

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 be 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 56 in 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.

4. Government Action Plan for Persons with Disabilities

In December 1995, Headquarters for Promotion the Welfare of Disabled Persons decided on the “Government Action Plan for Persons with Disabilities: A Seven Year Strategy to Achieve Normalization” that spans the seven years from fiscal 1996 to fiscal 2002. The Government Action Plan for Persons with Disabilities has the characteristics of priority measures implementation plan that will further promote the “New Long-term Program for Government Measures for Disabled Persons” formulated in March 1993. It has set up concrete numerical goals regarding what could be implemented by 2002.

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.

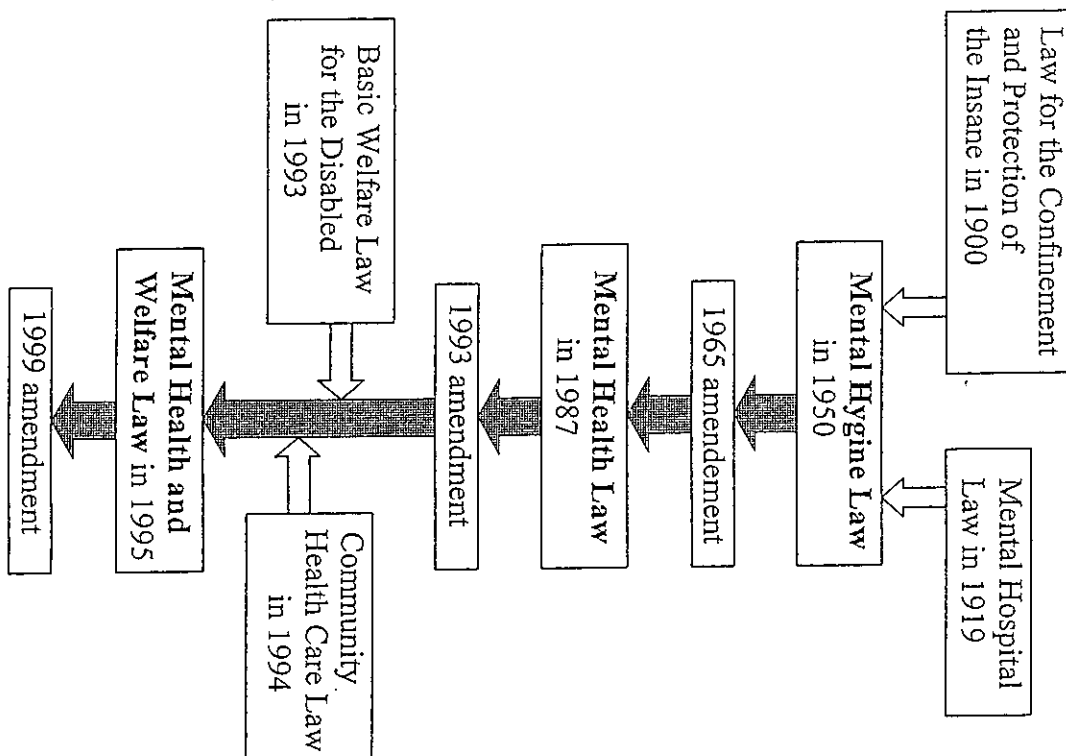
- (2) The rehabilitation program for long-term inpatients.

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.

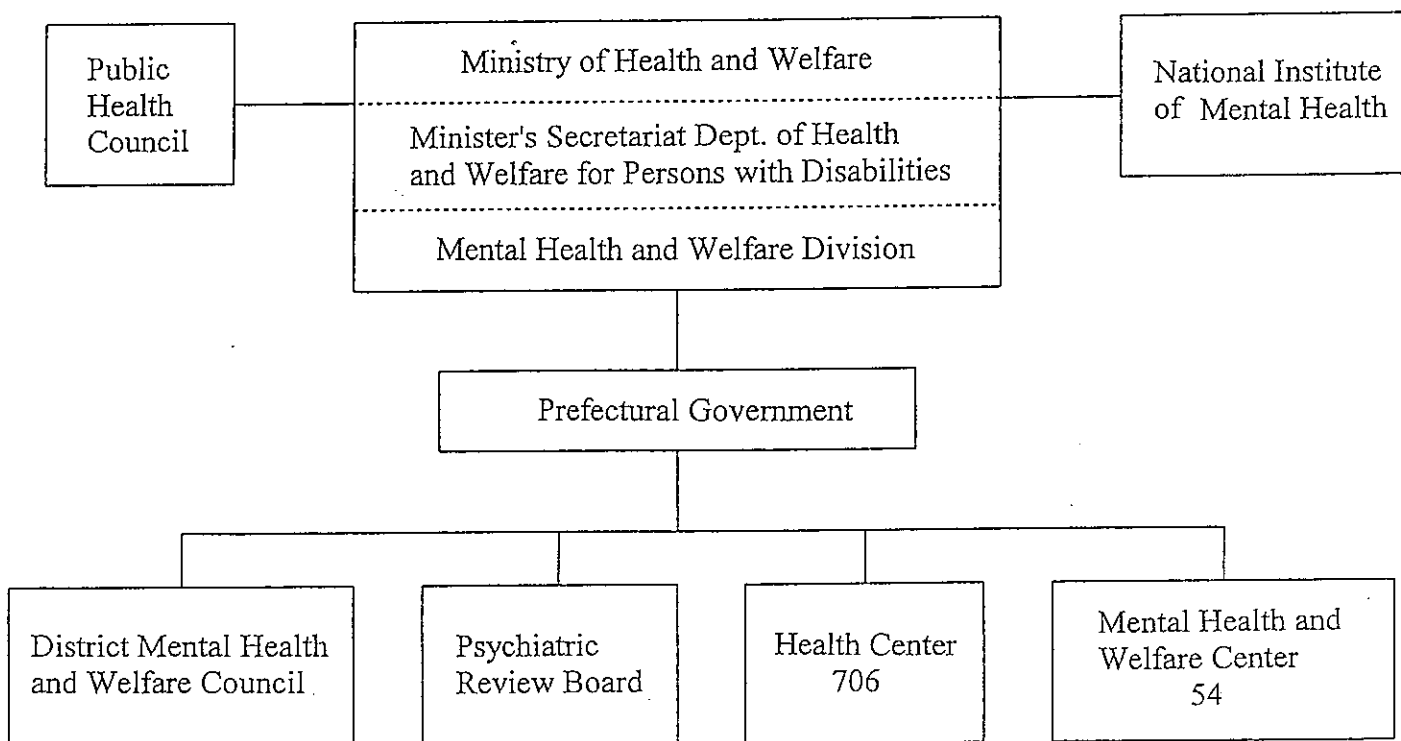
- (3) Promotion of community care and respect of self – determination of the users.

