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OVERVIEW

Japan is an island country stretching along the northeastern coast of the Asian continent. It consists of 4 main islands—Hokkaido, Honshu, Shikoku, and Kyushu, from north to south—and more than 6,800 smaller islands. With a total land area of 377,719 square kilometers, Japan accounts for less than 0.3 percent of the total land area of the world. Of its entire land area, 73 percent is mountainous and the remaining 27 percent is relatively flat. Thus the arable and habitable land is extremely limited.

The population of Japan as of October 1989 was 123 million, ranking seventh in the world with about 2.4 percent of the world population. The average annual rate of population increase from 1986 to 1989 was a little more than 1 percent. In 1989 the rate was as low as 0.38 percent. The population growth of Japan is caused mainly by natural increase, for net international migration is negligible. The birth rate declined sharply from its high level during the postwar baby-boom period of 1947–49 and became 10.1 per 1,000 population in 1989. In the same year the death rate was 6.5 per 1,000 population, the same as in the previous year. As a result, the rate of natural increase recorded was 3.7 per 1,000 population. The infant mortality rate improved to 4.7 per 1,000 live births in 1989. Except for the death rate, these ratios have been declining every year for several years.

The life expectancy at birth of the Japanese has shown a remarkable improvement and has been among the highest in the world. It declined slightly in 1988, when it was 75.54 years for males and 81.30 years for females.

The age structure of the Japanese changed markedly from the typical pyramid form with a broad base in the 1930s as a result of the decrease of the birth rate

and the death rate. In 1989 the proportion of the productive-age population (15–64 years of age) was 69.6 percent, the highest level among major industrial countries. However, the aged population (65 years old and over) is projected to attain the significant share of 23.4 percent in 2025. Besides, the age dependency ratio (ratio of children and aged to the productive-age population) is predicted to rise from 43.7 percent in 1989 to 72.8 percent in 2042, when the aged population will reach its peak of 24.2 percent. These estimates demonstrate the remarkable speed and extent of the aging of the population structure in Japan.

The real economic growth rate in fiscal 1988 was 5.3 percent, the second consecutive year of a rise exceeding 5 percent. The Japanese economy has continued its high rate of growth; its GNP now ranks second in the free world. On a per capita basis, GDP of Japan amounted to U.S. \$23,270 in 1988, meaning that Japan was ranked third among OECD members, an improvement from the rank of eighth (U.S. \$11,144) in 1985. The rapid rise in rank of GDP per capita, however, has been mainly due to the rapid appreciation of the yen.

EXTENT OF THE PROBLEM

The number of long-term patients in psychiatric hospitals is increasing every year. Currently, more than 50 percent of residential patients have been in the hospital for more than five years. The age of the hospitalized patients, becoming older every year, has reached a peak of between 45 and 55 years old. Patients over 65 years old accounted for 22 percent of all the psychiatric patients in 1989. According to the statistics of the Ministry of Health and Welfare in 1990, out of 349,000 hospitalized patients, schizophrenic psychoses were the leading diagnosis (61 percent). Other diagnoses included affective psychoses (4.6 percent), senile and presenile organic psychotic conditions (9.3 percent), alcoholic and drug psychoses (6.0 percent), neurosis (6.2 percent), epilepsy (3.5 percent), and mental retardation (4.4 percent).

Estimates of mentally disordered persons by the Ministry of Health and Welfare in 1990 were approximately 1,600,000 psychotic persons; about 400,000 mentally retarded persons; and about 2 million persons drinking more than 150 milliliters of alcohol per day (Ministry of Health and Welfare, 1990). In Japan there are now 1 million persons with senile dementia, and it is estimated that in twenty years their number will double. Among them, 25 percent of patients are treated in hospitals or other facilities.

MENTAL HEALTH HISTORY

In Japan before World War II 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 or her 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

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specifically to permit relatives or local authorities to exert their protective powers for safeguarding the public. After World War II, 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 over 90 percent of the population in mental hospitals in Japan in 1987 were involuntary patients.

Psychiatric care in Japan has stressed hospitalization. When the Mental Hygiene Law was enacted in 1950, in the aftermath of World War II, the number of beds occupied by "mentally ill" people was low (2 per 10,000 population). Following Japan's rapid industrial development beginning in 1951, a nationwide compulsory health insurance system was instituted in 1958. The government then decided to increase the number of psychiatric hospitals. Despite that move, the number of doctors per patient at these hospitals was only one-third the number of doctors per patient at general hospitals. In 1961 the government started to restrict the number of public hospital beds and to promote private hospitals. As of 1988 there were 345,000 psychiatric beds, a record high of 28 per 10,000 general population (Asai, Takahashi & Tsung-yi, 1991).

