

Mental Health Services in Japan

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Modern Japanese mental health services have their beginning with the conclusion of World War II. The system of services has since changed at all levels. New laws affording fundamental rights to mental patients were initiated in 1950, but reforms are in process even today that continue down the path toward more enlightened and specialized care. Demographic data are presented including the number of patients and their characteristics, and the number and kinds of service providers. An outline of the administration of mental health services is provided with special emphasis on institutional care. Future trends are highlighted.

Brief History of Mental Health Services in Japan

In Japan two pieces of legislation concerned the mentally ill prior to World War II. The Confinement and Protection for Lunatics Act of 1900 provided procedures to confine mentally ill patients in their own homes. The Mental Hospital Act of 1919 laid down administrative procedures for compulsory detention in an asylum. These two statutes were designed specifically to permit relatives or local authorities to exert their protective powers for safeguarding the public. The rights of the patients themselves were considered to be of secondary importance.

After the Second World War, under the Constitution newly promulgated in 1946, fundamental human rights of the Japanese people were afforded maximum respect. But unfortunately, the Mental Hygiene law of 1950 was not in harmony with the philosophy and principles of the Constitution. This law decreed that psychiatric patients be institutionalized in psychiatric hospitals. Private custody was prohibited ostensibly so that the mentally ill could receive adequate medical treatment. This law included the principle of compulsory admission by administrative order under the standard of "dangerous to self and others".

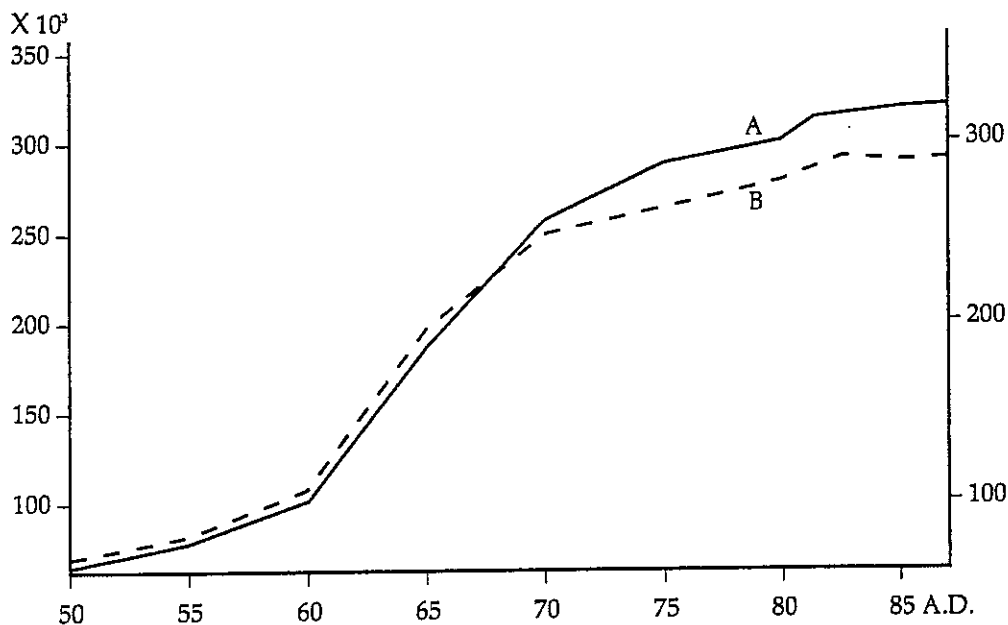
This involuntary admission system essentially transferred the right to make a decision regarding hospital admission from the patient to someone else. Therefore, as of 1987, over 90% of the population in mental hospitals in Japan consisted of involuntary patients.

Psychiatric care in Japan has emphasized hospitalization over other options. In 1950, the number of beds occupied by mentally ill people decreased to 2 per 10,000 general population. But, since 1951 Japan has undergone a rapid industrial development which has resulted in a rise in the utilization of inpatient facilities. By 1988 the total number of psychiatric beds reached a peak of 28 per 10,000 general population and the number of beds totaled 351,358.

In 1960 a plan was put forth (the Income Doubling Plan) which requested an increase in psychiatric beds to cope with the increasing number of patients who were involuntarily hospitalized by the governor and whose expenses were completely subsidized by the government. The government's response was

Figure 1.