Comparing to UN's Principle, further improvement should be made in the near future.

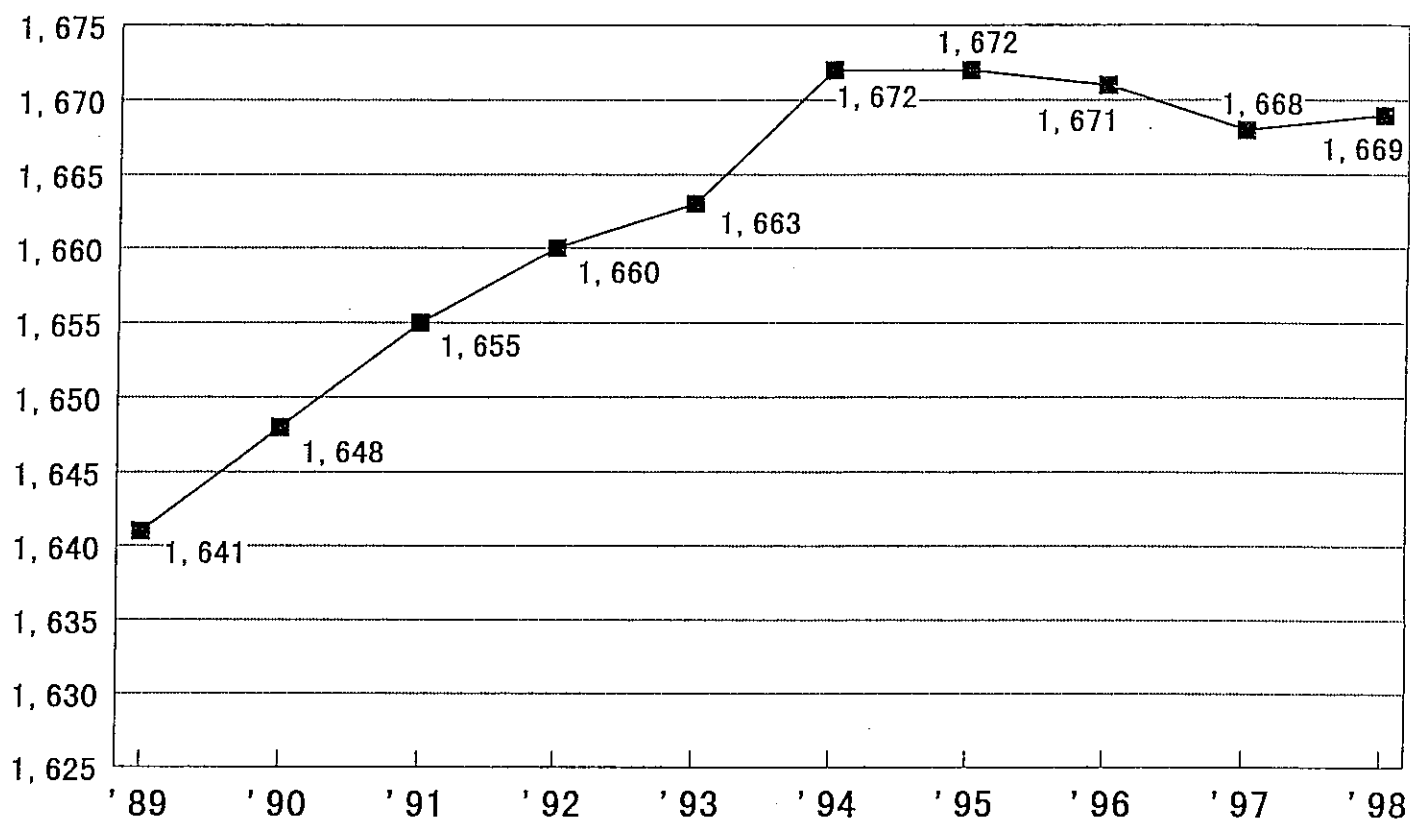
History of the Mental Health Law in Japan



