Mental Health Law in Japan

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In Japan, before the Second World War there were two pieces of legislation concerned with mentally ill people. The Confinement and Protection for Lunatics Act of 1900 provided procedures to confine the mentally ill patient at his own home and the Mental Hospital Act of 1919 laid down administrative procedures to detain him or her compulsorily in an asylum. These two statutes were designed specifically to permit relatives or local authorities to exert their protective powers for safeguarding the public. After the Second World War, under the Constitution newly promulgated in 1946, the fundamental human rights of the Japanese nation were held in maximum respect. But, unfortunately, the Mental Hygiene law of 1950 was not in line with the philosophies and principles of the Constitution.

Through this law, the government dictated a policy that psychiatric patients should be institutionalized in psychiatric hospitals. Private custody was prohibited so that the mentally ill could receive adequate medical treatment. This law decreed the principle of compulsory admission by administrative order under the standard of "dangerous to self and others" or involuntary admission by the proxy consent of a legally responsible person. Essentially, both channels were of a compulsory nature for the prospective patients, and yet over 90 percent of the population in mental hospitals in Japan in 1987 were involuntary patients.

In 1965, the Mental Hygiene Law was partially revised and the government started to partially subsidize outpatients and pointed out the necessity of transforming hospital psychiatric treatment to community-based psychiatric care. Since then, the total number of outpatients has been increasing every year and became more widespread gradually. Day care services and rehabilitation programs also were set up.

After some improper management of inpatients in Utsunomiya Hospital was reported in 1984, there were many protests domestically and internationally that mentally ill persons in Japan were being subjected to violations of human rights and the Government of Japan declared an amendment of the Mental Hygiene Law in August, 1985. There were some confrontations in the course of the investigation between psychiatrists and jurists in reference to the best way to assure patient's rights. After two years of investigations and discussions, the newly revised law called the Mental Health Law was legislated in 1987, and it has been in operation since July, 1988.

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The basic concepts in the amended Mental Health Law were:

1. The protection of the human rights of the patients.

2. The promotion of social rehabilitation for mentally disordered persons.

Concerning human rights, the main points of the 1987 amendment of the Mental Health Law, providing for protection of Patient's rights are:

a) In case of a need for admission to a mental hospital, the superintendent of the mental hospital shall endeavour to admit the mentally disordered person based on their consent (voluntary Admission).

b) To guarantee to every involuntarily admitted inpatient the right to appeal to the Prefectural Governor for his or her discharge regarding inappropriateness of treatment.

c) To establish a Psychiatric Review Board to review the necessity of involuntary hospitalization and the propriety of treatment through notice on admission and by regular report.

d) To prohibit restrictions on actions, such as correspondence, telephone calls and interviews of visitors.

e) To give written notice of patient's rights at admission.

The Mental Health Law provides for admission categories and the treatment of inpatients with mental disabilities with a view to providing appropriate care and protection while at the same time ensuring their human rights.

Admission categories are as follows:

a) voluntary admission

b) involuntary admission by prefectural governors

c) involuntary admission for medical protection

d) emergency admission

e) temporary admission.

Voluntary Admission

Voluntary admission was legislated into law for the first time. When the superintendent of a mental hospital intends to admit a mentally disordered person, the superintendent must endeavour to admit the person based on their consent and the patient must be informed in writing of his rights. In the case where a voluntarily admitted mentally disordered person has requested to be discharged, the superintendent of the mental hospital must discharge him. But, when the Designated Physician deems it necessary to continue the admission of the voluntarily admitted person for medical protection, the superintendent may refrain from discharging him for a period of not longer than 72 hours. This

voluntary admission was not provided for in the former Mental Hygiene Law. However, there were a few voluntary admissions (5-10% of total admissions); these were done through another type of voluntary admission (so called free admission) which was not included in the Mental Hygiene Law.

Involuntary Admission For Medical Protection

When a person has been deemed by the superintendent of a mental hospital, as a result of the medical examination of a designated physician, to be mentally disordered, and thus, to be in need of admission to a hospital for medical protection, and when a person responsible for his protection has consented to the admission, the superintendent may admit him to the hospital without his own voluntary consent, as an admission for medical protection.

Admission by consent of a legal guardian (referred to as consent admission hereafter) in the former law was changed more radically. This consent admission was rather unique in Japan. This type of admission was given a priority for admission, even if a person was willing to agree to a voluntary admission. Therefore, this type of admission had been used for both involuntary and voluntary admissions. More than 80 percent of inpatients were admitted with consent admissions which resulted in the criticism that more than 90 percent of inpatients were either consent admissions or involuntary admissions by governor's order and were detained involuntarily in Japan. This criticism was partially correct, partially incorrect as many voluntary admissions chose admission by consent of legal guardian to expedite admission.

