it is inevitable that the need for public support must be prioritised. For example, groups of individuals who require more intensive care packages, such as outreach services or home visits, need to be recognised. If this does not happen, intensive services might go to individuals who do not actually need them, rather than to those who do. Thornicroft and Tansella also pointed out and explained this issue using a clear model.[20]

As shown in Figure 2.1, the prevalence of mental illness has been increasing since 1999 and has now surpassed that of diabetes. With no change in the number of inpatient psychiatric beds, this rise is attributable to increases in the number of outpatients. Some of the related developments are as follows:

- The proportion of outpatient psychiatric care costs among all outpatient medical expenses has increased for all age groups. In particular, the increase was pronounced in the 15–44 age group, accounting for 10 per cent of all outpatient medical expenses.
- A home-visit care service is an essential community care service for the prevention of medication interruptions and to enable readmissions for persons with mental illness. Because Japan has long been promoting home-visit nursing services, the number of home visits to persons with mental illness has been climbing, from 4,427 visits in 2000 to 12,777 visits in 2007. In contrast, the number of home visits made by public health centres decreased from 405,966 visits made by 594 public health centres in 2000 to 332,810 visits made by 518 public health centres in 2007.[21]
- Among the different types of clinics operating, the number of outpatient psychiatric clinics without inpatient beds has increased substantially since the 1990s, from 4.3 per cent in 1987 to 8.2 per cent in 2005. Along with this change, the number of outpatients has shown a steady increase. Day care and night care services developed for persons with mental illness in the community have also increased.

The question is whether such increases in mental health services and clinics have actually brought uninterrupted care to persons with mental illness in need of continuous care. To answer this, a detailed analysis needs to be conducted because an adequate national database to analyse the characteristics and patterns of outpatients is currently not available. To improve services, it is necessary to clarify whether limited resources are being utilised for mentally ill persons in the order of highest to lowest priority.

Because of Japan's free-access health care system, which allows people to use health insurance at any medical facility, it is difficult to adjust medical reimbursements based on the severity of illness or to establish the role of medical facilities according to the needs of the community or the priority of target diseases. In that sense, it is particularly noteworthy that the health reimbursement policy was revised in 2010 to include severity of the illness in the reimbursement requirements for inpatient care. To move towards strengthening support for community life, a system is needed that can respond to an exacerbation in patients' conditions and provide the intensive mental health care they need. At the same time, a systematic framework for evaluating the system and facilities from a third party's perspective should be developed to certify the facilities. We should also consider developing outpatient policies.

A flexible catchment system

Japan's health care system has two characteristics: it is a universal national health insurance system as well as a free practice system. There is no general practitioner system in Japan. As a result, people in Japan are able to receive any type of health care service from any provider with minimal co-payment. Although this is an advantage, it also poses a problem: awareness of catchment areas is weak. Psychiatrists and mental health care professionals are simply required to treat patients who visit their clinics and hospitals, and under the current system, it is difficult to assess whether all residents in need of care in the community are accessing health care services. In addition, the policy does not offer strong incentives for preventing treatment interruptions. It is necessary, therefore, to strengthen support for groups with severe and persistent mental illness.

How to set up catchment areas is a major issue to be faced when developing a system to promote community care. Essentially, it falls to the public organisations responsible for the particular catchment area – the public health department, municipal government, mental health and welfare centres and so forth – to strengthen support for community life support and provide outreach services. In Japan, a catchment area system should be functioning under the initiative of the public health department, however, local governments face the financial difficulties to provide community health services. As the number of home-visit nurses and mental health counsellors continues to fall at public health centres, the concept of the catchment area is diminishing in local government.

Consequently, currently available private services should be used to supplement publicly provided care in the community. In the case of outpatient services, which

are provided on a fee-for-services basis, it is simpler, highly efficient and more profitable to provide services to a large number of visiting patients than to prevent some persons with severe mental illness in the community from discontinuing treatment. It is certainly not profitable – and therefore is rarely done – to visit and provide services to patients who refuse treatment.

At the same time, the free access to health care guaranteed by Japan's health care system does not make it easy for medical facilities to foster responsibility towards the community in which they operate. The following characterises the health care services of countries that implement a catchment system:

- Residents visit their primary care physician.
- Patients are referred by their primary care physician to a specialist as necessary.
- Primary care physicians are aware of residents who are in need of medical care.
- Primary care physicians are responsible for following their patients after discharge.

None of the above currently applies in Japan's system, where it is possible to visit any medical facility or specialised hospital using national health insurance. This, unfortunately, makes it difficult to develop a continuous care system and this is a major issue associated with a free-access system. Therefore, a flexible catchment area system needs to be established in Japan that ensures patients with severe and persistent mental disorders are treated.

Long-term inpatients

Psychiatric beds in Japan fall mainly into two distinct categories: beds in acute inpatient care units that meet international standards, and beds in chronic care units for patients with long-term or severe mental disorders. The challenge that Japan faces today is the future of chronic inpatient care units for long-stay patients and those with severe mental disorders.

As one of the visions of the Ministry of Health, Labour and Welfare in 2004, to shift from hospital-based care to community care, it was deemed necessary to transfer current expenditure for inpatient care to community services. This means that existing resources must be re-allocated as it is difficult to increase the national budget drastically. It is unlikely that private medical facilities will willingly reduce their profits or welcome radical change because they are generally conservative in nature. Therefore, it will be necessary to develop economic incentives that bring maximum profits to private psychiatric hospitals if they have to re-allocate some existing inpatient care staff to cover community care services.