The Relationship between Administrative Departments and Institutions

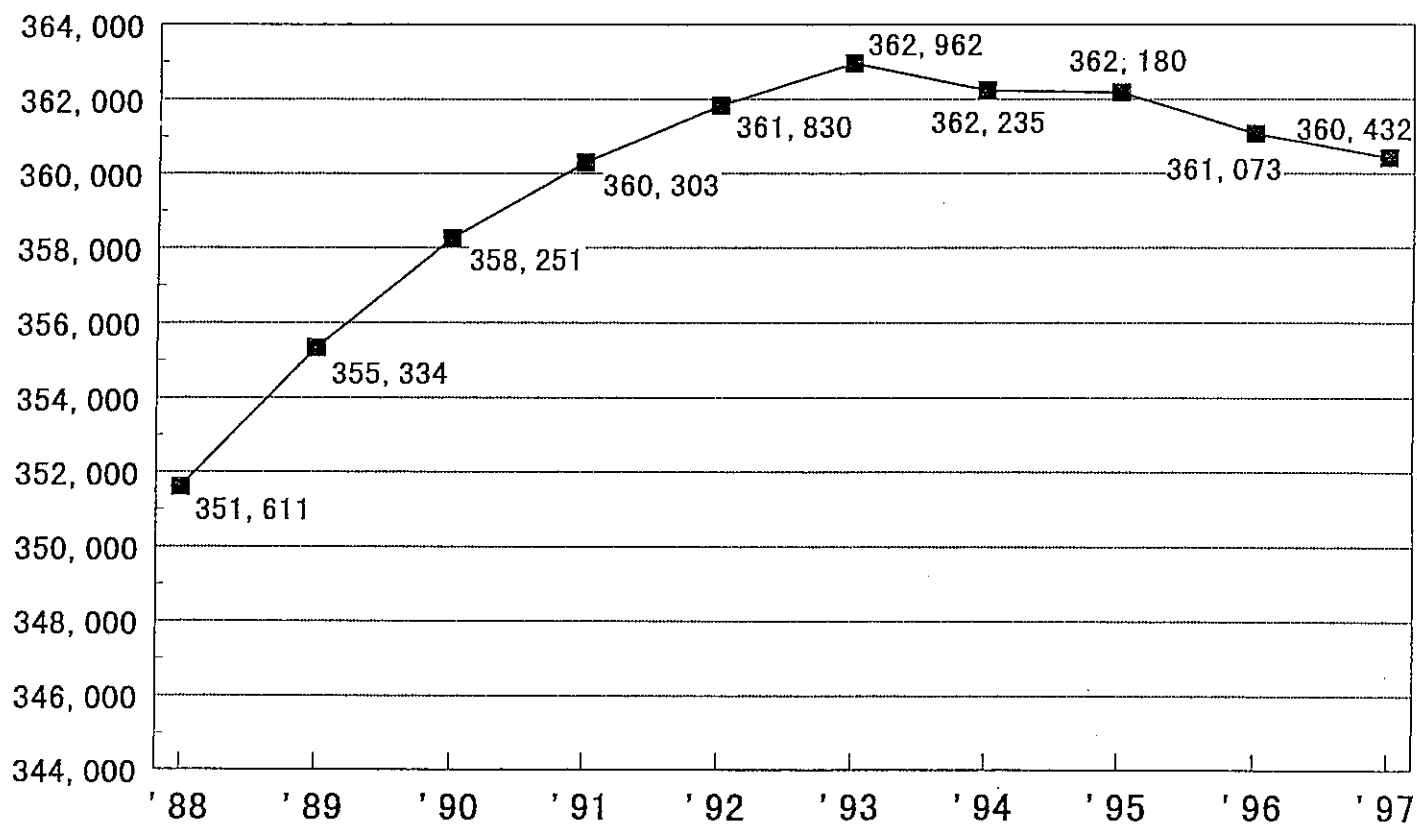


Number of Psychiatric Hospitals



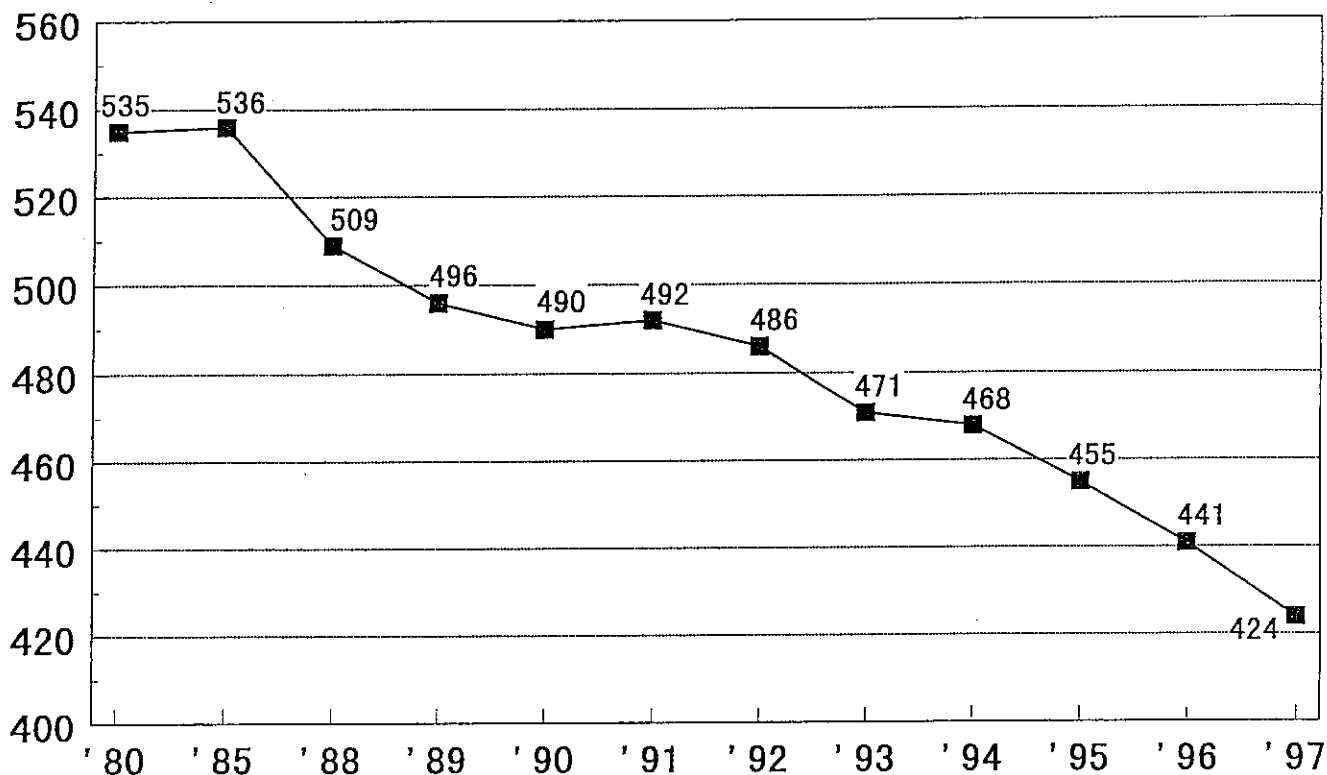
(Source : Ministry of Health and Welfare)