(A) The net number of inpatients in mental hospitals in Japan: 1950-1989
 (B) The number of inpatients per 10,000 population.



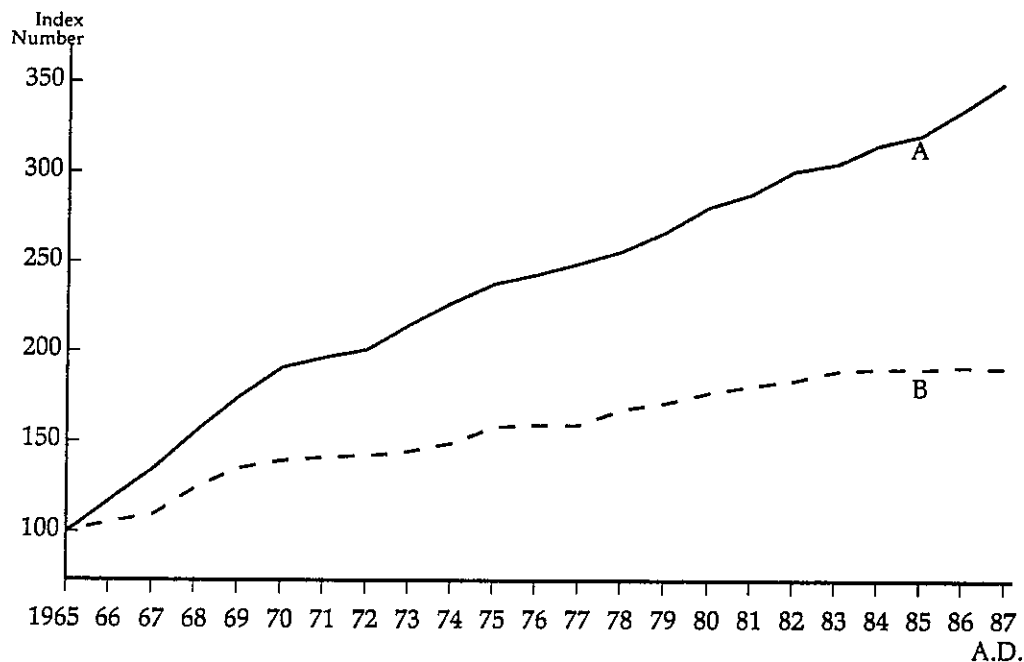
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to restrict the number of public hospital beds and subsidize private hospital beds. This policy, not surprisingly, increased the number of private psychiatric beds which is a characteristic of present day Japanese mental health care. Of the total number of beds in psychiatric facilities, 88.5% are in the private sector (most of them are incorporated and nonprofit).

In 1965, the Mental Hygiene Law was partially revised in order to encourage outpatient services and other mental health services at the community level. The revised law provided that each prefecture (although smaller geographically, a prefecture is a local governmental unit roughly equivalent to state level governmental units in the U.S.) establish a Prefectural Mental Health Center and public financial assistance for outpatient psychiatric services.

Figure 2.

- (A) The total number of outpatients in Japan: 1965-1989
- (B) The total number of outpatients



A comprehensive plan or budget has yet to be set forth by the government for community psychiatric care. Though a system of outpatient care has been developed, the percentage of outpatient care expenses relative to total psychiatric care expenses has remained static since 1965. This means that the basic