This consent admission was changed to admission for medical protection which was clearly defined as involuntary admission under the newly revised law.

Involuntary Admission By Prefectural Governors.

Under another type of involuntary admission, it was only after the results of the medical examinations, made by two designated physicians or more selected by the Prefectural Governor, which agreed on the fact that the examined person was mentally disordered and was liable to injure himself or others because of his mental disorder unless he was admitted to a hospital, could the Prefectural Governor order admittance to a mental hospital established by the National or Prefectural Government, or to a designated hospital.

Emergency Admission

This is involuntary admission of patients whose medical protection would be seriously impeded unless they are admitted to hospitals. The hospital stay should not be longer than 72 hours.

Temporary Admission

This is admission with the consent of families or others of patients who are suspected of being mentally disordered. The hospital stay should not be longer than three weeks.

Free admission, which was not included in the Mental Hygiene Law, has become general admission with certain diagnostic limitations, for example, neurosis.

Two years after the enforcement of the new law, the numbers of newly prescribed voluntary admissions was 52.9 percent and free admission was 3.7 percent. This shows that many inpatients moved from consent admission to voluntary admission. (Ministry of Health and Welfare, 1988 and1990)

Qualification for the Designated Physician of Mental Health

With a view to protecting the human rights of patients, the Law accredits physicians who have sufficient knowledge about psychiatry and experience as designated mental health physicians by the government. Psychiatrists are required to practice for more than five years, and prove their experience with eight case reports for registration. Designated mental health 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 a designated physician. So, treatment in psychiatric hospitals cannot be executed without a designated physician. In 1990, there were 7,815 designated mental health physicians.

As for the treatment of inpatients, certain restrictions on their actions, such as restrictions on sending or receiving correspondence, are prohibited. The isolation of patients for 12 hours or longer and the use of physical restraints require the approval of designated mental health physicians. Treatment standards set by the Minister of Health and Welfare should be followed.

Psychiatric Review Board

The law also provides for a Psychiatric Review Board. The members of a Psychiatric Review Board shall not be less than five nor more than fifteen. The Board includes a lawyer, a specialist of social welfare and three designated physicians of mental health. This Board is expected to review the necessity of involuntary hospitalisation and the propriety of the treatment. There are 47 Psychiatric Review Boards all over Japan.

Inpatients may request a prefectural governor to discharge them or improve treatment at hospitals. Requests are reviewed by the Psychiatric Review Board, a three panel organization set up in each prefecture.

Hospitals are required to make periodic reports regarding the medical condition of patients who have been admitted under the categories of involuntary admission for medical protection and/or by prefectural governors. The Psychiatric Review Board reviews whether the admission should be continued.

Three years after the enforcement of the new law, the type of admission was as follows:

Involuntary admission by prefectural governors	3.6%
Involuntary admission for medical protection	39.8%
Voluntary admission	52.9%
General admission	3.7%

As of the end of June, 1991, the institutional care statistics were as follows:

Total number of Hospitals	1,655
Psychiatric beds	358,251

Only 18.3% of total psychiatric hospitals and 11.4% of beds are public. Most of private psychiatric hospitals are incorporated and non-profit making.

There are 1,765 outpatients facilities and clinics, taking care of 700,000 patients. They deliver medical services including case management and counselling for recovering patients.

There are 45 Mental Health Centres and 852 Public Health Centres which coordinate the delivery of public mental health services including counselling, day service programs, information dissemination and other services.

The amended Mental Health Law set forth the legal framework for three kinds of social rehabilitation facilities.

As of June 1991, there were only 41 protective dormitories, 57 welfare homes and 41 sheltered workshops. The number of such residential facilities has not grown much these three years.

Because most of these social rehabilitation facilities were established by juridical persons and they are unable to raise funds to build or operate a facility without enough subsidies, the number of users will not increase unless the charge for using these facilities changes.

Of 186 approved day care facilities, only 42% of them were public facilities. There were 347 small sized workshops. These workshops are run by families or voluntary mental health personnel.

We have now 1,438 companies as vocational parents, but only 2,300 patients are working. In Japan, we have not yet a protected employment system for the mentally disabled persons.

We have now only 95 group homes with rooms for a total 916 persons all over Japan. Most of these group homes were established by private hospitals and self-help groups without subsidy.

Facilities needed for social rehabilitation of the mentally disordered in Japan still face many problems. And yet, Japan has obviously started making serious efforts to expand its resources in this regard. In order to solve problems in the future, the national government, municipal government, and other parties in psychiatric care must work closely and exert further efforts to develop social rehabilitation strategies based on the new Mental Health Law.