Number of Psychiatric-Beds



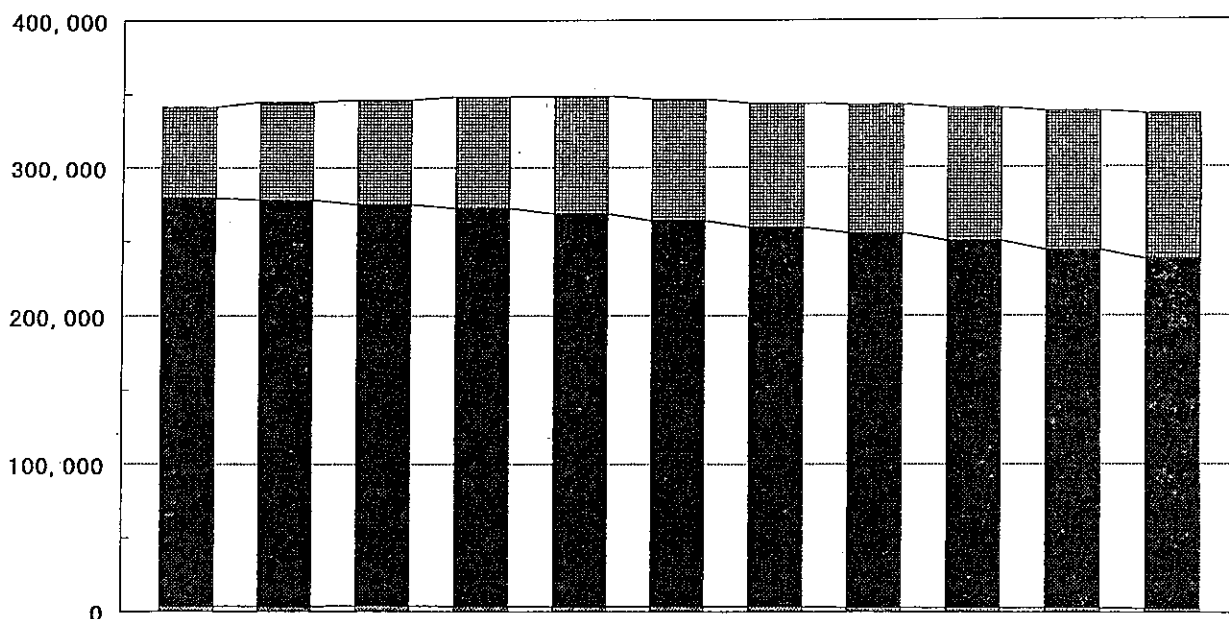
(Source : Ministry of Health and Welfare)

Average Stay of Hospitalization



(Source : Ministry of Health and Welfare)

