

# 24 Psychiatric Diagnosis and Mental Health Services in Japan

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Psychiatric care in Japan has emphasized hospitalization. When the Mental Hygiene Law was enacted in 1950, the number of beds occupied by "mentally ill" people was low, at 2 per 10,000 general population in the aftermath of World War II. 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, and in 1961, to restrict the number of public hospital beds and to promote private hospital beds. These policies brought an increase in the number of private psychiatric beds, which are characteristic of Japanese mental health care (Table 24.1).

Roughly speaking, 350,000 psychiatric patients are treated in 1640 mental hospitals, and nearly 1 million patients are treated on an outpatient basis. As of 1988, the number of psychiatric beds reached a peak of 28 per 10,000 general population. It is important to note that more than 85% of these beds are in the private sector (most of them are incorporated and nonprofit).

In 1965, the Mental Hygiene Law was partially revised to encourage outpatient services and other mental health services at the community level. The revised law provided that each prefecture establish the Prefectural Mental Health Center, and that public financial assistance for the outpatient psychiatric services be established. But, no plan or budget has yet been set forth for community psychiatric care. Although a system of outpatient care has been developed, the percentage of the expenses of the system in ratio to total psychiatric care expenses has stayed the same since 1965. This means that the basic pattern of psychiatric care delivery has not changed and psychiatric hospitals are still the major locus of care in Japan. (Asai 1984, 1991)

## 24. Psychiatric Diagnosis and Mental Health Services in Japan

TABLE 24.1. Psychiatric hospitals and beds in Japan.

Type of psychiatric hospital	No. of hospitals (%)	No. of beds (%)
Private	1341 (81.8)	310,868 (88.5)
Incorporated (nonprofit)	977	249,256
Private	364	61,612
Governmental	249 (15.1)	34,457 (9.8)
National	91	9,276
Local governmental	158	25,181
Other (established by Red Cross, etc)	51 (3.1)	6,033 (1.7)
Total	1641	351,358

Source: Ministry of Health and Welfare, June 30, 1988.

### Demographic Data Relevant to Mental Health

The number of patients with long hospitalizations is increasing every year. Now, more than 50% of inpatients have been in the hospital for more than 5 years. The age of hospitalized patients has increased every year and reached a current peak between 45 and 55 years of age. Patients over 65 years of age accounted for 19.6% of all psychiatric patients in 1988.

According to statistics of the Ministry of Health and Welfare in 1987, using ICD-9 (Figure 24.1), in 345,000 hospitalized patients, schizophrenic psychoses top the list at 61.0%, affective psychoses, 4.2%; senile and presenile organic psychotic conditions, 9.3%; neurotic disorders, 6.2%; alcoholic psychoses, 6.0%; mental retardation, 4.4%; epilepsy, 3.5%; and other psychoses, 5.0%. But among outpatients, schizophrenic psychoses decreased to 18.2%, neurotic disorders topped the list at 33.1%, and affective psychoses were at 12.7%.

According to the fact-finding survey of mental health carried out by the Ministry of Health and Welfare in 1983, more than 30% of hospitalized patients could leave hospitals immediately if there were enough social support systems in the community. Actually 60% of all families said that they could not afford to care for discharged patients because support services were lacking (Ministry of Health and Welfare 1988a).

The stigma of mental illness that has been traditionally prevalent in Japanese society still prevails, but seems to have diminished in the last decade.

But even now, some of the diagnoses or labels such as schizophrenia (*Bunretsu-sho*) are inhibitory factors for the rehabilitation of the patients (Asai 1983, 1987).