Conclusions and Discussion

To further develop community psychiatry in Japan, there needs to be, first, an ability to generate an appreciation about mental health among the general public and to obtain the support of society. Second, strong networks need to be established among public health centres, welfare bureaus, and consultation offices for children, and crisis intervention needs to be provided. Third, and most importantly, a good working relationship must be developed with public health nurses, who regularly visit homes where there are potential health problems, and they must be helped to remedy those problems. More importantly psychiatric hospitals should not isolate themselves from the rest of society. Psychiatric hospitals must be open, so that residents in the community will feel comfortable about them.

While public education and public understanding about mental illness is fostered, the country also needs to develop a variety of facilities, day care and night care services, supported dormitories, other half-way houses, and sheltered workshops for vocational opportunities and other appropriate programs. With a variety of facilities and services, people with mental disabilities will be able to try, according to their ability, to adapt to a new environment and eventually participate in society as independent individuals. However, psychiatric hospitals should continue to offer prompt medical intervention, if necessary, so as not to arouse unnecessary misgivings in the community.

Given its far-reaching value, rehabilitation services for the mentally ill should not be at the sole expense of psychiatric hospitals. Today, Japan needs a community psychiatry system suitable for its culture and its social needs. Japan also needs a policy which does not impose a financial burden on those willing to undertake community psychiatry.

Without registration for financial support to cover deficits almost inevitably incurred by rehabilitation services for former patients, and with the social stigma still remaining in this society, hospitals have been forced to withdraw from rehabilitation services in some cases.

The Mental Health Law says as follows: The National, Prefectural and Local Governments shall endeavour to enable mentally disordered persons, etc., to adapt themselves to social life, by expanding and improving the facilties needed for medical care, social rehabilitation and other welfare purposes and education. But, until today, no remarkable change can be found in the social rehabilitation of mentally disordered persons. Requests need to be made for more subsidies and legal support to promote the rehabilitation and community care of mentally ill people in Japan.

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Psychiatric Hospitals and Beds in Japan

	Hospitals		Beds	
Total	1,655		358,251	
Private psychiatric hospitals	1,352	(81.7%)	317,569	(88.6%)
Incorporated (non-profit)	1,026		261,102	
Private	326		56,467	
Governmental psychiatric hospitals	252	(15.2 %)	34,730	(9.7 %)
National	91		9,304	
Local government	61		25,426	
Other psychiatric hospitals (Public; established by Red Cross etc.)	51	(3.1 %)	5,952	(1.7 %)

(Ministry of Health and Welfare, June 30, 1991)

Mental Health Centres

Number of mental health centres	45
Number of mental health consultation	94,899
Number of special problem consultation	16,060

Public Health Centres

Number of public health centres	852
Number of mental health consultation	720,267
Number of mental health outreach consultation	317,115
Number of social rehabilitation consultation	21 ,855

(MHW FY 1989)

Measures for Community Mental Health

Number of employers in outpatient rehabilitation program		1,438
Number of patients attending outpatient rehabilitation program		2,300
Number of facilities licensed to provide psychiatric day care		186 - 207
Social Rehabilitation Facilities defined under Mental Health Law		
*Protective Dormitories	41	
*Welfare Homes	57	
*Sheltered Workshops	41	
Number of small-sized workshops	347	

(MHW, June 30, 1991)

Mental Health Statistics - Japan

Number of Inpatients

INPATIENTS	349,010	
INVOLUNTARY ADMISSION BY PREFECTURAL GOVERNORS	12,566	3.6%
INVOLUNTARY ADMISSION FOR MEDICAL PROTECTION	139,123	39.8%
VOLUNTARY ADMISSION	184,503	52.9%
GENERAL ADMISSION	12,818	3.7%

(Mental Health Division, June 30, 1991)

Psychiatric Hospitals and Clinics

NUMBER OF PSYCHIATRIC BEDS	349,010
NUMBER OF PSYCHIATRIC HOSPITALS	1,655
NUMBER OF PSYCHIATRIC CLINICS	1,765

Mental Health Personnel

PSYCHIATRISTS	8,725
DESIGNATED MENTAL HEALTH PHYSICIANS	7,815
NURSES	53,033
NURSING ASSISTANTS	14,025
OCCUPATIONAL THERAPISTS (Qualified)	469
PSYCHIATRIC SOCIAL WORKERS	1,235
CLINICAL PSYCHOLOGISTS	1,000 (approx)
MENTAL HEALTH WORKERS (in Public Health Centres)	1,656
PUBLIC HEALTH NURSES	8,749

(M.H.W. June 30, 1990)