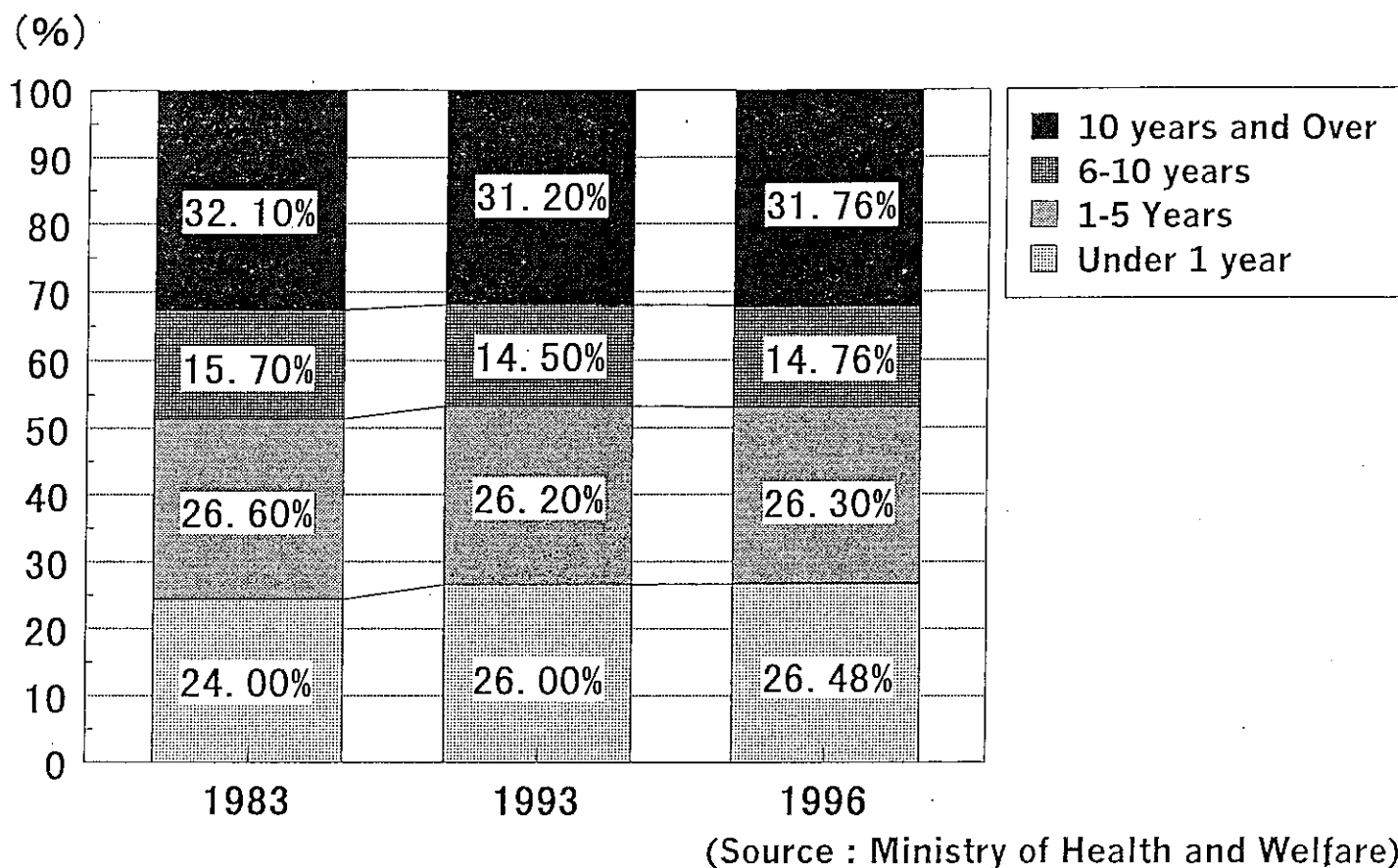
Age Range of the Inpatients



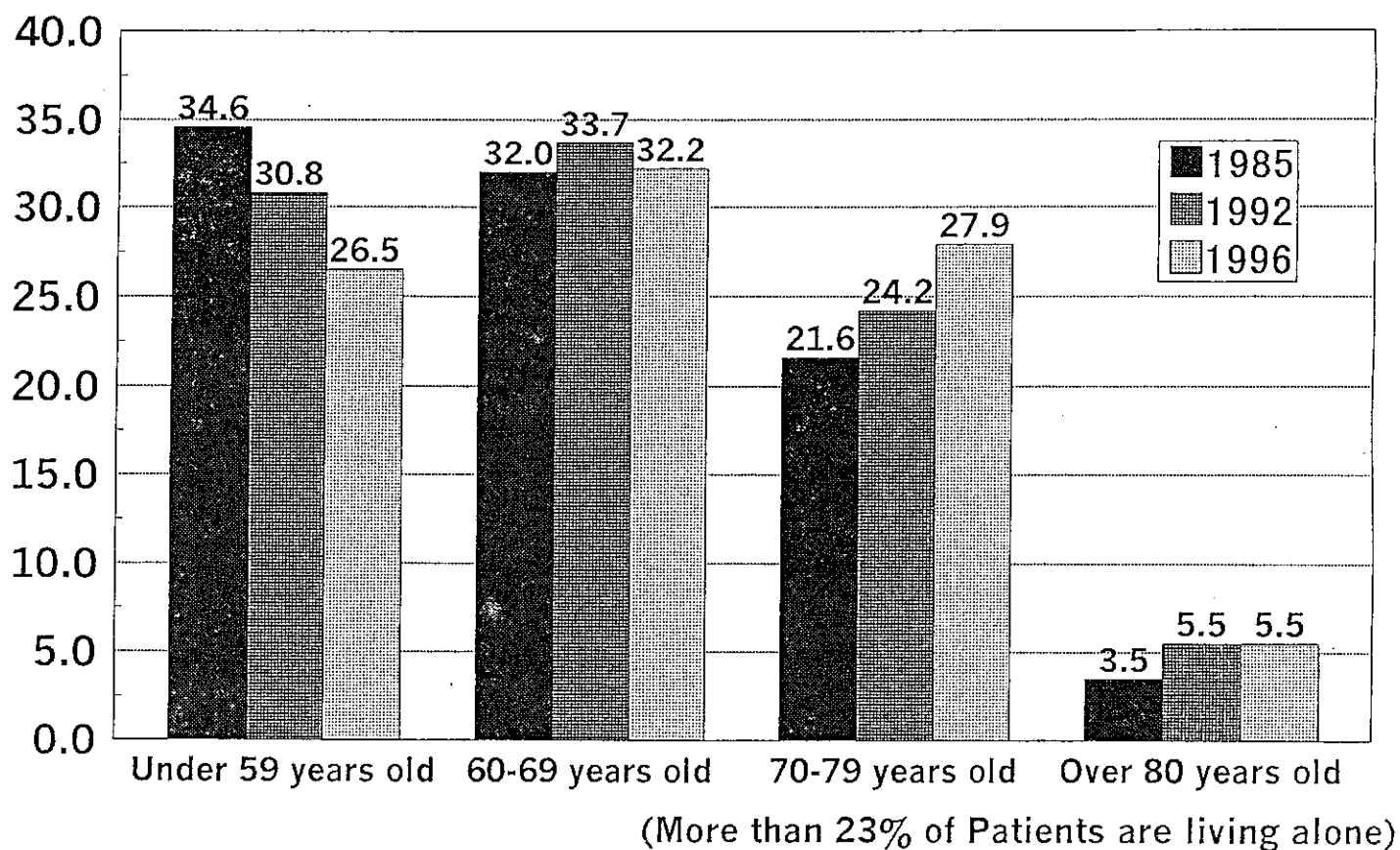
	'87	'88	'89	'90	'91	'92	'93	'94	'95	'96	'97
Under 19 years old	3,808	3,545	4,305	3,706	3,521	3,606	3,585	3,064	3,010	3,055	2,507
20-64 years old	275,381	274,066	270,135	268,384	264,829	259,944	255,305	252,140	246,856	240,714	235,188
Over 65 years old	62,728	67,534	71,958	76,920	80,840	83,380	85,036	87,922	91,175	94,945	98,780
	341,917	345,145	346,398	349,010	349,190	346,930	343,926	343,126	341,041	338,714	336,475

(Source : Ministry of Health and Welfare)