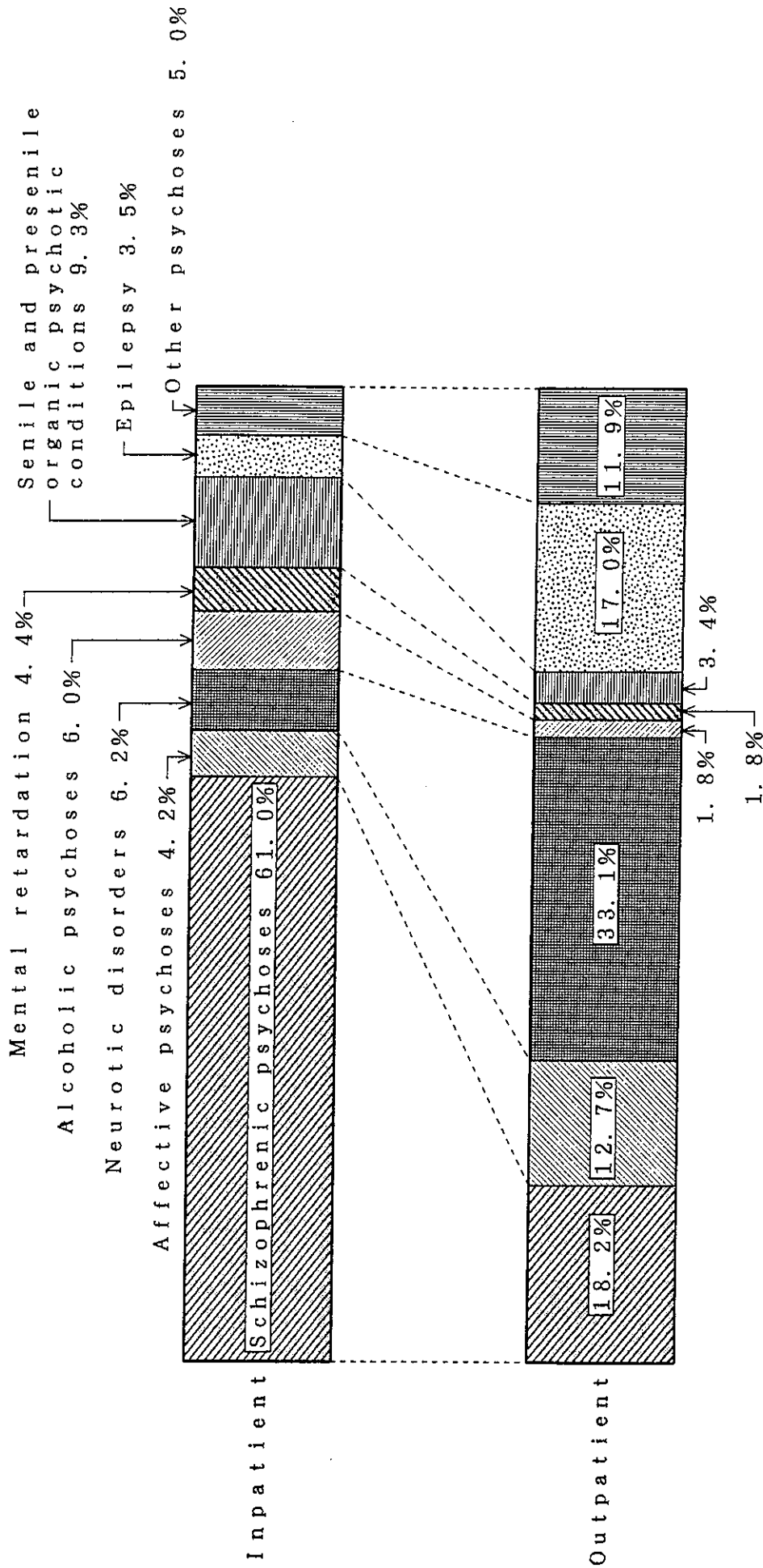


FIGURE 24.1. Distribution of Clinical Diagnosis. (Reprinted with permission from STAT. M.H.W., 1987.)

## Legislation Protecting Patient's Rights

After improper management of inpatients at Utsunomiya Hospital was reported in 1984, there were many protests domestically and internationally, suggesting that mentally ill people in Japan were being subjected to violations of human rights, and this led to the Government of Japan declaring an amendment to 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 ensure patient's rights. 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 (Ministry of Health and Welfare 1988).

The basic concepts in the amended Mental Health Law were as follows:

1. The protection of the human rights of the patients.
2. The promotion of social rehabilitation for the mentally disordered persons.
3. The establishment of the Psychiatric Review Board to protect the patient's rights.
4. Principal types of admission, as reformed, are voluntary admission, admission for medical care and custody, involuntary admission by the Prefectural Governor, and emergency admission.
5. The Designated Physician of Mental Health was recently legislated.

After the enforcement of the recently revised Mental Health Law, the newly prescribed voluntary admission already accounts for more than 50 percent of all admissions in 1989. The Psychiatric Review Board reviews the needs for involuntary admission and for its continuation on the basis of regular reports of the patient's condition and requests. More than 200 cases were discharged on the basis of such reviews in 1989.

The new law introduced designated Physicians of Mental Health to make judgments on legal procedures associated with a limitation of human rights.

According to an investigation carried out by the Japanese Association of Psychiatric Hospitals in 1989, 70% of the newly admitted patients were discharged from the hospital within 3 months, 83% within 6 months and 95% left the hospital within 1 year (Japanese Association of Psychiatric Hospitals 1990).

