NEW MENTAL HEALTH AND WELFARE LAW
AND RECENT MENTAL HEALTH POLICY
IN JAPAN

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1. History of Law on Persons with Mental Disabilities

Some time after Japan modernized itself after Meiji Restoration in 1868, there were two pieces of legislation concerned with mentally ill people. The Law for the Confinement and Protection of the Insane of 1900 provided procedures to confine the mentally ill patients 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, the Mental Hygiene Law was enacted in 1950. Through this law, the government dictated 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 were involuntary patients.

In 1965 the Mental Hygiene Law was revised, the Government 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 (clinics) were increased and gradually became more widespread. Day care services and social rehabilitation programs were also set up.

In 1984, after reports of improper management of inpatients in Utsunomiya
Hospital became public, there were many protests, both in Japan and from overseas, claiming that the mentally ill in Japan were being subjected to violations of their human rights. There was some confrontation and discussions between psychiatrists and jurists in reference to the best way to assure patients’ rights. The Newly revised law, called the Mental Health Law, was legislated in 1987.

The basic concepts of the Mental Health Law was (1) protection of the human rights of patients and (2) promotion of social rehabilitation for the mentally disordered persons.

In the newly revised Law, the following provisions are added in order to protect the human rights of the patients and to promote their rehabilitation:

* To make efforts to admit the mentally ill based on their own consent: voluntary admission
* To guarantee the right of every involuntarily admitted inpatients to appeal to the Prefectural Governor for his or her discharge
* To establish Psychiatric Review Board to review the necessity of involuntary hospitalization and the propriety of treatment by the admission notice and the regular report
* To prohibit restrictions on actions, such as correspondence and interviews
* To give written notice of the patient’s rights at admission time
* To promote rehabilitation measures for mentally ill persons

Since 1970, Community Care programs in Japan have gradually developed for persons with mental disabilities. However, they have not developed enough to become major sites of treatment.

A new climate resulted in December 1993, after the 1993 World Congress of WFMH JAPAN when the Basic Welfare Law for the disabled was put into effect.

With the establishment of this Law, people with mental disorders, as well as people with physical disabilities or mental retardation, clearly came under the Basic Welfare Law. This Law brought Japan’s mental health care into a new era where welfare measures are provided for those with mental disabilities.

In 1994, the establishment of the Community Health Care Law required the further strengthening of the community-based mental health care system. Given these developments, the government decided to amend the Mental Health Law. Under these background, “Mental Health and Welfare Law” was legislated in 1995. This Law intended to (1) provide welfare services for those with mental disabilities, (2) expand community-based mental health programs, (3) encourage the independence and social participation of individuals with mental disabilities.
2. Mental Health Administration and Its Policy Issues

The Mental Health and Welfare Law falls under the jurisdiction of the Mental Health and Welfare Division of the Ministry of Health and Welfare. Especially, from 1995, Mental Health and Welfare for Persons with Disabilities. In each prefectural government, department of bureau of public health are in charge of mental health services. All prefectures (47) and 12 big cities under Cabinet Order should have Mental Health and Welfare Centers which have responsibility for promoting mental health and welfare 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 706 public health centers.

3. Current Mental Health Services

According to the Mental Health Law, efforts to let the mentally ill be admitted based on their own consent shall be made by the superintendents of the psychiatric hospitals. But in the case of an application from community residents, or a report from the police, public prosecutors, or superintendents of probation officers, the Prefectural Governor can compulsorily commit a mentally ill person to an institution, provided that the person by diagnosed by two Designated Physicians of mental health, in full accord with the compulsory admission. The number of involuntarily hospitalized patients have been decreasing. On the contrary, the ratio of voluntary admission have been rapidly increasing. Now, 3,000 outpatients facilities and clinics taking care of more than 700,000 patients are delivering medical services including case management and counseling for recovering patients.

(1) Number of Inpatients per 10,000 population

Average number of inpatients in 1998 were 26.8.

As shown in the Figure, number of inpatients are very different among each prefectures; maximum 56in Kagoshima, 55 Nagasaki (Kyushu districts), minimum 17 in Shiga, Kanagawa, Saitama prefecture.

We should make optimum beds – line in the near future.

(2) Type of Admission

Ten years after the implementation of Mental Health Law, the type of admission were as follows: Number of voluntary admissions 68.6%, Number of admissions for medical protection 28.2%, Number of involuntary admissions by the prefectural governors 1.6%, Free admission 1.8%.
(3) Number of Involuntary Admission by Prefectural Governors per 10,000 Population are also very different among each prefectures.