The Ministry of Health, Labour and Welfare announced in 2009 that the number of patients with schizophrenia in inpatient care would be likely to decrease. The number of inpatients with schizophrenia was 215,000 in 1996 and 196,000 in 2005. According to the estimate, the number will decrease to 172,000 in 2014, 149,000 in 2020 and 124,000 in 2026. It is not difficult to see that the money generated

from eliminating excessive beds due to a decrease in the number of inpatients with schizophrenia could be used for community care.

Monitoring quality

Although the Japanese insurance reimbursement system predetermines health care prices, it is up to health care providers to decide (1) the types of patients they treat and (2) the types of treatments they provide, as long as they fulfil institutional requirements. The health insurance payments are not directly linked with the types of patients they treat, for example, the patient with a severe and persistent disorder, which is an upcoming challenge for Japan. Patient characteristics and treatment types need to be incorporated with the health insurance payment system.

Academics, including professors in psychiatry and professional groups, have developed guidelines and algorithms for schizophrenia and mood disorders. The Japanese versions of major guidelines for diagnosis and treatment, such as those of the American Psychiatric Association and Maudsley Hospital in London, are also available. Accurate diagnosis and appropriate practice guidelines are important for delivering high-quality care. For diagnosis, both the International Classification of Diseases 10 (ICD-10) and the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV) are used in clinical practice.

The quality of medical care is evaluated based on a system in which standard medical care is (1) developed by health care providers; (2) assessed by a third party; and (3) selected by patients.[22] Hospital care has been evaluated by a third party since 1997,[23] with the results being made public since 2007. This system of third-party evaluation and release of the results is rather novel even by international standards.[24] Some hospitals have been participating in the development of an international framework for evaluating psychiatric care performance and outcomes.[25] Starting in 2013 in Japan, prefectures will evaluate their own psychiatric care system as well as develop and implement health care plans. The evaluation of health care services by the individual prefecture responsible for the community will be an important initiative for Japan. If information on the aspects of health care evaluated by each prefecture is made publicly available, people will be able to obtain better treatment as they are free to visit hospitals of their choice.

The schematic diagram in Figure 2.4 showing the direction for optimal services was generated based on a model figure recommended by WHO.[26] While specialised care might not be needed often, the demand for psychiatric care provided by a primary care system might be high. Moreover, it is essential that social services such as those promoting and implementing suicide prevention measures are enhanced in order to improve public mental health. When developing user-centred services, it is important to include self-care tips for patients at every level.

Recommendations and conclusions

Japan has continuously changed psychiatric care services in decades. The Japanese psychiatric care system reflects both the strengths and weaknesses of Japan's health

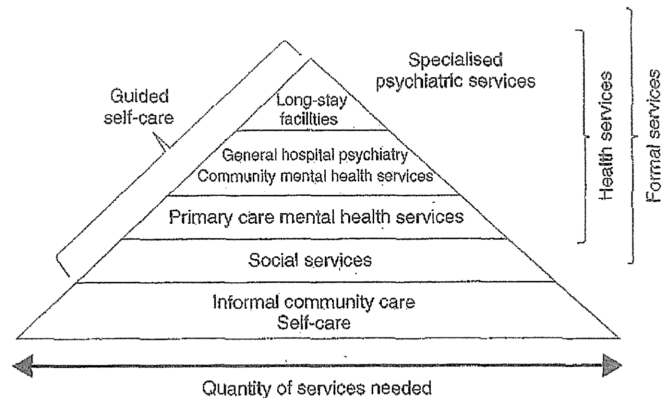

Figure 2.4 Direction for optimal services.

Source: Modified from the WHO Service Organisation Pyramid.

care system, and the country has made various attempts to address the weaknesses while maintaining the strengths. Below, some helpful points are summarised, derived from Japan's own experiences.

Legislation

- Institutional requirements, such as patient and staff ratio, should not be downgraded at any time in order to ensure the quality of care.
- It is effective to develop acute care units with a provision that limits length of stay.
- A regulation (ceiling) on the total number of beds per prefecture effectively prevents psychiatric beds from increasing.

Integration with the general health system

- Psychiatric care should be placed within general medical care.

Support for those who are most in need

- With a highly accessible health care system, it is necessary to establish a system to identify and support persons with severe mental illness.

Policy making

- It is necessary to incorporate the viewpoint of users in every aspect of policy making and daily clinical practice.
- It is necessary to reduce the burden of family responsibility, especially in regard to the treatment of mental illness.

- As policy, the issues of 'illness that can affect anyone (anti-stigma)' and 'measures for severe mental illness' need to be addressed.
- In countries with an ageing society, to prevent the current psychiatric care costs from being converted into medical care expenses for the elderly, general mental health care needs to be separated from the care provided to the elderly with mental illness or dementia.
- In a country with a highly accessible health care system, a flexible catchment area system should be developed.

Funding and economic incentives

- Deciding what types of financial assistance and incentives should supplement the services provided is a major challenge. Financial incentives should be developed to improve the quality of care (creating academic guidelines, a third-party evaluation system and patient selection of medical facilities through disclosure of information).

Notes

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