Chapter II

HISTORY AND THE PRESENT STATE OF PSYCHIATRIC CARE

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I. History of mental health

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. 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 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 the 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 allowed for compulsory admission by administrative order under the category 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 patient, and over ninety 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, the number of beds occupied by "mentally ill" people was low (2 per 10,000 population). In 1958, following Japan's rapid industrial development, a nationwide compulsory health insurance system was instituted. 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 of the general population (Asai, Takahashi & Tsung-yi 1991).

In 1965 the Mental Hygiene Law was revised, and the Ministry of Health and Welfare started to partially subsidize outpatients and recognized the necessity of transferring 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. Daycare services and rehabilitation programs were also set up. Since then, the total number of outpatients has been increasing every year. However, neither a plan nor a budget provided for community based 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.

II. 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. 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 non-government psychiatric hospitals have begun rehabilitation services, their goodwill and efforts alone are not sufficient.

In 1984, after reports of improper management of inpatients in Utsunomiya Hospital became public, there were many protests, both in Japan and overseas, claiming that the mentally ill in Japan were being subjected to violations of their human rights. In August 1985, the Government of Japan declared its intention to amend the Mental Hygiene Law. During the course of the investigation into the above incident, there was some confrontation 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. This law has been in operation since July 1988. The basic concepts in the amended Mental Health Law included :

- the protection of the human rights of patients ;
- the promotion of social rehabilitation for mentally disordered persons.

The increase in 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 a 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 train-ed, 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 have specialized in these fields is insufficient. The need for policy improvement regarding these disorders can not be overemphasized (Asai 1993).

III. Current mental health organization

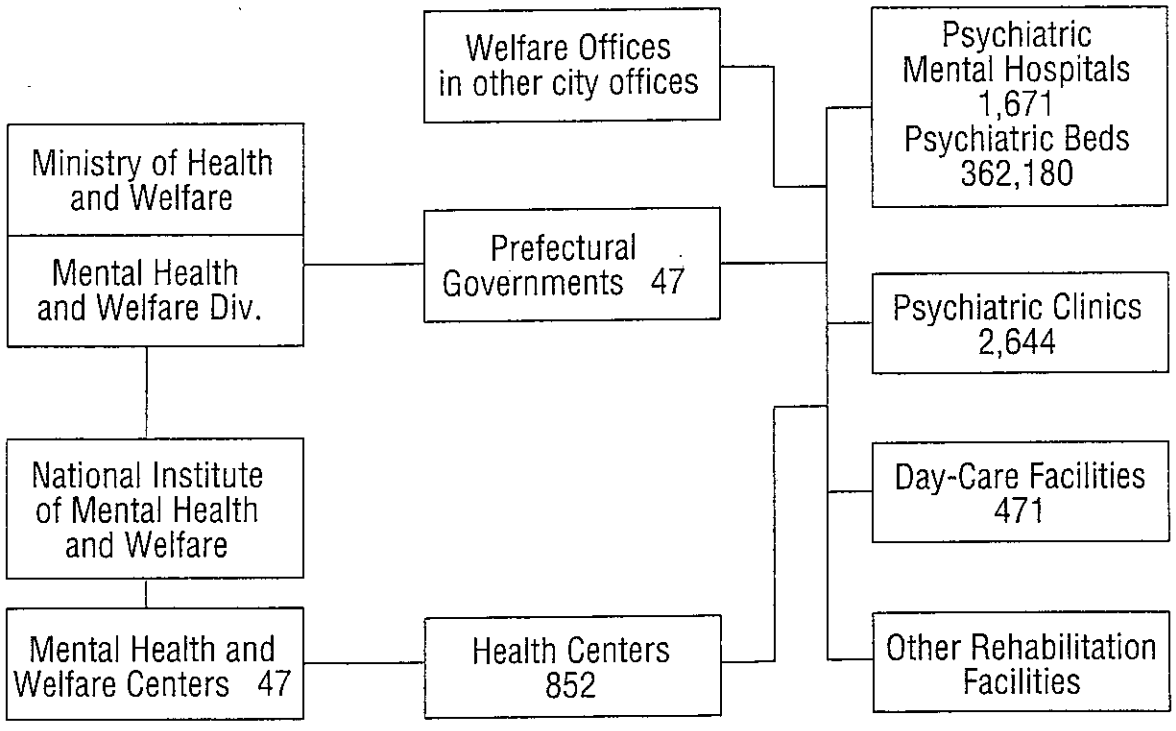
Japan has 47 prefectural community mental health centers and 852 public health centers. The activities of the community mental health services of the public health centers are neither well organized nor cooperate effectively with psychiatric hospitals in the community.