In 1965 the Mental Hygiene Law was partially revised, and the Ministry of Health and Welfare started to partially subsidize outpatients and pointed out the necessity of transforming hospital psychiatric treatment to community-based psychiatric care. In accordance with this revised law and its measures, outpatient psychiatric services were increased and gradually became more widespread. Day-care services and rehabilitation programs also were set up. Since then, the total number of outpatients has been increasing every year. However, neither a plan nor a budget were provided for community psychiatric care. Although a system of outpatient care has been developed, the expenditure for outpatient care as a percentage of the total psychiatric care expenditure has remained almost the same since 1965. This means that the basic pattern of psychiatric care delivery has not changed and that the main site of mental health care is still psychiatric hospitals.

POLICY, ORGANIZATION, AND SERVICES IN THE 1980s AND 1990s

Current Policy Developments

Until recently, Japanese psychiatry emphasized hospitalization, where "treating and protecting mental patients" was regarded as the overriding objective.

However, now the philosophy of community psychiatry has become as important as hospitalization.

Although the importance of community psychiatry has been long acknowledged in Japan, application has been relatively slow. For one thing, even today, the social rehabilitation of those with psychiatric disabilities is not supported by the government's welfare policy; this is still left to the goodwill of psychiatric hospitals or the patient's family associations. While many nongovernmental psychiatric hospitals have begun rehabilitation services, their goodwill and efforts alone are not sufficient.

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. The government of Japan then 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 patients' rights. After two years of investigations and discussions, the newly revised law, called the Mental Health Law, was legislated in 1987 and has been in operation since July 1988. The basic concepts in the amended Mental Health Law were (1) the protection of the human rights of patients and (2) the promotion of social rehabilitation for mentally disordered persons.

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 the older population increases the number of patients with dementia. It is also believed that these changes in demography affect the appropriate operation of the social security system. The Ministry of Health and Welfare established the Task Panel for the Demented Elderly in 1986, and the panel emphasized in its report in 1987 (Ministry of Health and Welfare, 1988a) that the following policies should be executed immediately:

- To enforce health promotion activities that 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 form the basis of needed services, staff must be attracted, retained, and trained, and a network for a continuous care system must be formed.

Mental disorders of childhood or adolescence with social and behavioral symptoms are also of great interest, although the number of institutions with health personnel that are specialized in these fields is insufficient. The need for policy improvement regarding these disorders can not be overemphasized.

Current Organization

Japan has 45 prefectural community mental health centers and 852 public health centers. The activities of the community mental health services of the

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public health centers are neither well organized nor cooperative with psychiatric hospitals in the community.

According to a 1983 fact-finding survey of mental health by the Ministry of Health and Welfare, more than 30 percent of hospitalized patients could leave the hospitals immediately if there were enough social support systems in the community. However, 60 percent of the patients' families said that they could not look after discharged patients (Asai et al., 1991).

The Mental Health Law is under the jurisdiction of the Mental Health Division of the Health Service Bureau of the Ministry of Health and Welfare. In each prefectural government departments or bureaus of public health are in charge of mental health services, and most prefectures have mental health centers, which have responsibility for promoting public mental health services and for information dissemination at the prefectural level through consultation services, training, education, research, and surveys.

In local districts consultations, visiting guidance, and other mental health activities are carried out mainly by mental health counselors or public health nurses who belong to the health centers. The relationship between these departments and institutions is shown in figure 8.1.