In Japan, community care programs for psychiatric patients have gradually developed since 1970. These community care programs include: (1) Day services at community mental health centers and public health centers (monthly or weekly), (2) day care services in private or public hospitals (but in 1988, in all of Japan, there were only 186 approved day care services [58% of them in private hospitals]), (3) an aid system for employers of ex-mental patients (the only system for vocational

rehabilitation for mental patients), (4) small-scale sheltered workshops (almost 500), and (5) community residence programs.

Although day services and the aid system for employers of ex-mental patients are programs of the Japanese government, the sheltered workshops and community residence programs are run either by patient's family associations or by voluntary mental health personnel.

Recently, the national government and local self-governing bodies have given small subsidies to some of the small-scale sheltered workshops. However, there are not enough social support systems in the community to accept hospitalized patients.

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

There are only 44 prefectural community mental health centers and 852 public health centers in Japan. The activities of community mental health services of these public health centers are not well coordinated with psychiatric hospitals in the community.

In terms of rehabilitation, the 1988 law set forth a policy which had been neglected since the 1965 amendment. Psychiatric rehabilitation was included in the purpose of the Law stated in Article 1 and Article 2, which prescribe that the completion and increase of rehabilitation facilities is a duty of national and local governments. The kinds of social rehabilitation facilities for mentally disordered persons, designated under the law are Activities of Daily Living training facilities and Sheltered Workshops.

Day care, small-scale workshop and group homes (by self-help groups or private) have been already started, but they are now in short supply. Therefore, most of the chronic patients in mental hospitals are unable to transfer to the community (Ministry of Health and Welfare 1990).

Schizophrenic psychosis is the most frequent primary diagnosis of mental disorders for admission and outpatient medical care. Most of the programs for social rehabilitation are designed for patients with these psychoses, working toward the idea of normalization.

## Field Trial of ICD-10 Chapter V

In Japan, *The International Classification of Diseases*, 9th revision (ICD-9) (World Health Organization 1977) has been applied for developing official statistics. National mental health policy has largely relied on statistical and epidemiological data. For example, according to these data, the government enforced the Law for the Health of the Aged in 1982 and set the policy of health care, medical care, and welfare measures for the demented elderly. The Ministry of Health and Welfare established

a Task Panel for the Demented Elderly in 1986, and the Panel made a report in 1987.

In (1990), the government established a system for financing the treatment and care of elderly patients very similar to the Diagnosis-Related-Groups (DRG) system in the USA. Recently, the Ministry of Health and Welfare started countermeasures against the epidemic of alcoholic psychoses and drug psychoses.

In research settings, most Japanese clinicians now systematically refer to the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd edition (DSM-III) or the revised edition (DSM-III-R). In addition, we have been interested in the ICD-10 Draft of Chapter V. This is because ICD-10 contains many more categories than ICD-9, and a multi-axial system is being prepared. Until now, we have used ICD-9 and DSM-III-R in our usual clinical practice.

In our preliminary study, using the 1988 Draft of ICD-10 Chapter V, Clinical Descriptions and Diagnostic Guidelines, we tried to apply ICD-10 to psychiatric disorders in three populations by 30 clinicians. The first population involved patients who were admitted to Asai Hospital from 1987 to 1989 (Asai Hospital is a private mental hospital located in suburban Tokyo). The second encompassed outpatients who visited Asai Hospital for the first time in 1989. The last involved outpatients who in 1989 visited the Hospital of Tokyo Medical and Dental University (a general hospital in Tokyo).

## Results

1. Frequency of patients by ICD-10 (two-digit category in F code) (Figure 24.2): F2, Schizophrenia, Schizotypal, and Delusional Disorders top the list at 44% among the inpatients of Asai Hospital. But, F2 and F3, Mood Disorders, are almost equal at 23% among the outpatients of Asai Hospital. As for the outpatients of Tokyo Medical and Dental University, F4, Neurotic, Stress-Related, and Somatoform Disorders top the list at 40%; F2, Schizophrenic, 24%; and F3, Mood Disorders, 17%.

2. Frequency of patients by three-digit category in F3 code, Mood Disorders (Figure 24.3): F31, Depressive Episode accounted for 70% of outpatients of Asai Hospital; and for 59% of Tokyo Medical and Dental University. As for the inpatients of Asai Hospital, F31, Depressive Episode accounted for 37%, and F32, Bipolar Affective Episode, 35%.

3. Frequency of patients by four-digit category within the F2 code, Schizophrenia (Figure 24.4): Many research studies in Japan reported that among subcategories of Schizophrenic Psychoses, based on ICD-9, Hebephrenic Type topped the list from 30 to 68%. As can be seen in Figure 24.4, F20.0, Paranoid Schizophrenia tops the list at 45 to 74%, and F20.1, Hebephrenic Schizophrenia is at 9 to 32%.