According to a 1983 fact-finding survey of mental health conducted by the Ministry of Health and Welfare, it was estimated that 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 falls 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 bureaux of public health are in charge of mental health services. All prefectures have mental health centers which have responsibility for promoting public mental health services and for disseminating information 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 public health centers. The relationship between these departments and institutions is shown in Figure 1.

Figure 1: The Relationship between Administrative Departments and Institutions in Japan



Source : Ministry of Health and Welfare, 1995

As of the end of June 1995 the institutional care statistics were as follows :

Number of institutions	1,671
Number of psychiatric beds	362,180
Number of inpatients	340,785
Percentage of beds occupied (average per year)	94.1 %
Psychiatric beds per 10,000 population	27.5

Only 18.3 percent of psychiatric hospitals are public, and only 11.3 percent of psychiatric beds are public. Most of the private psychiatric hospitals are incorporated and are nonprofit organizations.

Six years after the implementation of the new Mental Health Law, the types of admission were as follows :

Number of voluntary admissions	224,857	65.9 %
Number of admissions for medical care and protection	102,549	30.1 %
Number of involuntary admissions by the prefectural government	5,854	1.7 %
Voluntary admission	7,781	2.3 %

There are 2,644 outpatient facilities and clinics taking care of 700,000 patients. They deliver medical services, including case management and counseling for recovering patients. The 47 prefectural mental health centers and 852 health centers coordinate the delivery of public mental health services, including counseling, day-care programs, information dissemination, and other services.

In theory, mental health facilities and services fall under 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 non-government hospitals are aware of the importance of community psychiatry, many of them find it extremely difficult to start loss-producing rehabilitation services without subsidies.