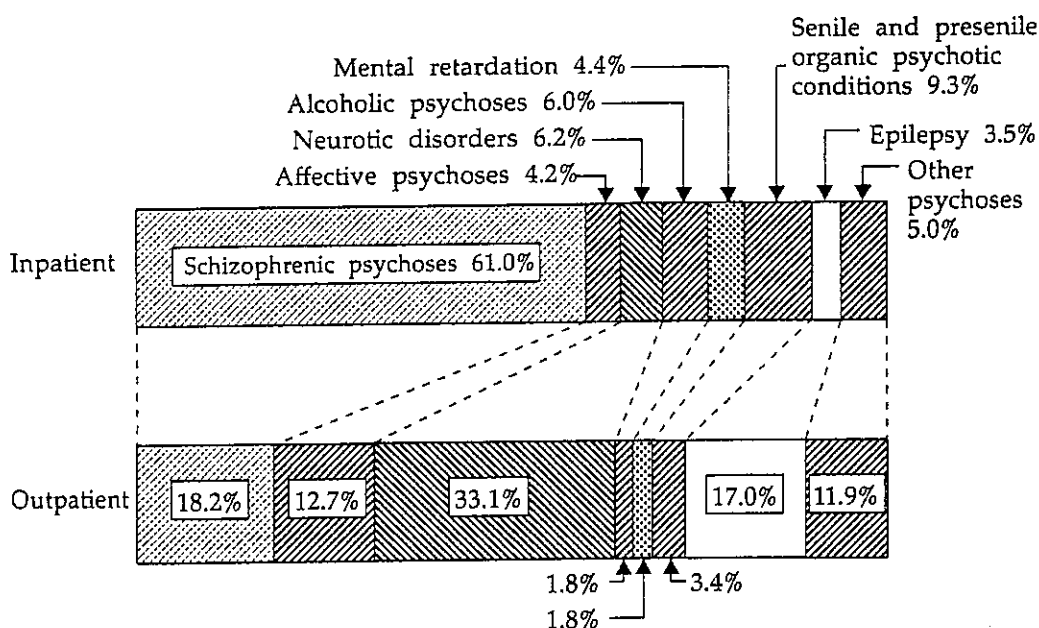
pattern of psychiatric care delivery has not changed in the last twenty-five years. The primary means of treatment for the mentally ill in Japan remains the psychiatric hospital.

Demographic Data Relevant to Mental Health

The total number of long term patients is increasing every year. Currently more than 50% of inpatients have been in the hospital for more than five years. The average age of hospitalized patients has increased every year and reached a current peak of between 45 and 55 years. The patients over 65 years old accounted for 19.6% of all psychiatric patients in 1988. As shown in Figure 3, schizophrenic psychoses are the most frequent primary diagnoses of the mental disorders for admission and outpatient care. Most of the social rehabilitation programs for patients with these psychoses work toward normalization.

Although not shown in Figure 3, alcohol dependence is 20 times more frequent in males than in females. Consultation service, information dissemination, and voluntary support

Figure 3. Distribution of clinical diagnosis



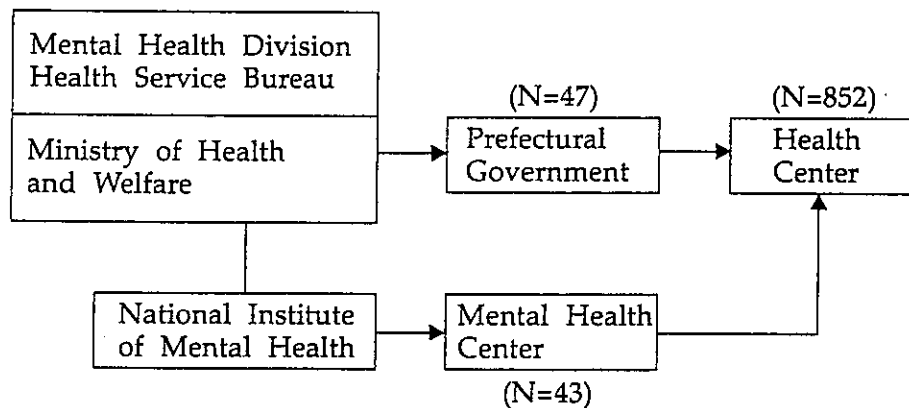
Source: stat. M.H.W. 1987

programs in the community for alcoholics and their families are arranged for these disorders.

Outline of Mental Health Administration

Mental Health Law is within the jurisdiction of the Mental Health Division of the Health Service Bureau of the Ministry of Health and Welfare. In each Prefectural Government, the Department of Public Health is in charge of mental health services, and most prefectures have mental health centers. Mental health centers have responsibility for promoting public mental health services and disseminating information at the prefectural level by carrying out consultation, training, education, and research. In local districts, consultations and other mental health activities are carried out chiefly by mental health counselors or public health nurses who belong to health centers. The relation between these departments and institutions is shown in Fig. 4.

Figure 4. The relationship between departments and institutions



Institutional Care

As of June 1988, the statistics concerning institutional care were as follows: number of inpatients -341,962; psychiatric beds per 10,000 population -28.4; number of involuntary admissions by the Prefectural Governor -21,803; mean length of stay in days -513.8; 18.3% of the psychiatric hospitals are public and 11.7% of the beds are public. For more institutional statistics, see Table 1. Japan has no special hospital security unit for mentally

disordered offenders and refractory patients. Most of them are hospitalized in the public and private mental hospitals.