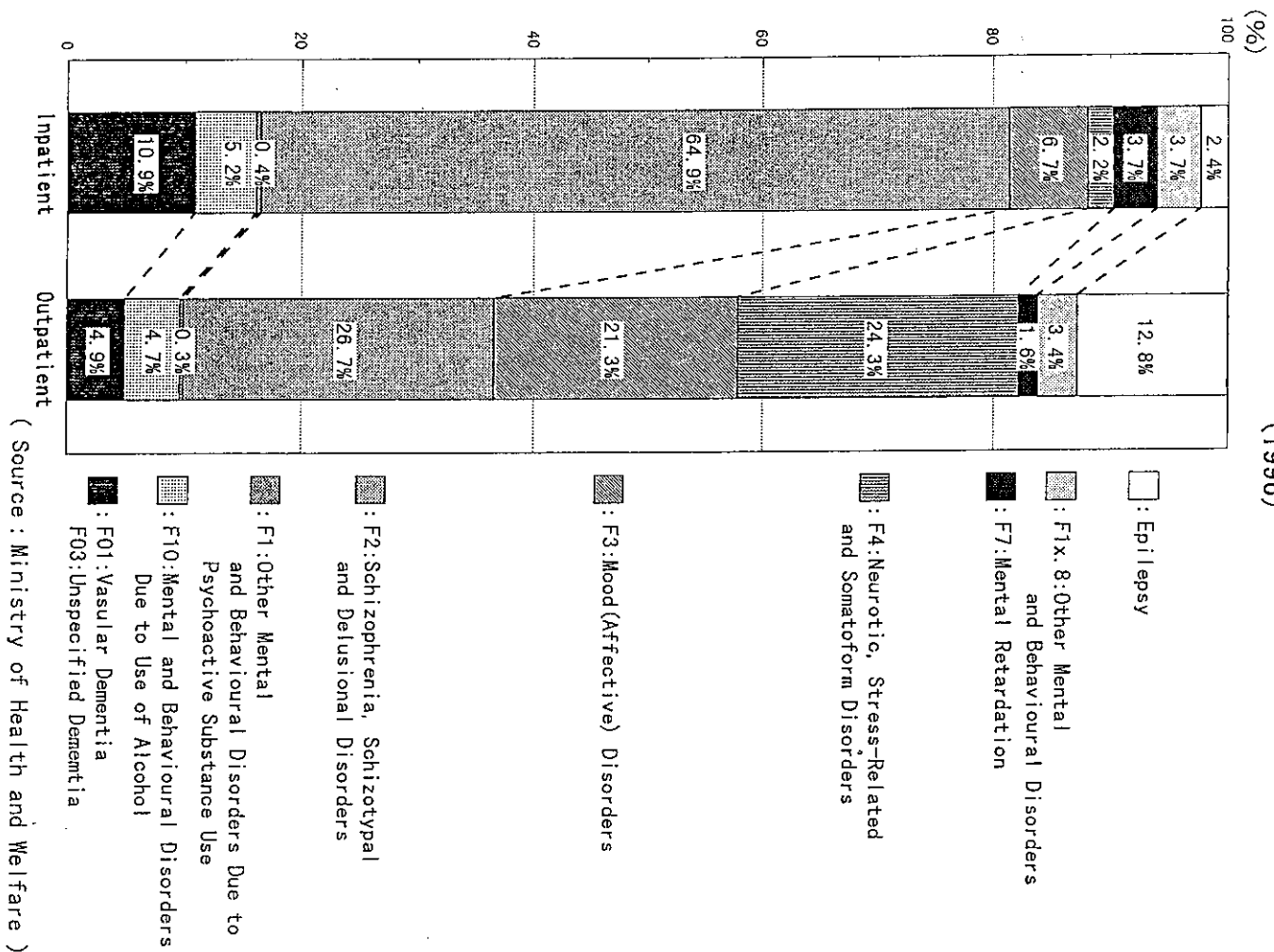
Duration of Hospitalization



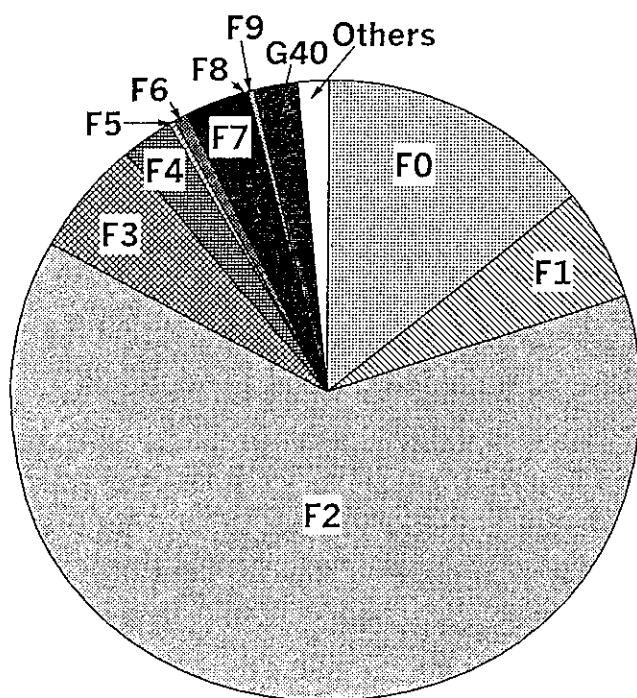
Transition of the Family-Age



Distribution of Clinical Diagnosis (ICD-10) (1996)



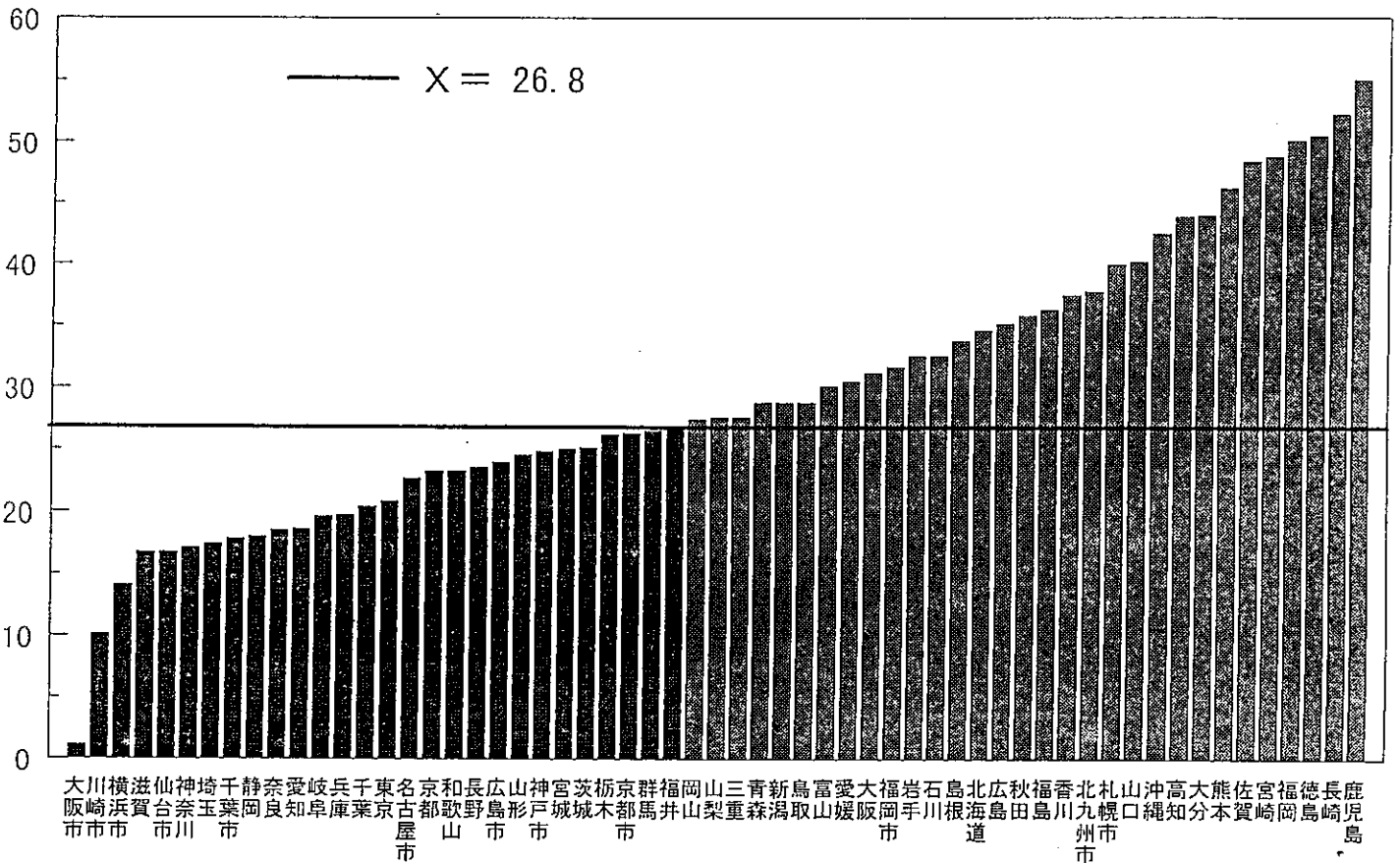
Distribution of Clinical Diagnosis of Inpatients (ICD-10)