As of the end of June 1990 the institutional care statistics were as follows:

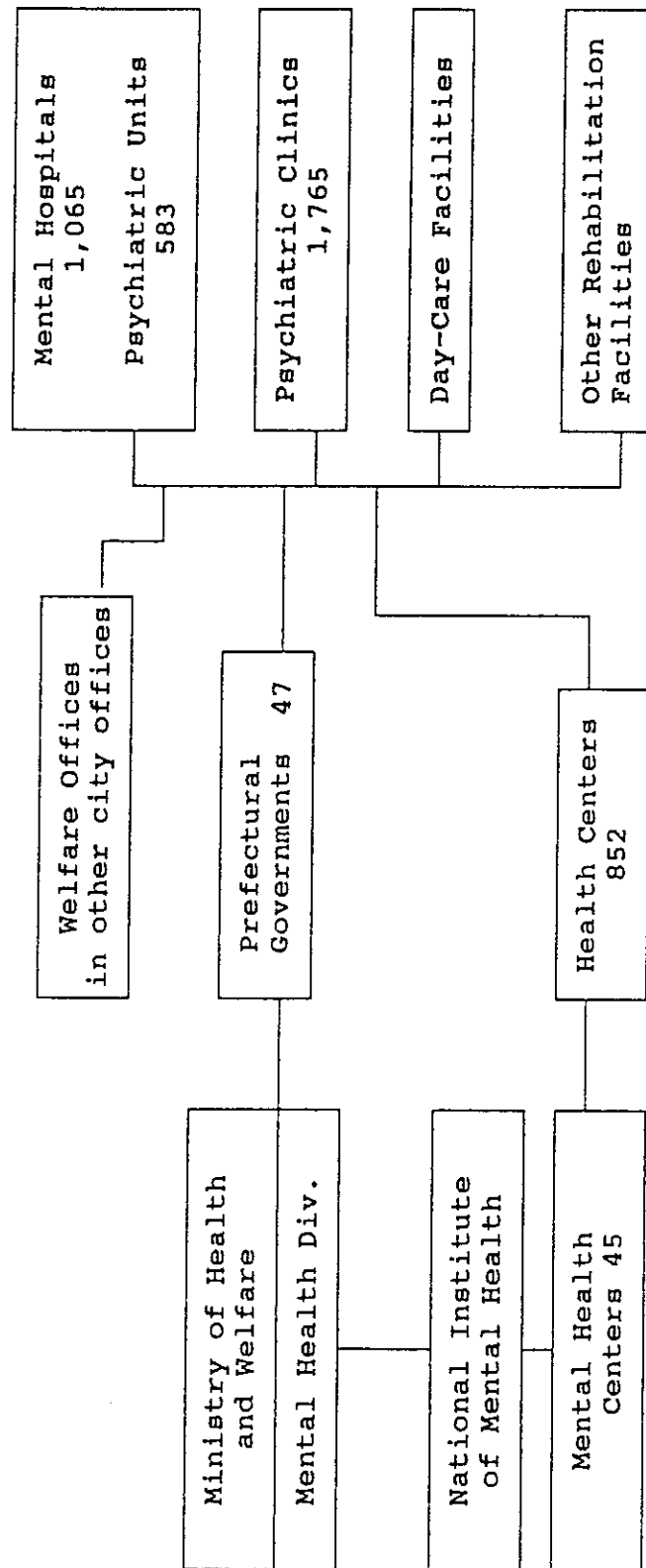
Number of institutions	1,648
Number of psychiatric beds	358,128
Number of inpatients	349,010
Percentage of beds occupied (average per year)	90.0%
Psychiatric beds per 10,000 population	28.4

Only 18.3 percent of total psychiatric hospitals are public, and only 11.7 percent of psychiatric beds are public. Most of the private psychiatric hospitals are incorporated and nonprofit. Two years after implementation of the new Mental Health Law, the types of admission were as follows:

Number of voluntary admissions	184,503	52.9%
Number of admissions for medical protection	139,123	39.8%
Number of involuntary admissions by the prefectural governor	12,566	3.6%
Free admission	12,818	3.7%

There are 1,765 outpatient facilities and clinics, taking care of 700,000 patients. They deliver medical services, including case management and counselling for recovering patients. There are 45 prefectural mental health centers and 852 health centers that coordinate the delivery of public mental health services,

Figure 8.1
The Relationship between Administrative Departments and Institutions in Japan



Source: Ministry of Health and Welfare, 1990

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including counselling, day-care programs, information dissemination, and other services.

Theoretically speaking, mental health facilities and services fall into the public domain. The Mental Health Law, amended in 1988, refers to the social rehabilitation needs of the mentally ill, but states that only "municipalities and medical juridical persons may establish social rehabilitation facilities for persons with mental disorders." Consequently, though nongovernmental hospitals are aware of the importance of community psychiatry, many of them find it extremely difficult to start loss-producing rehabilitation services without subsidies.