Table 1

*Table of Psychiatric Hospitals and Beds in Japan**

	Hospitals	Beds
Total	1,641	351,358
Private psychiatric hospitals	1,341 (81.8%)	310,868 (88.5%)
incorporated (nonprofit)	977	249,256
private	364	61,612
Governmental psychiatric hospitals	249 (15.1%)	34,457 (9.8%)
national	91	9,276
local government	158	25,181
Another psychiatric hospitals (Established by Red Cross etc.)	51 (3.1%)	6,033 (1.7%)

*(Ministry of Health and Welfare)
JUNE 30, 1988

Staffing Patterns

As of June 1987, there were 8,725 psychiatrists, 37,087 nurses, 36,402 assistant nurses, and 20,342 nurse aides. The exact number of allied health staff working in psychiatric hospitals is not known. It is estimated that there are 500 occupational therapists, 830 psychiatric social workers, and 600 clinical psychologists. Among them, only occupational therapists have national regulation.

Community Care

Community care programs have gradually developed since 1970, but they have not been an important factor in the treatment of psychiatric patients. Community care programs include: (a) day services (monthly or weekly) at public health centers, (b) day-care services in private or public hospitals, (c) aid system for the employers of ex-mental patients, (d) approximately 400

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small scale sheltered workshops, and (e) community residence programs. Japan has only 125 approved day-care programs (50% of them are private). The aid system for employers is the only system for vocational rehabilitation for mental patients. While (a) and (c) are the programs of Japanese government, (d) and (e) are either run by patients' family associations or voluntary mental health personnel.

Japan has 43 prefectural community mental health centers and 852 public health centers. The activities of community mental health services of these public health centers are not well coordinated with psychiatric hospitals in the community.

According to the fact-finding survey of mental health conducted by Ministry of Health and Welfare in 1983, more than 30% of hospitalized patients could leave the hospitals immediately, if there were enough social support systems in the community. Sixty percent of the families of patients said that they could not afford to look after relatives who were discharged from the hospital.

Community Mental Health Services

Community Mental Health services in Japan are shown in Figures 5 and 6. One thousand four hundred and twenty five outpatient facilities and clinics take care of 700,000 patients and deliver medical services including case management and counseling for recovering patients. Forty three Prefectural Mental Health Centers and 852 Health Centers are in coordination to deliver public mental health services including counseling, day care programs, information dissemination, and other services.

Day Care Centers are day treatment facilities which provide medical therapy and social activities for several hours during the day. Nonresidential Social Rehabilitation Facilities deliver occupational and recreational activities and family support. However, Japan does not have enough social support systems in the community to accept many hospitalized patients.

Current Issues

After some improprieties with inpatients in Utsunomiya Hospital were reported in 1984, many protest that mentally ill

Figure 5. Overview of mental health services (June, 1988)