**Psychiatric Review Board**

Each prefectural government (47) and 12 big cities shall establish a psychiatric review board to protect the human rights of the patients. A psychiatric review board shall review cases by a collegial body composed of three members appointed from those with knowledge and experience in the psychiatric care of the mentally disordered persons, one member from those with knowledge and experience in the law, and one member appointed from those with knowledge and experience in other disciplines.

(1) Review based on Request for Discharge have been between 700 and 1,000. Among these cases 5% of patients’ requests were accepted and discharged from hospital. Request for Improvement of Treatment have been between 26 and 65.

(2) The number of Review based on request for discharge are very different among prefectures. Ohsaka, Tokyo and Fukuoka occupied 30% of total requests for discharge.

(1) Mental Health Personnel in 1998

As of the end of June 1998, mental health personnel were the following:

- Psychiatrists: 12,000 (approx)
  - (Designated physicians of mental health: 10,161)
- Nurses: 34,866
- Assistance Nurses: 39,266
- Nurse Aides: 23,885
- Qualified Occupational Therapists: 1,624
- Qualified Psychiatric Social Workers: 4,338
- Clinical Psychologists: 1,200 (approx)
- Mental Health Workers
  - (in public health centers): 2,200 (approx)
- Public Health Nurses: 2,000 (approx)

Among co-medical staffs, occupational therapists and psychiatric social workers meet national qualifications. There is nationwide shortage of labor both in medical and other professional fields. Mental Hospitals also suffer because of shortage of nurses and other professionals.

(2) **Designated Physician of Mental Health**

Instead of the psychiatric judgement doctor system used under the Mental Hygiene
Law, the New Mental Health Law in 1987 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 experienced with eight case reports for registration. The designated physicians of mental health are responsible for daily activities such as decisions on all admissions and discharges, except for voluntary admissions, 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 of mental health. The number of designated physicians have been increasing every year – 10,161 in 1998.


This Plan aims to implement a concept of rehabilitation that aims for the restoration of rights as a full citizen in all stage of life, and a concept of normalization that aims for a society in which people with disabilities live their lives and are active the same as people without disabilities.

Based on the above philosophy, policies have priority in the following seven viewpoints:
(1) To Live Together in the Community
(2) To Promote Social Self-Sufficiency
(3) To Promote Barrier-Free Access
(4) Aiming to Improve Quality of Life (QOL)
(5) To Ensure Safe Livelihood
(6) To Eliminate Mental Barriers
(7) To Promote International Cooperation and Exchange Suited to Japan

5. Expanding Programs on Health, Medical Care and Welfare for Persons with Mental Disabilities
(1) Promotion Social Rehabilitation and Expanding Welfare Programs

Social Rehabilitation Facilities

Rehabilitation facilities under the Mental Health and Welfare Law are as follows;

Daily-Living Training Facility
Welfare Home
Group Home
Sheltered Workshop with Accommodation
Sheltered Workshop without Accommodation
Welfare Workshop

These six types of rehabilitation facilities are subsidized from National and Local Governments which include 75% of initial construction cost and management cost.

a. The provision of Daily-Living Training Facility for persons with mental disabilities for 300 facilities – 6,000 persons (target figure), and each Daily-Living Training Facility may have Short Stay Beds which are very important for soft crisis intervention. Welfare Home provide social adaptation training programs for 300 facilities – 3,000 persons by 2,002. Community living support programs – Group home – for 920 facilities – 5,000 persons by 2,002.

b. The provision of the training programs for working – such as Sheltered Workshop (target; 400 facilities), Welfare Factory (target; 59 facilities) and Small – sized Sheltered Workshop run by patient – family association and self-help groups.

c. Community – Living Support Center provide services to support for the daily life of persons with mental disabilities in their local communities, as well as everyday consultation and exchange with other persons in the community, to be carried out at the level of two centers per 300,000 population – (target; 650 facilities).

d. The expansion of local health and welfare programs for persons with mental disabilities including: expansion of counseling and instruction from Mental Health and Welfare Centers and Public Health Centers; support for family groups and patient groups; expansion of the services of the Center for promotion the social rehabilitation of persons with mental disabilities and expansion of welfare services based on welfare certificates.

e. The expansion of training for social rehabilitation (giving careful consideration to the individual characteristics of persons with mental disabilities), and cooperation with employment policies in order to develop social independence by promotion the transition from training to employment.