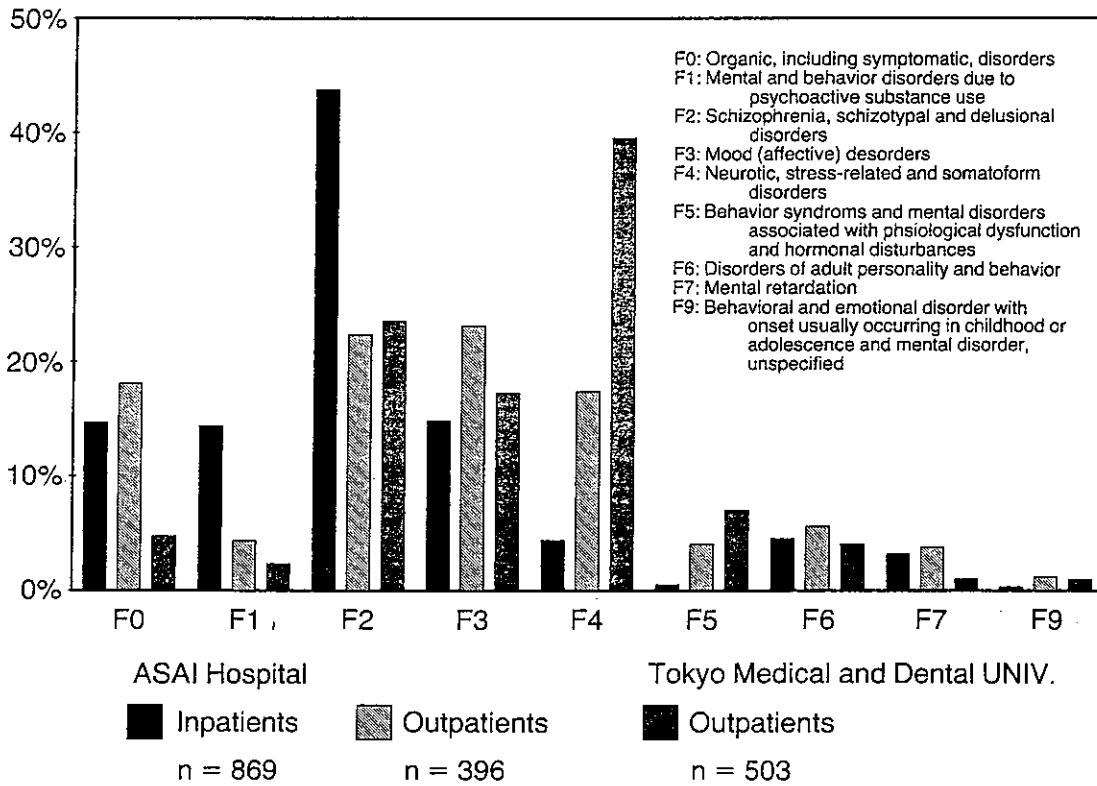


FIGURE 24.2. Frequency of Patients by ICD-10 Two-Digit Categories within the F code.