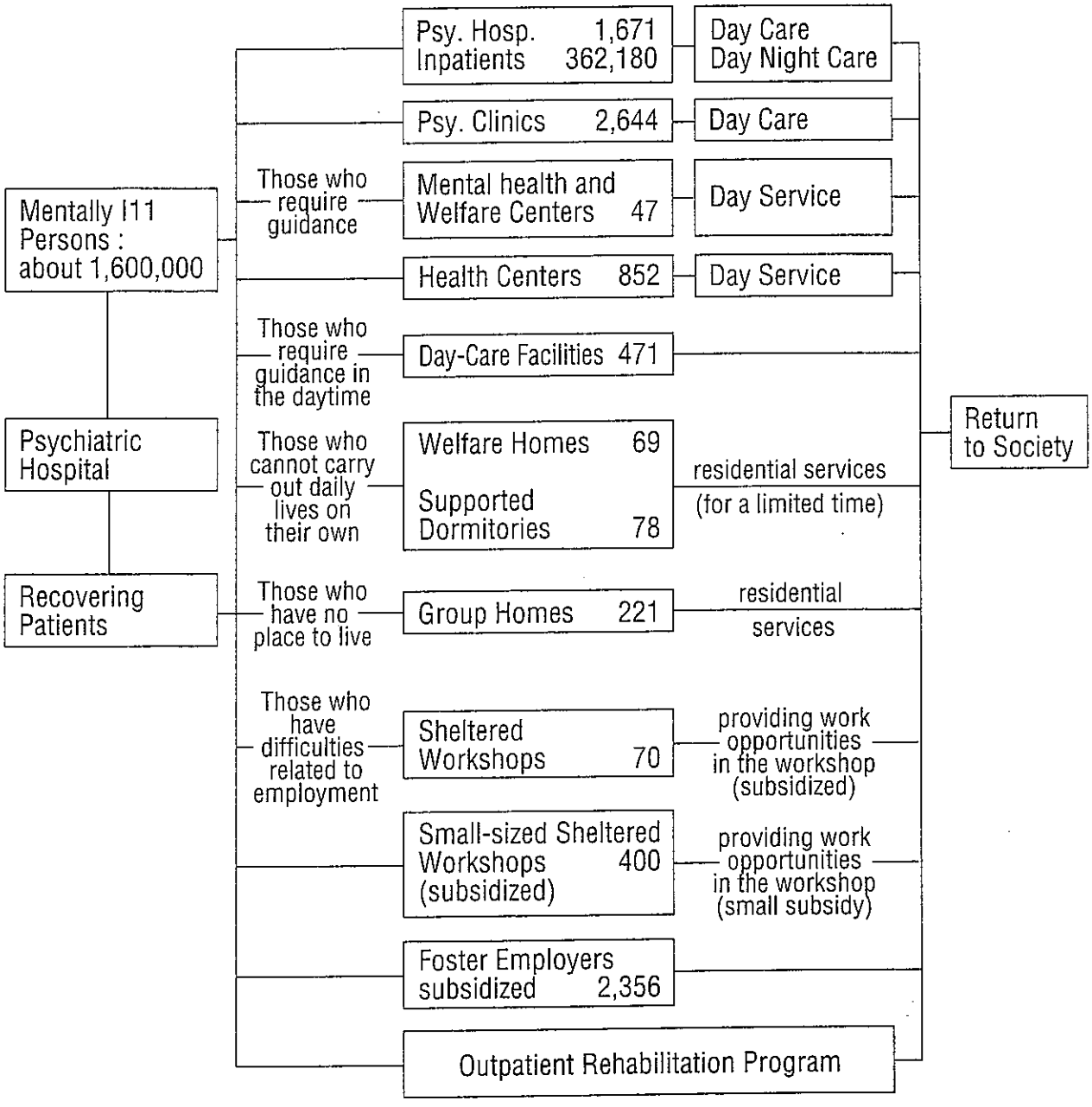
IV. Current mental health services

Since 1970, community care programs for psychiatric patients in Japan have gradually been developed. However, they have not developed enough to become major sites of treatment.

Social resources for activities for the mentally disabled in 1994 (Figure 2) included

small sized sheltered workshops, which began in the 1960s, for the physically handicapped, the mentally retarded, and the mentally disordered. As of 1 October 1995, there were 2,231 such workshops, of which 400 served mainly those with mental disorders and were subsidized. These small-sized sheltered workshops are run by families or voluntary mental health personnel. There are only 70 sheltered workshops subsidized under the Mental Health Law. There are 471 approved day-care facilities, but only 22 per cent of them are public.

Figure 2: Rehabilitation System for the Mentally Ill in Community Mental Health and Welfare in Japan, 1995



Source : Ministry of Health and Welfare, April 1, 1995

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 desig-nated and registered as vocational "parents". There are now 2,356 such companies.

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 equivalent to those for physically handicapped or mentally retarded persons.

Social resources for living were limited as of 1995. There are poor community residential facilities in Japan. The amended Mental Health Law of 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 1995 there were only 69 welfare homes and 73 supported dormitories. The number of such residential facilities has not grown significantly. Most of these social rehabilitation facilities were established by juridical persons, and 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 221 group homes established by private hospitals and self-help groups with minimum subsidy.

While facilities needed for the social rehabilitation of the mentally disordered in Japan still have many problems, Japan has started to make 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 effort to develop social rehabilitation strategies based on the new Mental Health Law.