Current Services

In Japan since 1970 community care programs have gradually developed for psychiatric patients (figure 8.2). However, they have not developed enough to become major sites of treatment.

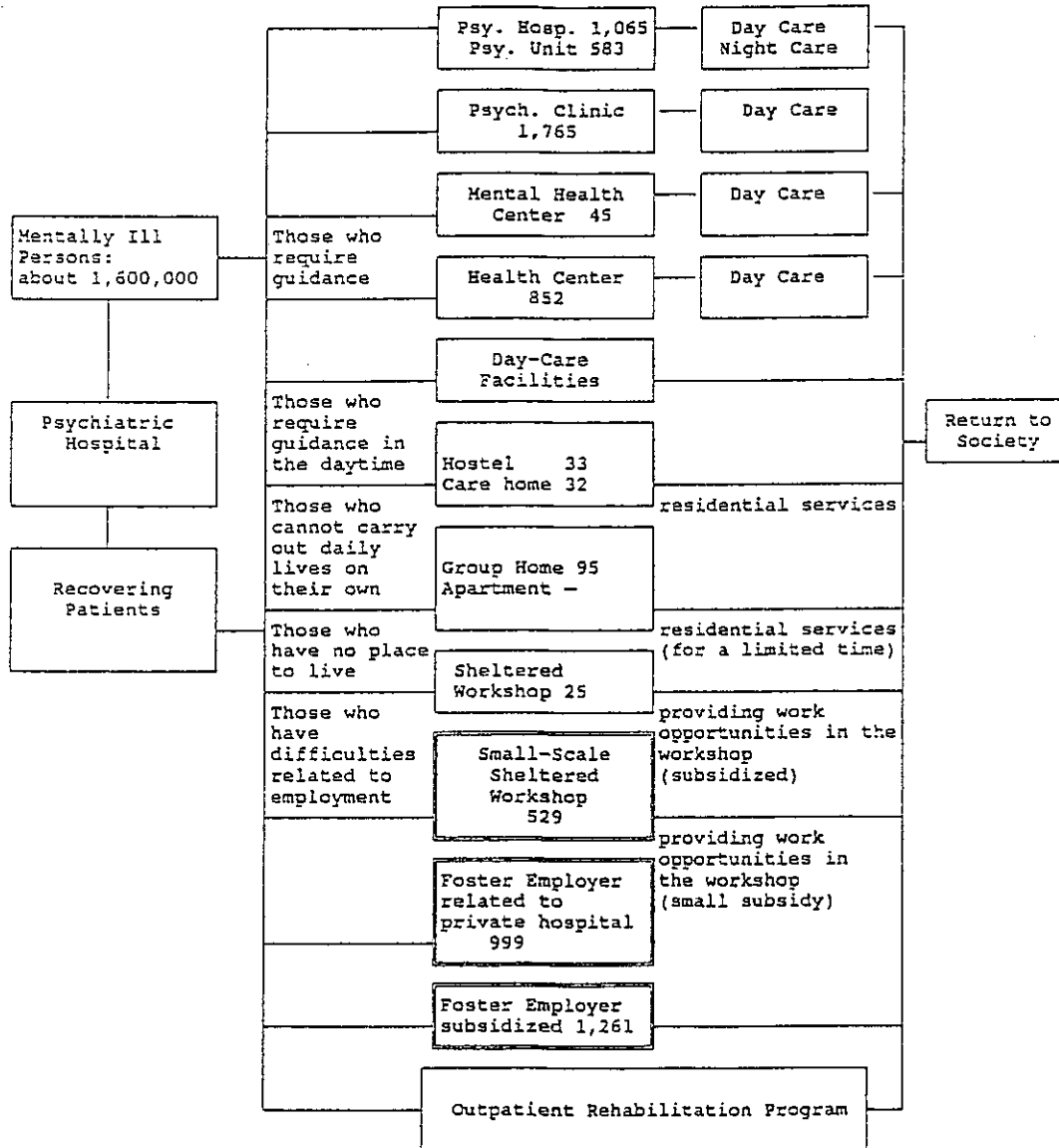
Social resources for activities for the mentally disabled in 1990 (table 8.1) included sheltered workshops, which began in the 1960s, for the physically handicapped, the mentally retarded, and the mentally disordered. As of October 1, 1990, there were 2,231 such workshops, of which 554 served mainly those with mental disorders. These sheltered workshops are run by families or voluntary mental health personnel. There are only 25 sheltered workshops subsidized under the Mental Health Law. There are 186 approved day-care facilities, but only 42 percent of them are public. Among 852 public health centers, 665 centers have community care programs. There are 209 patient clubs in the community.