F0	14.1%	ORGANIC, INCLUDING SYMPTOMATIC, MENTAL DISORDERS
F1	5.8%	MENTAL AND BEHAVIOURAL DISORDERS DUE TO PSYCHOACTIVE SUBSTANCE USE
F2	62.9%	SCHIZOPHRENIA, SCHIZOTYPAL AND DELUSIONAL DISORDERS
F3	5.9%	MOOD (AFFECTIVE) DISORDERS
F4	2.6%	NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS
F5	0.3%	BEHAVIOURAL SYNDROMES ASSOCIATED WITH PHYSIOLOGICAL DISTURBANCES AND PHYSICAL FACTORS
F6	0.7%	DISORDERS OF ADULT PERSONALITY AND BEHAVIOUR
F7	3.2%	MENTAL RETARDATION
F8	0.1%	DISORDERS OF PSYCHOLOGICAL DEVELOPMENT
F9	0.3%	BEHAVIOURAL AND EMOTIONAL DISORDERS WITH ONSET USUALLY OCCURRING IN CHILD-HOOD AND ADOLESCENCE, UNSPECIFIED MENTAL DISORDER
G40	2.3%	EPILEPSY
Others	1.6%	

Source: Ministry of Mental Health and Welfare, 1998

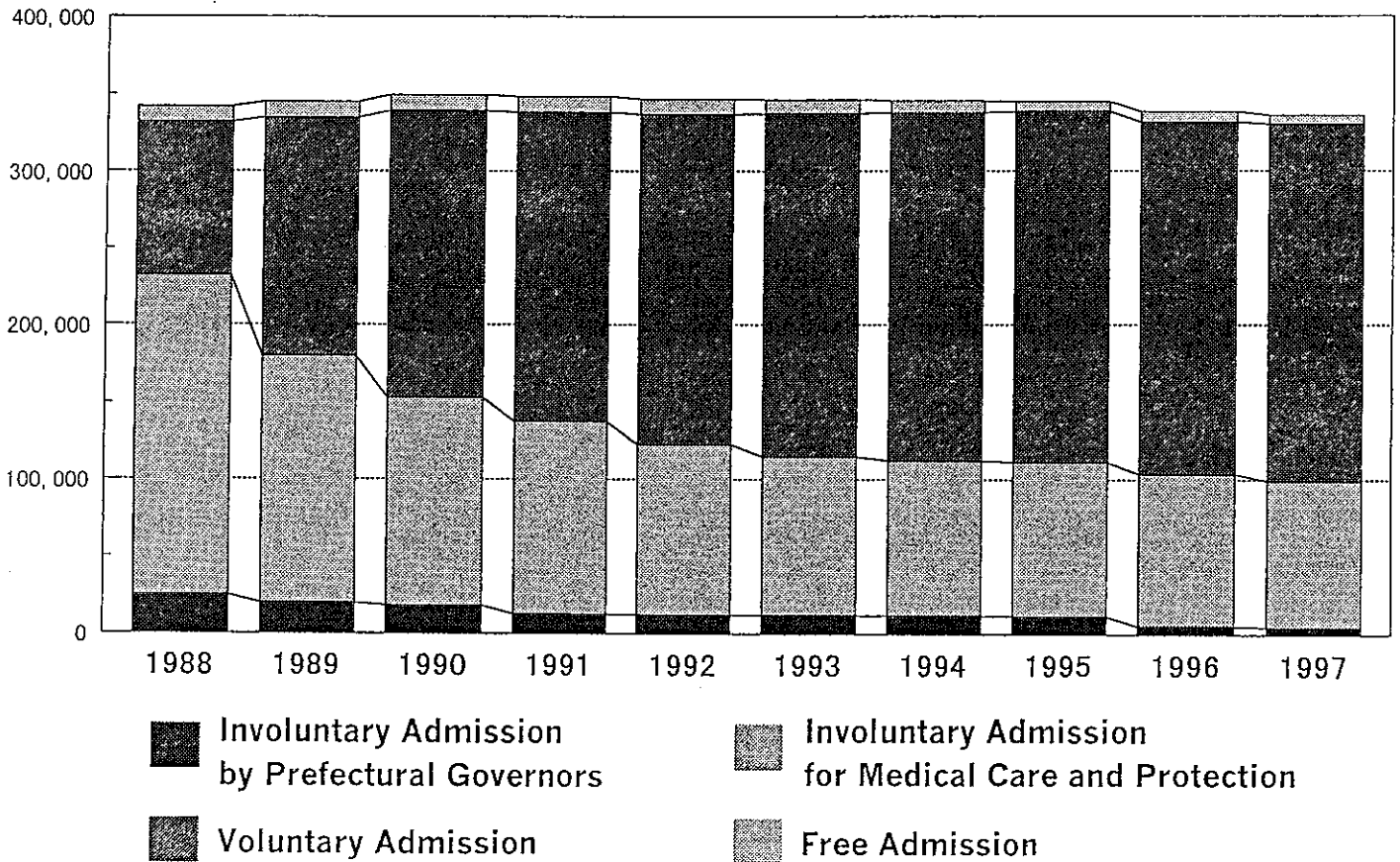
Number of Inpatients per 10,000



(Source: Ministry of Health and Welfare Jun.30.1998)