In Japan, deinstitutionalization has not progressed very far. Psychiatric hospitals in Japan play a role that intermediate facilities should play. They provide hospital facil-ities such as security, emergency services, and acute, subacute, and chronic services, for which the same base charge is applied. At the same time, psychiatric hospitals, again for the same base charge, have to serve as nursing homes or sometimes as board-and-care facilities. The consequence of this is that there are few street people in the community.

As of the end of June 1994, medical personnel in mental hospitals were as follows :

Psychiatrists	***8,988***
(Designated physicians of mental health)	***(8,406)***
Nurses	***37,087***

Assistant nurses	36,402
Nurse aides	20,342
Qualified occupational therapists	1,014
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 auxiliary medical personnel, 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 psychiatric judgments being made by any doctor, as was the case under the former law, the new 1988 law specifies that the doctor must be 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 before they can obtain registration. The designated physicians are responsible for daily activities such as decisions relating to both admissions and discharges, except for voluntary ones. Any restriction of patient activities specified by the minister of health and welfare must be justified by a designated physician. Thus, in general, the treatment in psychiatric hospitals cannot be executed without a designated physician. By the end of 1994 there were 8,406 designated physicians in Japan.

V. Transition from mental health law to mental health welfare law

In December 1993, the Basic Law for the Disabled was enacted. This law, which explicitly included those with mental disabilities as its target population, brought Japan's mental health care into a new era where welfare measures are provided for those with mental disabilities. For many years, the only legislative measures for this group had been health care provided under the Mental Health Law (Yoshida 1995).

The Community Health Care Law came into effect in July 1994. This law offers new perspectives to community-level health care measures, for example, by proposing a new sharing of functions among the national, prefectural, and municipal governments. In fact, this law now allows more discretion to municipal governments in implementing mental health measures, a move designed to further enhance mental healthcare measures in the community.

Given these developments, the Japanese government decided to partially amend the

Mental Health Law from 1 July 1995. The amendment has several objectives. First, the Mental Health Law amendment is designed to incorporate welfare measures, now that the new Basic Law for the Disabled includes those with mental disabilities as beneficiaries of the law. Second, the Mental Health Law incorporates provisions made under the new Community Health Law. Third, the Mental Health Law incorporates the various changes made since 1993 when the Law was last amended. Key changes in the amendment are as follows :

1. Changes related to the improvement of health care and welfare measures for those with mental disabilities

1.1. Changes regarding the names of the law and other related issues

a. To change the name of the Law from the Mental Health Law to the Law Concerning Mental Health and the Welfare of those with Mental Disabilities.
b. To refer to the purpose of the Law, as "promoting the independence of those with mental disabilities and their participation in socio-economic activites".
c. To refer to "promoting the independence of those with mental disabilities and their participation in socio-economic activites" as the responsibility of the national, prefectural, and municipal governments, as the responsibility of the general public, and as the responsibility of the operators of hospitals and other relevant facilities.
d. To add a new section devoted to "health care and welfare".

1.2. Changes regarding health care and welfare certificates for those with mental disabilities

a. To allow those with mental disabilities to apply to receive health care and wel-fare certificates by submitting an application, together with documents provided for under the Ordinance of the Ministry of Health and Welfare, to the governors of the prefectures in which these persons reside (or, the prefectures of their present addresses in the case of those with no fixed residence), and to require the governor to grant such certificates when, and if, the applicants are found to be suffering from mental disabilities as provided for under the Government Ordinance.
b. To require prefectural governors to hear the opinions of the Local Mental Health and Welfare Councils in determining whether health care and welfare certificates would be issued when applied for, except for cases in which the applicant has been receiving a pension because of a mental disability.
c. To require those with mental disabilities who have been issued health care and welfare certificates to have the conditions of their mental disabilities verified by prefectural governors every two years.