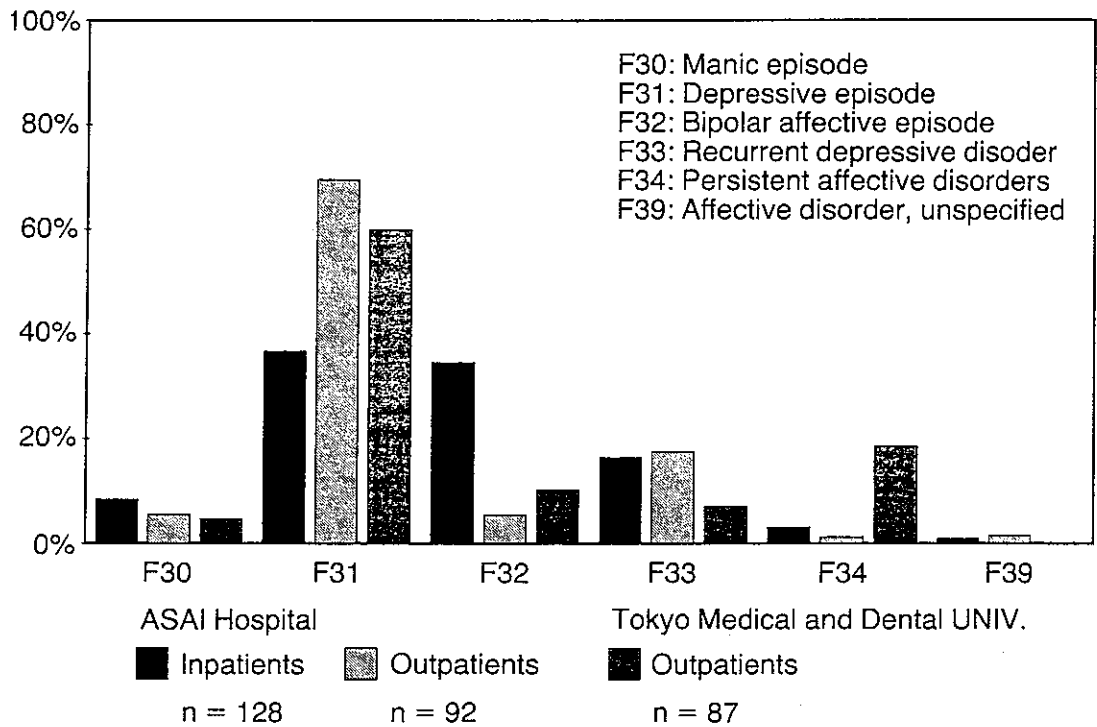


FIGURE 24.3. Frequency of Patients by ICD-10 Three-Digit Categories within the F3\* code.

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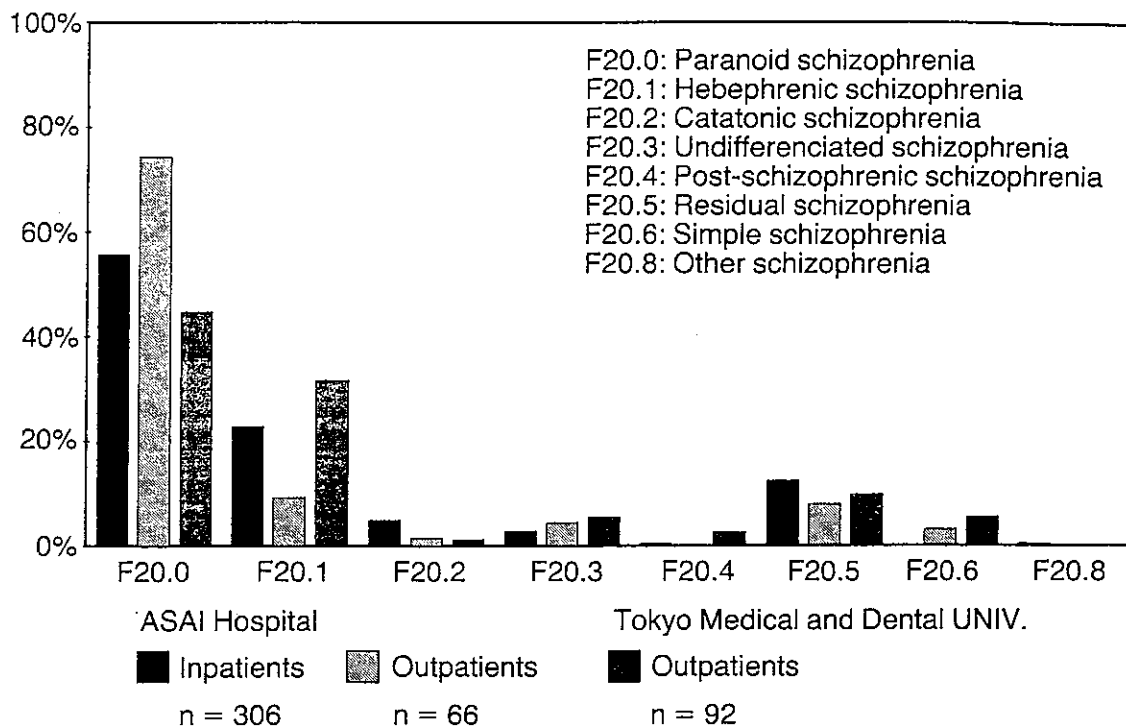


FIGURE 24.4. Frequency of Patients by ICD-10 Four-Digit Categories within the F20\* code.

### 4. Diagnostic conversion of ICD-9 Schizophrenic Psychoses, in ICD-10 F2, Schizophrenic, Schizotypal, and Delusional Disorders (Figure 24.5).

As for the inpatients of Asai Hospital, there were several patients whose diagnosis changed from Hebephrenic Type in ICD-9 to Paranoid Schizophrenia in ICD-10.

Most of the psychiatrists said that the concept of Paranoid Schizophrenia in ICD-10 was broader and that of Hebephrenic was narrower than our conventional concepts.