In 1982 the Ministry of Health and Welfare launched a Rehabilitation Program for Outpatients in close collaboration with prefectural governments. The central government allocates funds to prefectural governments to contract with companies designated and registered as vocational parents. There are now 1,438 companies that are vocational parents, but only 2,300 patients are working.

In Japan there is not yet a protected employment system for mentally disabled persons. In the near future there should be well-organized vocational rehabilitation systems for mentally disabled persons that will be nearly the same as for physically handicapped or mentally retarded persons.

Social resources for living were limited as of 1991. There are poor community residential facilities in Japan (see table 8.2). The amended Mental Health Law in 1988 set forth the legal framework for two types of residential facilities, which may be established and operated by prefectural governments, municipal governments, social welfare juridical persons, and others. As of June 1990 there were only 33 hostel-mental health facilities for social adjustment and 32 care homes. The number of such residential facilities has not grown much. Most of these social rehabilitation facilities were established by juridical persons, and they have been unable to raise funds to build or operate facilities without sufficient subsidies. The number of users will not increase unless the charges for using these facilities change. There are now 95 group homes established by private

Figure 8.2
Rehabilitation System for the Mentally Ill in Community Mental Health in Japan, 1991



Source: Ministry of Health and Welfare, 1991.

Table 8.1
Social Resources for Activities in Japan, 1990

	Facilities	Clients	Notes
1. Sheltered workshops with subsidies	25	500	By Mental Health Law
2. Small-scale sheltered workshops	529 *(209)	9,500	Not by Mental Health Law *Subsidized by the local government and other sources.
Subtotal	554	10,000	
3. Day-care facilities (in hospitals & clinics)	186	4,000	
4. Day-care services community care program (in public health centers)	20	—	
5. Patient clubs and social programs	209	—	
Subtotal	1,080	25,885	
6. System for foster employers of ex-mental patients	1,438	2,300	By government subsidy for employers
7. Foster employer system (for inpatients and outpatients) (related to 280 mental hospitals)	999	about 2,000	Nonsubsidized by hospital.

Source: Ministry of Health and Welfare, 1990.

Table 8.2
Social Resources for Living in Japan: Residential Facilities, 1990

	Facilities	Patients	Notes
1. Hostels	33	995	With government subsidy by Mental Health Law
Mental health facilities for social adjustment	↓ [4,000]	↓ [8,000]	Capacity: 20
2. Care homes	32	320	Subsidized by Mental Health Law
	↓ [500]	↓ [5,000]	Capacity: 10
3. Group homes	95	916	By private hospital & self-help group
	↓ [2,000]	↓ [9,000]	
4. Independent apartments			
		[10,000]	
5. Urgent care institutions	171	15,428	Subsidized by welfare law
		*(6,171)	*40% of them are for the mentally disordered
6. Institutions for rehabilitation	18	1,768	
7. Geriatric nursing homes	—	[13,000]	
Subtotal	189	[20,939]	Under welfare law
Total	3,000 <	50,000 <	

Note: [] = the number of facilities needed and patients estimated in future.
Source: Ministry of Health and Welfare, 1990.

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hospitals and self-help groups without subsidy. The number of facilities needed and the estimated patients to be served in the future are shown in table 8.2, but there exists a very big gap.

Facilities needed for social rehabilitation of the mentally disordered in Japan still face many problems. 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 governments, and other parties involved in psychiatric care must work closely together and exert greater efforts to develop social rehabilitation strategies based on the new Mental Health Law.

In Japan deinstitutionalization has not yet progressed. Psychiatric hospitals in Japan play a role that intermediate facilities should play. Therefore, psychiatric hospitals provide hospital functions such as security, emergency services, and acute, subacute, and chronic services, to which the same base charge is applied. Simultaneously, psychiatric hospitals, again for the same base charge, have to serve as nursing homes or sometimes as board-and-care facilities as well. Consequently, there are not street people in the community.