During recent 10 years, User (Consumer) movements in Japan became very active. Many Self-help groups exist all over Japan. Policy of User-Involvements have been
gradually developing and became most important matter.

f. Other Community-based Programs

The Ministry of Health and Welfare intends to expand other support programs in the community: helping the target population live independently in public houses and apartment houses; and assisting the activity of small-scale sheltered workshops that are operated mainly by patients' families and volunteers.

Certificates for Persons with Mental Disabilities will provide various benefits to facilitate living in the community. The Ministry also intends to work more closely with the Ministry of Labor so that those with mental disabilities will enjoy various measures taken by the Ministry of Labor to help persons with mental disabilities get jobs.

g. As shown, “International Comparison of Psychiatric Beds and Capacity of Residential Facilities”, in Japan, although there are many psychiatric beds (30% of inpatients are over 65 years old), capacity of residential facilities are not sufficient.

But the total number of institutions of these countries (U.S.A., Canada and U.K.) are almost same as Japan – 27 per 10,000 population.

(2) Improvement of Psychiatric Medical Services

a. The provision of 1,000 psychiatric day care centers (target figure) during the period of the Action Plan for the purposes of providing medical rehabilitation programs to promote social rehabilitation, which will cover 50,000 members.

b. The establishment of the system of psychiatric emergency medical services in 47 prefectures are provided during nights and weekends.

c. The development of the system of psychiatric medical services in which treatment for complications and other symptoms in properly provided, with consideration of the rights of persons with mental disabilities.

d. The improvement of the medical treatment environment by modernizing the facilities of mental hospitals. During these two years, medical council of the Government have been discussing to amend the Medical Law to make the new standard of amenity of the hospital ward and manpower.

e. The advancement of multi-faceted investigation into the most appropriate form of medical treatment for long-term patients, to enable them to enjoy reliable and high-quality medical treatment.

6. Conclusion

Given these developments, the Government revised the Mental Health and Welfare Law again in May, 1999.
The principal items of the reform are as follows:

(1) Empowerment of the Psychiatric Review Board: The Secretariat of Psychiatric Review Board move from the Bureau of the Prefectural Government to the Mental Health and Welfare Center to keep independency.

(2) Each Prefectural Government should make new transportation system for the admission of emergency patients.

(3) Strengthening the duties of the designated physician of mental health to carry out compulsory admission and to protect patients' right.

(4) Empowerment of the control over mental hospitals by the national and prefectural government.

(5) Reviewing obligation concerning family's responsibility.

(6) Promoting further social welfare measures for people with mental disorders.

For this purpose, from 2002, social welfare measures move to local government.

After the amendment of this year, the subjects left to the next reform in 2004 are as follows:

(1) Legislation for mentally disordered offenders.

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 this problem.

(2) The rehabilitation program for long-term inpatients.

We have now official discussion on new measures of rehabilitation facilities for long term inpatients with key persons of Mental Health and Welfare Division of Governments.

(3) Promotion of community care and respect of self - determination of the users.

Comparing to UN's Principle, further improvement should be made in the near future.
The Relationship between Administrative Departments and Institutions

History of the Mental Health Law in Japan
Number of Psychiatric Hospitals

(Source: Ministry of Health and Welfare)

Number of Psychiatric-Beds

(Source: Ministry of Health and Welfare)
Average Stay of Hospitalization

(Source: Ministry of Health and Welfare)

Age Range of the Inpatients

(Source: Ministry of Health and Welfare)
Duration of Hospitalization

(Source: Ministry of Health and Welfare)

Transition of the Family-Age

(More than 23% of Patients are living alone)
Number of Inpatients per 10,000

\[ X = 26.8 \]


Number of Patients

Type of Admission

- Involuntary Admission by Prefectural Governors
- Involuntary Admission for Medical Care and Protection
- Voluntary Admission
- Free Admission

(Source: Ministry of Health and Welfare)
Type of Admission in 1997
(N = 338,714)

Involuntary Admission by Prefectural Governors
1.6% (N=4,772)

Free Admission
1.8% (N=5,893)

Involuntary Admission for Medical Care and Protection
28.2% (N=94,827)

Voluntary Admission
68.6% (N=230,983)

(Source: Ministry of Health and Welfare, June 30, 1997)