5. Frequency of patients by three-digit categories within the F4 code, Neurotic, Stress-Related, and Somatoform disorders. F45, Somatoform Disorders accounted for 40% of inpatients of Asai Hospital, and for 26% of outpatients of Tokyo Medical and Dental University. As for the outpatients of Asai Hospital, F43, Reaction to Severe Stress and Adjustment Disorder accounted for 35%; F41, Other Anxiety Disorders was 21%. As for the outpatients at the University, F45, Somatoform Disorders; F41, Other Anxiety Disorders; and F43, Reaction to Severe Stress and Adjustment Disorder together ranged between 26 and 23% (Figure 24.6).

6. Diagnostic conversion of ICD-9, Affective Psychoses, in ICD-10 F3, Mood Disorders. Manic-depressive psychoses branched into many subcategories of ICD-10 (Figure 24.7). I think these subcategories of Mood Disorders of ICD-10 are more complicated for clinical use.



## ICD-9

295.0 Simple Type	3
295.1 Hebeephrenic Type	75
295.2 Catatonic Type	14
295.3 Paranoid Type	134
295.4 Acute schizophrenic episode	9
295.5 Latent schizophrenia	3
295.6 Residual schizophrenia	30
295.7 Schizoaffective Type	19
295.8 Others	3

## ICD-10

154 F20.0 Paranoid schizophrenia	
56 F20.1 Hebeephrenic schizophrenia	
12 F20.2 Catatonic schizophrenia	
6 F20.3 Undifferentiated schizophrenia	
1 F20.4 Post-schizophrenic schizophrenia	
30 F20.5 Residual schizophrenia	
1 F20.8 Other schizophrenia	
5 F21 Schizotypal disorder	
1 F22.8 Other persistent delusional disorder	
2 F23.1 Acute polymorphic psychotic disorder with symptoms of schizophrenia	
1 F23.2 Acute schizophrenia-like psychotic disorder	
11 F25.0 Schizoaffective disorder, manic type	
3 F25.1 Schizoaffective disorder, depressive type	
4 F25.2 Schizoaffective disorder, mixed	
5 Others	

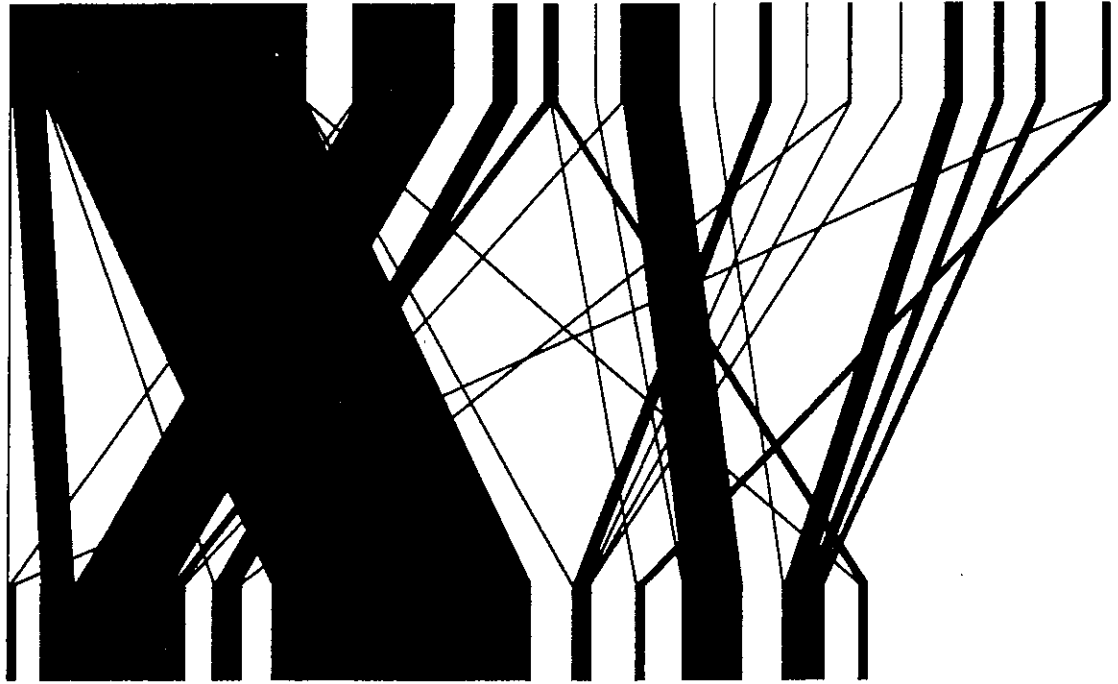


FIGURE 24.5. Changes of diagnosis from ICD-9 to ICD-10 for schizophrenia and related disorders.