Mental Health Personnel and Treatment

As of the end of June 1988, medical personnel in mental hospitals were the following:

Psychiatrists	8,725
(Designated physicians of mental health)	(7,815)
Nurses	37,087
Assistant nurses	36,402
Nurse's aides	20,342
Qualified occupational therapists	469
Psychiatric social workers	1,235
Clinical psychologists	about 1,000
Mental health workers (in public health centers)	1,656
Public health nurses	8,749

Among paramedical staffs, only occupational therapists meet national qualifications. There is a nationwide shortage of labor both in medical and other professional fields. Mental hospitals also suffer because of a shortage of nurses and other professionals.

Instead of the psychiatric judgment doctor system used under the former law, the new 1988 law specifies a designated physician of mental health. In this system psychiatrists are required to have practiced psychiatry for more than five years and to have proved their experience with eight case reports for registration.

The designated physicians are responsible for daily activities such as decisions on all admissions and discharges, except for voluntary ones, and they are responsible for many kinds of reports. Any restrictions on actions of patients specified by the minister of health and welfare are justified by a designated physician. Thus the treatment in psychiatric hospitals, in general, cannot be executed without a designated physician. The number of designated physicians at the end of 1988 was about 7,815.

SPECIAL POLICY ISSUES

The Mentally Ill and the Mentally Retarded

The estimated number of mentally retarded persons by the Ministry of Health and Welfare in 1990 was about 400,000. Of this number, 14,386 were hospitalized as patients in facilities for the mentally ill. Out of total hospitalized patients, mental retardation accounted for 4.4 percent.

As of October 1, 1988, there were 313 homes and 216 day-care facilities for mentally retarded children. For adult mentally retarded persons, there were 794 rehabilitation facilities, 105 day-care facilities, 167 residential facilities with sheltered workshops, 343 sheltered workshops, and 133 group homes. In 1960 a new Welfare Law for Mentally Retarded Persons was enacted. Under this legislation many kinds of social resources for activities and community residential facilities for mentally retarded persons have been developed.

The Mentally Ill and Substance Abuse

According to the statistics of the Ministry of Health and Welfare in 1990, out of 349,000 hospitalized patients, alcoholic and drug psychoses accounted for 6.0 percent. The number with alcoholism accounted for 19,259, amphetamine addiction for 587, and other drug addiction for 948.

The drinking population and estimated heavy drinkers in Japan have increased annually in proportion to alcohol consumption per capita, doubling from 1965 to 1987. While present alcohol consumption is not as high as in some of the Western countries, the rate of increase may be considered one of the highest. There is a concurrent increase in alcohol-related disabilities, and the mortality in males for liver cirrhosis nearly doubled from 1950 to 1980, while the rate of alcoholism as a whole also doubled.

The Japanese drinking culture is well known as very permissive. More than 50 million people, almost two-thirds of the adult population, are drinkers. Although only a small proportion of those drinking have need of medical care, the increase in the drinking population has definitely led to an increase in the number of clinical cases.

Danshukai is an alcohol self-help group spread widely throughout Japan. Established in 1963, it has 500 local Danshukai and over 45,000 members. More

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than 70 percent of these members have abstained from drinking for over one year and have succeeded in social rehabilitation.

The Mentally Disordered Offender

The Japanese criminal code provides for pleas of not guilty by reason of insanity and sentence mitigation by reason of mental distress. It does not provide, however, for committing criminals with psychiatric disorders to mental institutions for medical care and custody. Persons with mental disorders who have committed criminal actions come under the jurisdiction of the Mental Health Law and are committed under either "admission for medical protection" or "involuntary admission by the prefectural governor." In Japan there are neither security hospitals nor security units for mentally disordered offenders and refractory patients. Most of them have been hospitalized in some of the public and private mental hospitals. With the progress of community care and open-door treatment for hospitalized persons, forensic psychiatric problems have become more important. The government has decided to establish policies to address that problem.

Funding Issues

Japan has a national medical insurance system where every citizen is covered and accorded equal access to medical services. Under this system the Japanese government determines the charge for each medical service category and thus regulates how much hospitals can claim for reimbursement for their services. One of the claimable categories is for basic inpatient services, which include doctors' fees, medication, and basic nursing. This charge, which is partly borne by the patient and paid mostly through reimbursement from the government is ¥7,200 or U.S. \$55 per day per patient.