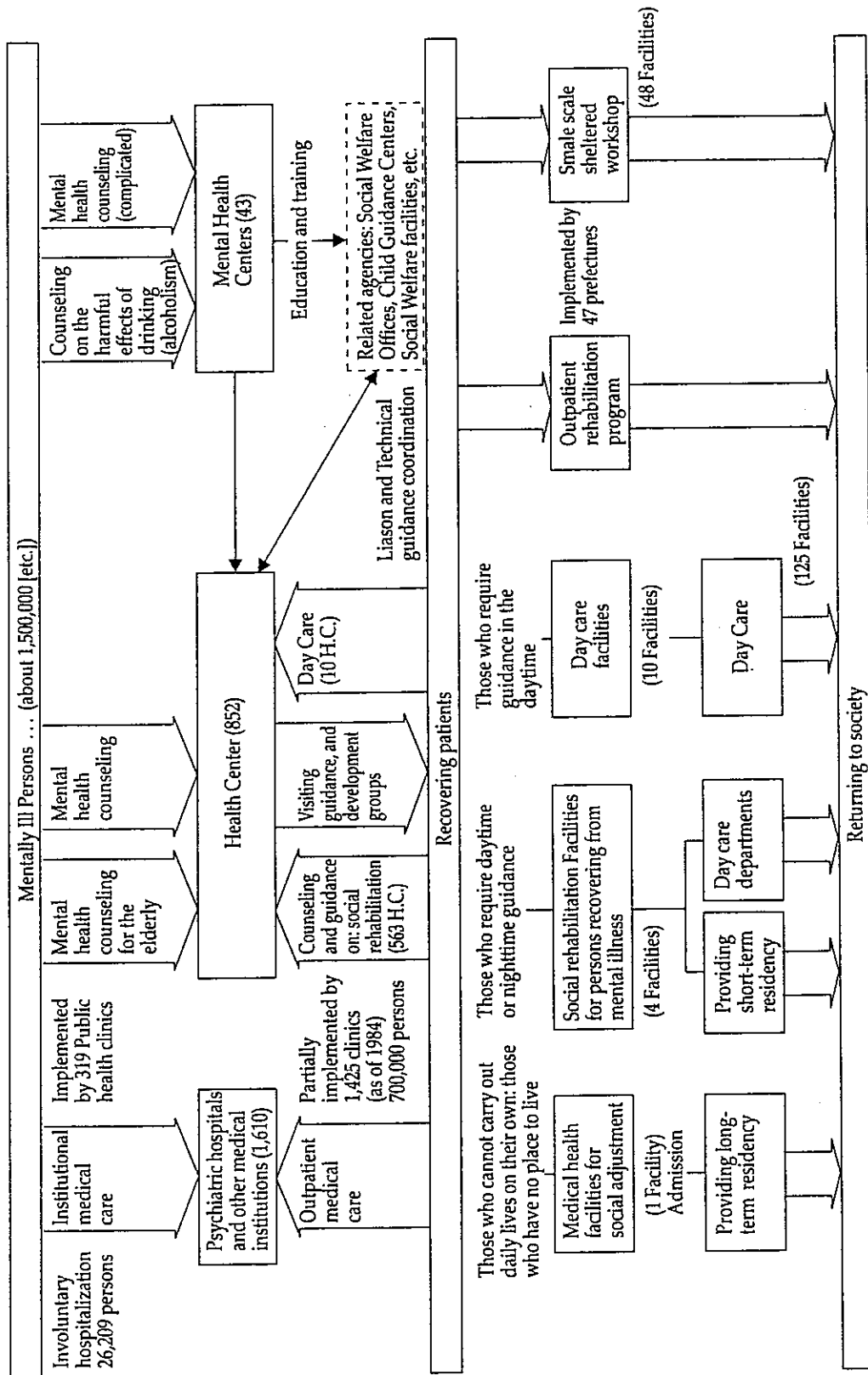
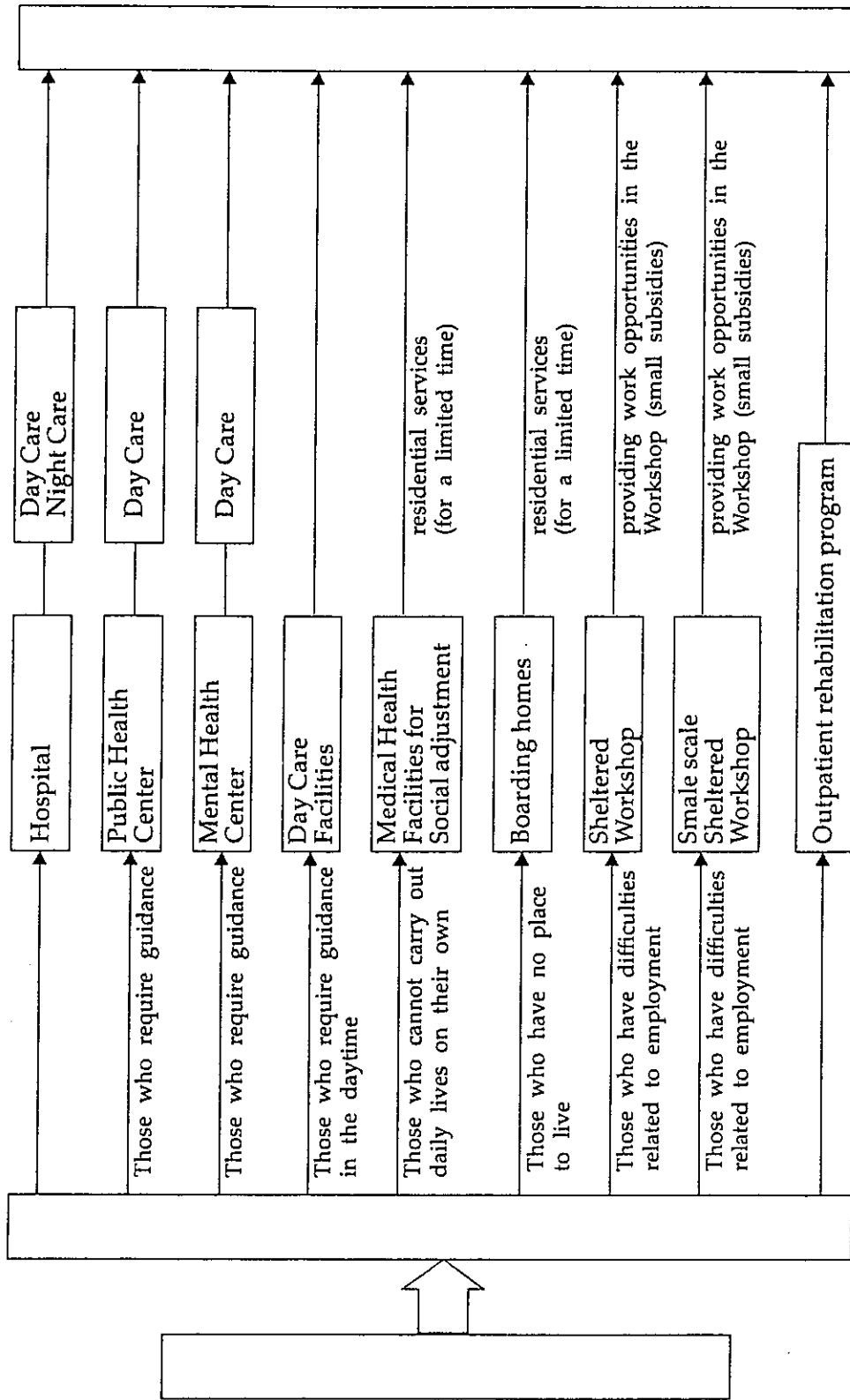