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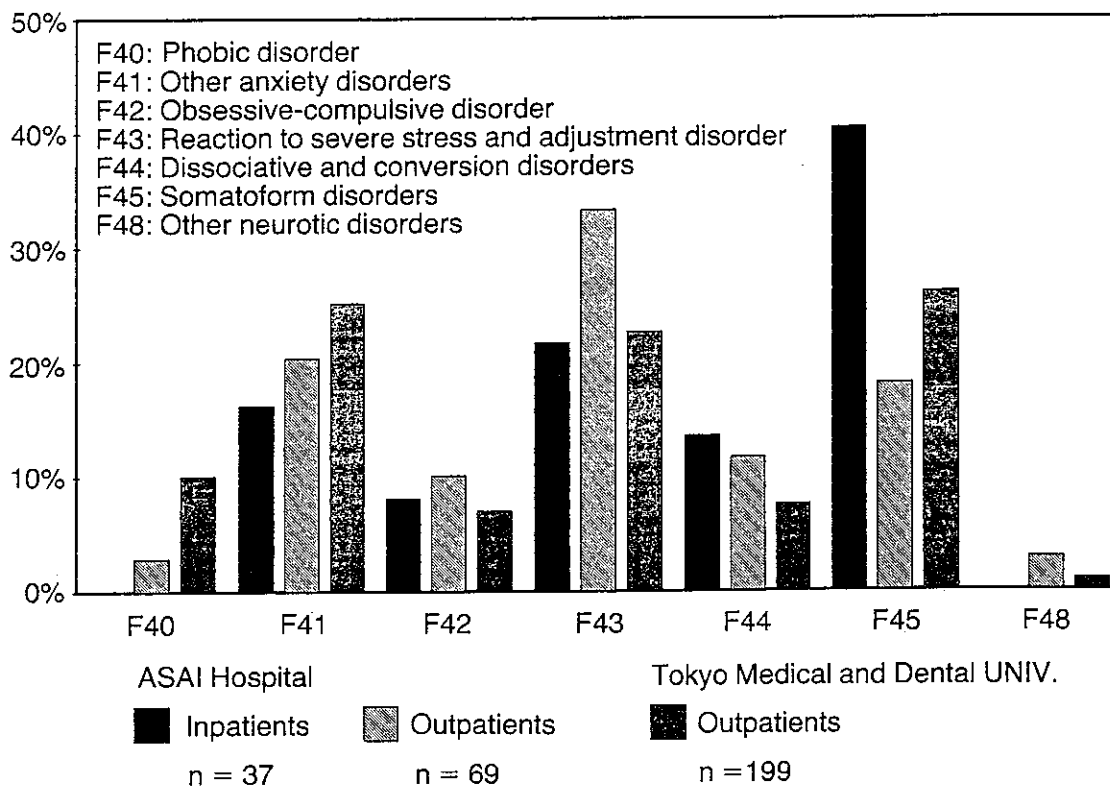


FIGURE 24.6. Frequency of Patients by ICD-10 Three-Digit Categories within the F4\* code.

7. Diagnostic conversion of ICD-9, Senile and Presenile Organic Psychotic Conditions to ICD-10 F0, Organic Including Symptomatic Disorders. Dementia, Alzheimer-Type tops the list and Multi-Infarct Vascular Dementia amounts to almost half (Figure 24.8).

As for the assessment of the diagnostic categories by psychiatrists, some difficulties were found in using the same subcategories of F23, Acute and Transient Psychotic Disorders; F25, Schizo-Affective Disorders; F45, Somatoform Disorders; and F60, Specific Personality Disorder.

## Conclusion

ICD-10 Chapter V is very useful not only for clinical practice but also for educational and research purposes. Furthermore, we are expecting that the multiaxial diagnostic system, and a simplified classification for use in primary health care will be completed soon. They should play a very important role as a common language all over the world. A good psychiatric classification should have an effective impact not only in forming mental health policy in Japan but also on management and insurance. There is the hope that deep-rooted, traditional attitudes to

## ICD-9

296.0 Manic-depressive psychosis, manic type	16
296.1 Manic-depressive psychosis, depressed type	57
296.2 Manic-depressive psychosis, circular type but currently manic	24
296.3 Manic-depressive psychosis, circular type but currently depressed	12
296.6 Manic-depressive psychosis, other and unspecified	1