In 1988 gross national medical expenditures were 5.15 percent of GNP—almost ¥19 trillion or U.S. \$146,000,000,000. The problem, however, is that medical resources are not evenly distributed. For example, medical expenditures reimbursed to psychiatric hospitals make up 6.2 percent of total disbursements, although psychiatry has a 22 percent share in terms of number of beds. Monthly medical expenditures per psychiatric patient are approximately half of the average medical expenditures for patients in other medical specialities. It should be added that these expenditures are already much lower than in other countries.

Among the total expenditures of psychiatry—¥1.14 trillion—87 percent were medical expenditures for hospitalization. Medical expenditures for promoting psychiatric rehabilitation in 1989 accounted for ¥101 million or U.S. \$7,700,000. From 1984 to 1989 these expenditures increased three times. But Japan needs more funding for psychiatric rehabilitation.

Consumer Rights

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

1. In case of a need for admission to a mental hospital, the superintendent of the mental hospital shall endeavor to admit the mentally disordered person based on his or her consent (voluntary admission).
2. To guarantee to every involuntarily admitted inpatient the right to appeal to the prefectural governor for his or her discharge or regarding inappropriateness of treatment.
3. 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.
4. To prohibit restrictions on actions, such as correspondence, telephone use, and interviews.
5. To give written notice of the patient's rights at admission.

The principal reforms involved voluntary admission, admission for medical care and custody, involuntary admission by the prefectural governor, and emergency 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 endeavor to admit the person based on his or her consent, and the patient must be informed in writing of his or her 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 or her. 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 or her for a period not longer than seventy-two hours. This voluntary admission was not provided for in the former Mental Hygiene Law. However, there were a few voluntary admissions (5 to 10 percent of total admissions). These were done through another type of voluntary admission (so-called free admission) that was not included in the Mental Hygiene Law. 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 or her protection has consented to the admission, the superintendent may admit the person to the hospital without his or her own voluntary consent as an admission for medical protection.

Admission by consent of a legal guardian (referred to hereafter as consent admission) in the former law was changed more radically. This consent admission was unique in Japan. This type of admission was given a priority for admission,

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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 and partially incorrect, as many voluntary admissions chose admission by consent of legal guardian to expedite admission. This consent admission was changed to an admission for medical protection that was clearly defined as involuntary admission under the newly revised law.

Under another type of involuntary admission, admission occurs only after medical examinations, made by two or more designated physicians selected by the prefectural governor, lead to agreement on the fact that the examined person is mentally disordered and is liable to injure himself or herself or others because of his or her mental disorder unless he or she is admitted to a hospital. Then the prefectural governor can order admittance to a mental hospital established by the national or prefectural government, or to a designated hospital.

In addition, in cases where the superintendent of a mental hospital designated by a prefectural governor as a facility in compliance with the criteria specified by the minister of health and welfare is required to take urgent action with regard to a person for whom the superintendent has been requested to provide medical care and custody, and for whom he has been unable to obtain the consent of a person responsible for custody, the superintendent may admit the person under an emergency admission to the hospital for a period not longer than seventy-two hours without the consent of the mentally disordered person himself or herself. This may be done only after the superintendent has concluded, as a result of the medical examination conducted by a designated physician, that the person in question is mentally disordered, and there would be extreme interference with his or her medical care and custody unless he or she was admitted to the hospital without delay.

Temporary admission has not changed. 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 percentage of newly prescribed voluntary admissions was 52.9 percent, and that of free admissions was 3.7 percent. This shows that many inpatients moved from consent admission to voluntary admission (Ministry of Health and Welfare, 1988a, 1990).

The law also provides for a Psychiatric Review Board. The number of 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 hospitalization and the propriety of the treatment. There are forty-seven Psychiatric Review Boards all over Japan.

CONCLUSIONS AND DISCUSSION

To further develop community psychiatry in Japan, there first needs to be 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 centers, welfare bureaus, and consultation offices for children, and crisis intervention needs to be provided. Third, 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. Fourth, and most important, 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 admission to one.

While public education and public understanding about mental illness are fostered, the country also needs to develop a variety of facilities: day-care and night-care services, supported dormitories, other halfway houses, 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 their far-reaching value, rehabilitation services of 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 that does not impose a financial burden on those willing to undertake community psychiatry. Without registration for financial support to cover almost-inevitable deficits 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 provides that the national, prefectural, and local governments shall endeavor to enable mentally disordered persons to adapt themselves to social life by expanding and improving the facilities needed for medical care, social rehabilitation, and other welfare purposes and education. But there is still no remarkable change to 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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