Ratio of voluntary Admission

X = 68.6

Number of Inpatients
(Involuntary Admission by Prefectural Governors)
per 10,000

\[ X = 0.38 \]


Review based on Request for Discharge and Request for Improvement of Treatment

(Source: Ministry of Health and Welfare)
Mental Health Personnel in 1998

- Public Health Nurses (approx. 2,000)
- Mental Health Workers (approx. 2,200)
- Clinical psychologists (approx. 1,700)
- Qualified Psychiatric Social Workers (approx. 4,338)
- Qualified Occupational Therapists (approx. 1,624)
- Nurse Aides (approx. 2,885)
- Assistant Nurses (approx. 3,926)
- Nurses (approx. 3,496)
- Psychiatrists (approx. 1,016)
- Psychiatric Review Board (1997)
(2) To Promote Social Self-Sufficiency
(3) To Promote Barrier-Free Access
(4) Aiming to Improve Quality of Life (QOL)
(5) To Ensure Safe Livelihood
(6) To Eliminate Mental Barriers
(7) To Promote International Cooperation and Exchange 추진도 일본으로

1996 — 2002
The Government Action Plan — A Seven-Year Strategy
— for Persons with Disabilities
Admitted in 1994
Investigated in 1998
JAPH (102 Hospitals)
ASAI HOSPITAL

Staying Rate
## Mental Health Community Programs as of FY2002

<table>
<thead>
<tr>
<th>Facility</th>
<th>FY 1998</th>
<th>FY 2002</th>
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<tbody>
<tr>
<td></td>
<td>number of facilities</td>
<td>number of service recipients</td>
</tr>
<tr>
<td>Daily-Living Training Facility</td>
<td>172</td>
<td>3,440</td>
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<tr>
<td>Welfare Homes</td>
<td>155</td>
<td>1,550</td>
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<tr>
<td>Group Homes</td>
<td>576</td>
<td>3,168</td>
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<tr>
<td>Sheltered Workshops with accommodation</td>
<td>15</td>
<td>450</td>
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<td>Sheltered Workshops without accommodation</td>
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<td>2,260</td>
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<tr>
<td>Welfare Workshops</td>
<td>23</td>
<td>690</td>
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<tr>
<td>Community-Living Support Center</td>
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<td>Social Adjustment Training Programs</td>
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<td></td>
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<tr>
<td>Outpatient Rehabilitation Programs</td>
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<tr>
<td>Day Care Facilities</td>
<td>658</td>
<td>32,900</td>
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(Source: Ministry of Health and Welfare)
Day Care Facilities

Number of Facilities

<table>
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<th>Year</th>
<th>Facilities</th>
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<tr>
<td>1987</td>
<td>103</td>
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<tr>
<td>1988</td>
<td>125</td>
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<td>1989</td>
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<td>1996</td>
<td>570</td>
</tr>
<tr>
<td>1997</td>
<td>658</td>
</tr>
</tbody>
</table>

(Source: Ministry of Health and Welfare)

Social Rehabilitation Facilities for Living and Working
— A Seven-year Normalization Strategy —

Daily-Living Training Facility

Welfare Home

Group Home

Sheltered Workshop with Living Facility

Sheltered Workshop

Welfare Factory

Community-Living Support Center

Day Care Facility

Source: Ministry of Health and Welfare
Daily-Living Training Facility

(Source: Ministry of Health and Welfare)

Welfare Home

(Source: Ministry of Health and Welfare)
Number of Facilities

Group Home

220 430 540 576 920
(Source: Ministry of Health and Welfare)

Sheltered Workshop with Living Facility

7 14 24 26 100
(Source: Ministry of Health and Welfare)
Day Care Facilities

(Source: Ministry of Health and Welfare)

International Comparison of Psychiatric beds and Residential Facilities

<table>
<thead>
<tr>
<th></th>
<th>U.S.A</th>
<th>CANADA (British Columbia)</th>
<th>U.K.</th>
<th>JAPAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Beds</td>
<td>13</td>
<td>16</td>
<td>15</td>
<td>27</td>
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<tr>
<td>Capacity of Residential Facilities</td>
<td>15</td>
<td>11</td>
<td>5</td>
<td>0.5</td>
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<tr>
<td>Total Capacity of Facilities</td>
<td>28</td>
<td>27</td>
<td>20</td>
<td>27.5</td>
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* Psychiatric Beds (Including Forensic Beds) per 10,000 population