Figure 6. Scheme of mental health services (1989)



persons in Japan were subjected to violations of human rights. These protests were made domestically and internationally, and the government of Japan declared an amendment to the Mental Hygiene Law in August 1985. After two years of investigations and discussion, the newly revised Mental Health Law was legislated in 1987, and it has been in operation since July 1988.

In the course of the investigations, there were confrontations between psychiatrists and jurists in reference to the best way to assure patients' rights. The basic concept in amending the Mental Health Law was the protection of the human rights of the patients, changing conditions of admission, changing standards for designated physicians, and the promotion of social rehabilitation for mentally disordered persons.

The main points of the amendment for the protection of patients' right are:

(a) in case of admission to a mental hospital, the superintendent of a mental hospital shall endeavor to admit the mentally disordered person on his/her consent (Voluntary Admission); (b) to guarantee all patients' rights to appeal to the Prefectural Governor for discharge or to report inappropriateness of treatment; (c) to establish The Psychiatric Review Board to review the necessity of involuntary hospitalization and the propriety of treatment; (d) to prohibit restrictions on actions, such as correspondence, telephone calls and visitors; and, (e) to give the notice of patients' rights in writing at admission. Such rights include: (a) particular restrictions on actions, such as the use of seclusion room for over 12 hours or physical restraint by suitable apparatus, should be decided only by a designated physician; (b) the director of the psychiatric hospital must inform the patient of these rights at admission; (c) as to admission for medical care and custody and involuntary admission by the Prefectural Governor, the director is required to give a regular report to the governor; and, these reports and the appeals of patients concerning discharge or better treatment may be reviewed by the newly established Psychiatric Review Board.

The principle reform concerning type of admission is the introduction of the voluntary admission. If the superintendent of a mental hospital decides to admit a mentally disordered person, it shall be done by voluntary consent if possible and

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the patient should be informed of his/her rights. If a voluntarily admitted person requests discharge, the superintendent shall do so unless a physician deems it necessary to continue that admission for medical care and custody. In this case, the superintendent may refrain from discharging that person for a period of not longer than 72 hours. This voluntary admission option was not provided in the original Mental Hygiene Law, although Japan had another type of voluntary admission (so-called "free" admission, 5-10% of total admissions) which was not included in the original law.