## ICD-10

3 F30.0 Manic episode Hypomania	3
5 F30.1 Mania without psychotic symptoms	5
1 F30.2 Mania without psychotic symptoms	1
1 F30.8 Other	1
10 F31.0 Depressive episode Mild severity	10
20 F31.1 Moderate severity	20
4 F31.2 Severe depressive episode without psychotic symptoms	4
8 F31.3 Severe depressive episode with psychotic symptoms	8
6 F32.0 Bipolar affective disorder Current episode hypomanic	6
18 F32.1 Current episode manic without psychotic symptoms	18
4 F32.2 Current episode manic with psychotic symptoms	4
6 F32.3 Current episode moderate or mild depression	6
2 F32.4 Current episode severe depression without psychotic symptoms	2
1 F32.5 Bipolar affective disorder Current episode severe depression with psychotic symptoms	1
1 F33.0 Current episode mild severity	1
3 F33.1 Current episode moderate severity	3
3 F33.2 Current episode severe depression without psychotic symptoms	3
4 F33.3 Current episode severe depression with psychotic symptoms	4
3 F33.4 Current in remission	3
1 F39 Affective disorder, unspecified	1
5 Others	5

FIGURE 24.7. Changes of diagnosis from ICD-9 manic-depressive psychoses to pertinent ICD-10 categories.

## ICD-9

290.0 Senile dementia, simple type	23
290.1 Presenile dementia	3
290.2 Senile dementia, depressed or paranoid type	9
290.3 Senile dementia with acute confusional state	3
290.4 Arteriosclerotic dementia	13
290.8 Other	1

## ICD-10

F00.0 Dementia, Alzheimer, simple type	26
F00.1 Dementia, Alzheimer type, presenile onset (type 2)	1
F00.2 Dementia, Alzheimer type, atypical or mixed type	2
F01.1 Multi-infarct (predominantly cortical) vascular dementia	13
F01.2 Vascular dementia, other than cortical	1
F02.1 Dementia in Creutzfeldt-Jakob disease	1
F05.1 Delirium, superimposed on dementia	3
F10.2 Disorders resulting from use of alcohol	1
F20.0 Paranoid schizophrenia	1
F20.2 Catatonic schizophrenia	1
NON	2

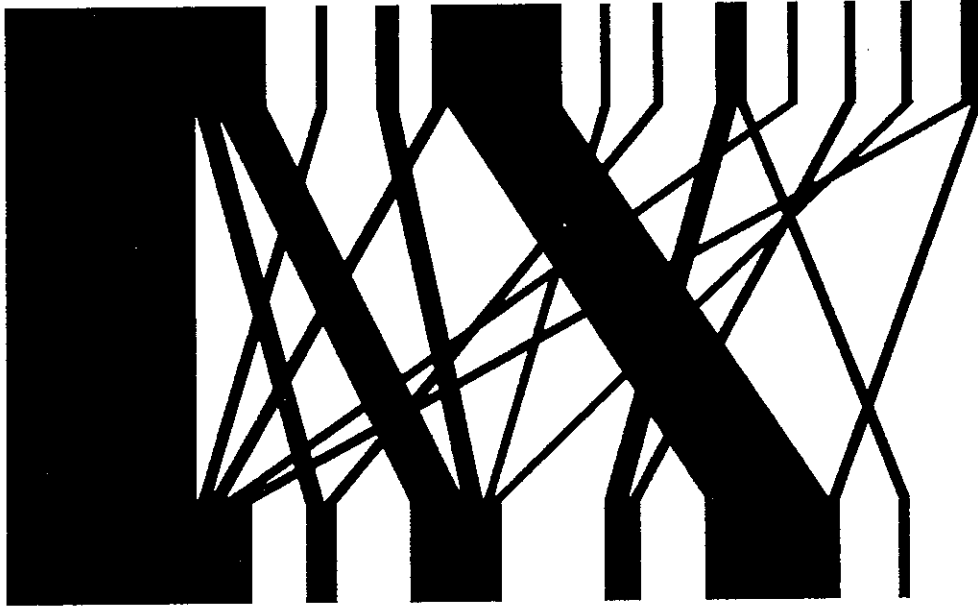


FIGURE 24.8. Changes of diagnosis from ICD-9 dementias to pertinent ICD-10 categories.

mental illness can change if the providers of mental health services demonstrate therapeutic skill and establish a trusting relationship with patients, families, and the community.

Today, Japan needs a community psychiatry system suitable to our culture and social needs. Japan also needs a policy that does not impose a financial burden on those willing to undertake community psychiatric services. Without legislation for financial support, rehabilitation services for former mental patients will almost inevitably incur a heavy deficit.

The Mental Health Law says that the National, Prefectural, and Local Governments shall endeavor to enable mentally disordered persons to adapt themselves to society by expanding and improving the facilities needed for medical care, social rehabilitation, and other welfare purposes and education. But until now, no notable change has been made 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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