1.3. Changes regarding social rehabilitation facilities

a. To refer specifically to "welfare homes for those with mental disabilities" and "welfare workshops for those with mental disabilities" as new types of social rehabilitation facilities.
b. To have welfare homes promote the social rehabilitation and independence of those with mental disabilities by making available rooms and other facilities, at low rates, to those in need of places to live and by providing daily living-related conveniences.
c. To have sheltered workshops promote the social rehabilitation of those with mental disabilities and their participation in socio-economic activities by employing those with mental disabilities whose employment is otherwise difficult and by providing guidance needed for their adjustment to social living.

1.4. Changes regarding social adjustment training services

To require prefectural governments to assist social adjustment training services for those with mental disabilities to promote their social rehabilitation and their participation in socio-economic activities (in which social adjustment training services, popularly known as Outpatient Rehabilitation Services, are services in which employers are encouraged to promote participation of those with mental disabilities in socio-economic activities, and to provide jobs on a contract basis with the prefectural governments to those persons whose employment in normal business entities is difficult, and provide training needed for adjustment to social living).

2. *Changes related to ensuring appropriate mental health care and other related issues*

2.1. Changes regarding designated mental health physicians

a. To cancel the designation of designated mental health physicians if they fail to undergo scheduled training every five years, except for those cases in which the Minister of Health and Welfare accepts that there is a valid reason for such a physician not to undergo such training.
b. To require mental hospitals to have a full time designated mental health physician, pursuant to the Ordinance of the Ministry of Health and Welfare, if such hospitals are qualified to accept involuntary admissions by prefectural governors of patients dangerous to themselves and/or others and to accept admissions for medical care and protection without the consent of patients but not if such hospitals accept voluntary admissions only.

2.2. Changes regarding designated hospitals

To state specifically in the legislation that hospitals which meet the criteria set by the Minister of Health and Welfare are qualified as designated hospitals, and to allow the Minister to cancel the designation when and if a designated hospital fails to meet the criteria.

3. Changes related to cost sharing of mental health care

3.1. Changes regarding the application of public funds to pay for involuntary admissions by prefectural governors

To continue paying, out of public funds, fees for involuntary admissions by prefectural governors of patients dangerous to themselves and/or others, provided, however, that the fees to be borne by prefectural governments are reduced to the extent that the patients involved are entitled to receive health care-related benefits under the Social Insurance Acts or the Elderly Health Care Law.

3.2. Changes regarding the application of public funds to pay for psychiatric outpatient medical fees

To enable prefectural governments to choose, if so desired, to pay 95 percent of psychiatric outpatient medical fees, provided, however, that the fees to be borne by prefectural governments are reduced to the extent that the patients involved are entitled to receive health care-related benefits under the Social Insurance Acts or the Elderly Health Care Law.

VI. Conclusion 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 the community in general. Second, strong networks need to be established among public health centers, welfare bureaux, and consultation offices for children, with the provision of crisis intervention when needed. 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.

While public education and public understanding of mental illness is being fostered,

Japan also needs to develop a variety of facilities and services to help those with mental disabilities to better cope with their environment and eventually participate in society as independent individuals (for example through day-care and night-care services, supported dormitories, other halfway houses, sheltered workshops for vocational opportunities, and other appropriate programs). Where appropriate, psychiatric hospitals should continue to offer prompt medical intervention, so as to ensure that anxiety within the community is not aroused to a negative extent.

Given their long term 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 both its culture and 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 the almost inevitable deficits incurred by rehabilitation services for former patients, and with the social stigma still remaining in society, some hospitals have been forced to withdraw from rehabilitation services.

The Mental Health Law states that the national, prefectural, and local governments shall endeavor to enable mentally disordered persons to adjust themselves to social life by expanding and improving the facilities needed for their medical care, social rehabilitation, and other welfare and education needs. However, despite this aim, there is still no major change in the social rehabilitation of mentally disordered persons.

Further progress needs to be made, for example, in terms of promoting the social rehabilitation of those with mental disabilities, ensuring better health care, improving welfare measures for those with mental disabilities, and providing facilities and services in the community. Finally, more financial and legal support is required to ensure that the rehabilitation and community care of mentally ill people in Japan is promoted and conducted adequately.

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