A person who has been deemed mentally disordered by the superintendent of a mental hospital, as a result of an examination by a physician, and thus in need of admission, can be admitted involuntarily, when a person responsible for his custody consents to the admission. Previously, this consent admission had priority at the admission, even if a patient agreed to the admission. More than 80% of inpatients were admitted with the consent admission. Thus, it is misleading to say that

Table 2

*The Transfer Between Admission Types in the Two Years after the Enforcement of The New Mental Health Law, July 1, 1988. (The Findings of Private Mental Hospitals, 842, J.P.M.H. June 30, 1990)**

Type of Admission	June 1988	June 1990 New Admissions as of June 1990	
A. Voluntary Admission	not legislated -0-	51.5%	63.8%
B. Involuntary Admission	consent by guardian inv. & vol. admission 82.4%	41.5%	28.0%
C. Involuntary Admission by Governor	5.7%	4.0%	1.5%
D. Free or General Admission not Included in MHL	free admission 11.9%	general admission 3.0%	6.7%

*Emergency admission and temporary admission are very few.

more than 90% of inpatients were involuntary admissions. Six months after the enforcement of the new law, 34% of new admissions were voluntary which shows that many inpatients had previously been misclassified.

Involuntary admission by the Prefectural Governor

A person may be involuntarily admitted only when the results of medical examinations made by two physicians, designated by a Prefectural Governor, have agreed that the examined person has been deemed liable to injure himself or others because of a mental disorder.

Emergency admission

A mental hospital may admit a person for a period of not longer than 72 hours, without the consent of the mentally disordered person, after the superintendent has concluded as a result of a medical examination that the person in question is mentally disordered, and there would be extreme interference with his medical care and custody unless he is admitted to the hospital without delay.

Qualifications for the Designated Physician of Mental Health

The Designated Physician of Mental Health is defined by Article 18 of the mental health law. Psychiatrists are required to practice for more than five years, and prove their experiences with eight case reports for registration. Designated Physicians are responsible for daily activities and decisions on all admissions and discharges except for voluntary ones. The restrictions on action specified by the Minister of Health and Welfare should be judged by Designated Physician. So, treatment in psychiatric hospitals cannot be executed without a Designated Physician. In 1988, there were 7,000 Designated Physicians.

The psychiatric rehabilitation system in Japan is underdeveloped compared with psychiatric rehabilitation facilities in other developed countries. Many chronic psychiatric patients hesitate to leave the hospital and live in the community because of the lower cost of admission and lack of rehabilitation facilities.

Concerning rehabilitation, the new law set forth a policy which had been neglected since the amendment in 1965. Psychiatric rehabilitation was included in the purpose of the law stated in Articles 1 and 2, which prescribes that the completion and increase of rehabilitation facilities is a duty of the national and local governments. The law requires that information about government standards concerning patients' rights should be made more easily available to the patients. Ninety percent of all hospitals believe the new law should be amended again, because too much paperwork is required and the psychiatric rehabilitation policy lacks an adequate social support system and financial support. Many Japanese psychiatrists are working diligently on a compromise between psychiatric practices and patients' rights.

Challenges for the Future

The elongation of mean life expectancy represents a human triumph, but at the same time, the explosion in the absolute number and relative proportion of an elder population increases the number of patients with dementia. It is considered likely that these changes in demography also affect the operation of the social security system. The Ministry of Health and Welfare established a Task Panel for the Demented Elderly in 1986, and the Panel emphasized in its recent report in 1987, that the following policies should be implemented immediately:

To enforce health promotion activities which are intended to prevent geriatric diseases, so as to reduce the incidence of cerebrovascular diseases, the most frequent cause of dementia in Japan.

To improve the availability and accessibility of home care and institutional care.

To establish needed services, staff must be attracted, retained and trained, and a network for a continuous care system must be formed.

Mental disorders in childhood or adolescence accompanying social and behavioral symptoms are of great interest lately, although the number of institutions or health personnel that are specialized in these fields is lacking. Policy improvement regarding these disorders cannot be overemphasized.

The Mental Health Law says: The National, Prefectural and Local Governments shall endeavor to enable mentally disordered, etc., to adapt themselves to the social life, by expanding and improving the facilities needed for medical care, social rehabilitation and other welfare purposes and education. . . . Today, no remarkable change can be found in the social rehabilitation of mentally disordered persons. A request should be made for more subsidies and legal support to promote the rehabilitation and community care of the mentally ill people in Japan.

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