Type of Admission

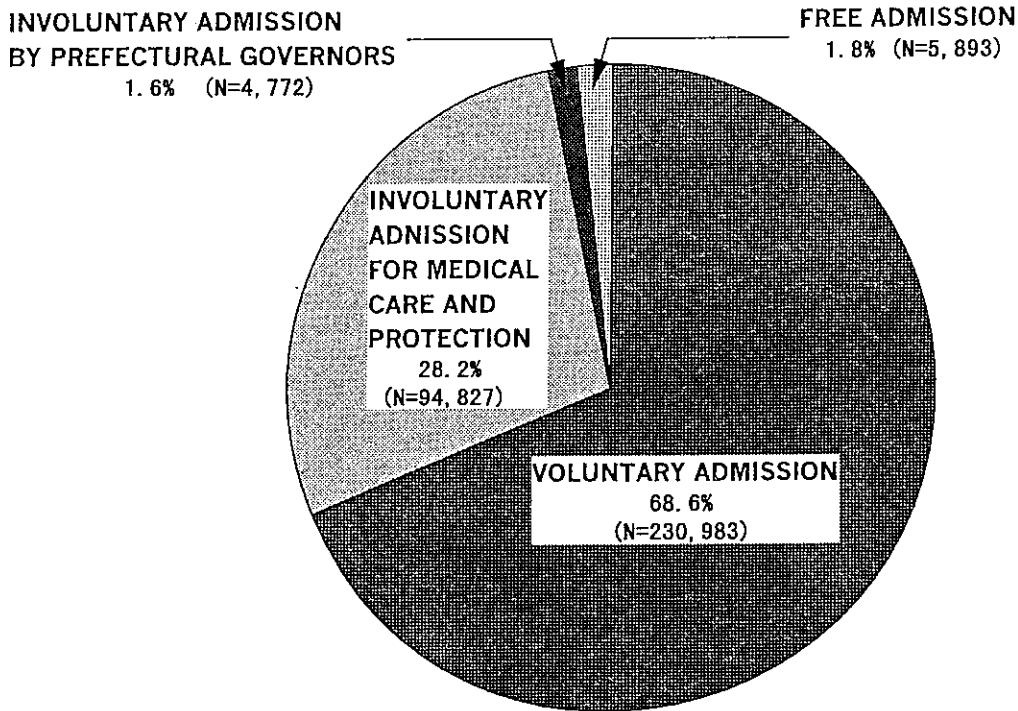
Number of Patients



(Source : Ministry of Health and Welfare)

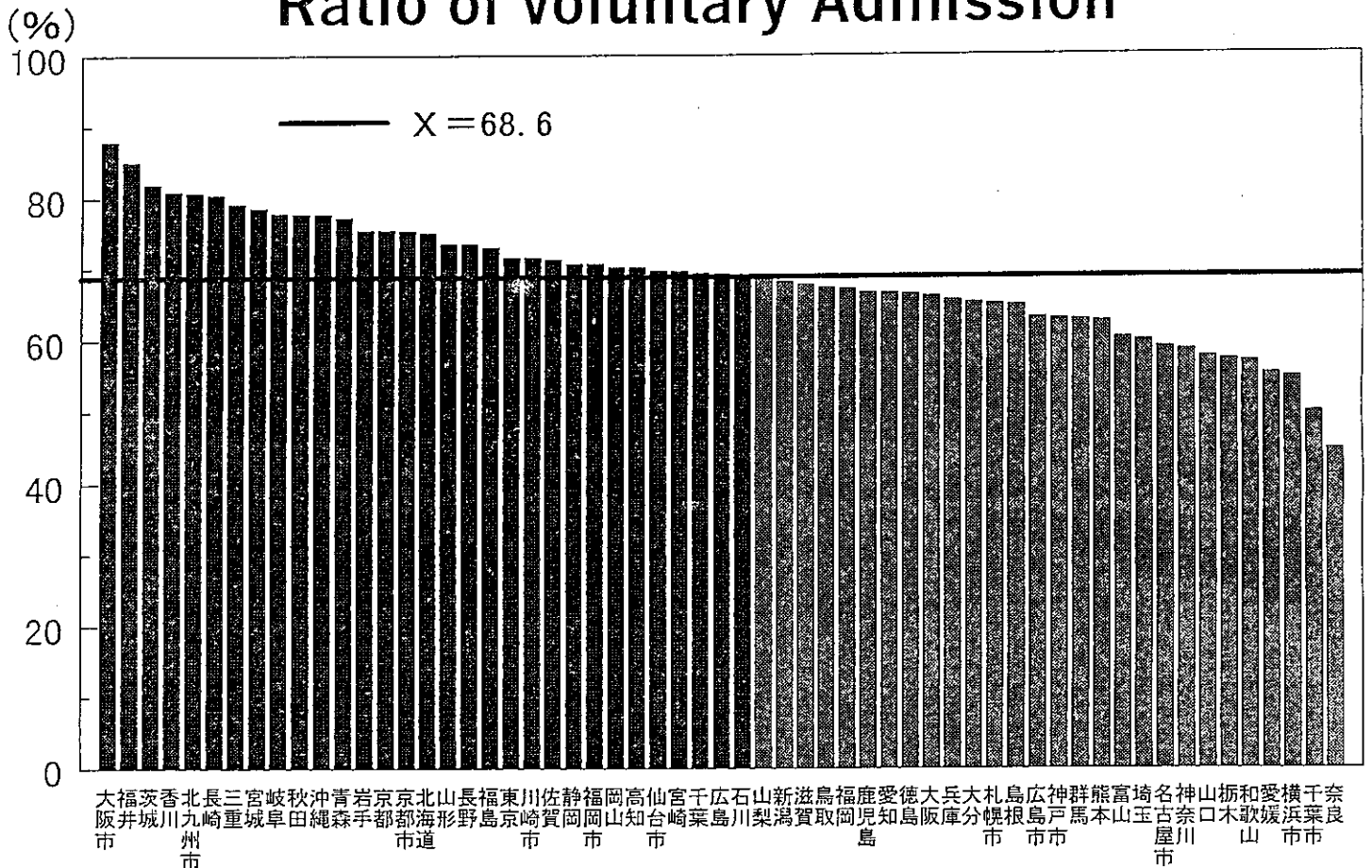
Type of Admission in 1997

(N = 338,714)



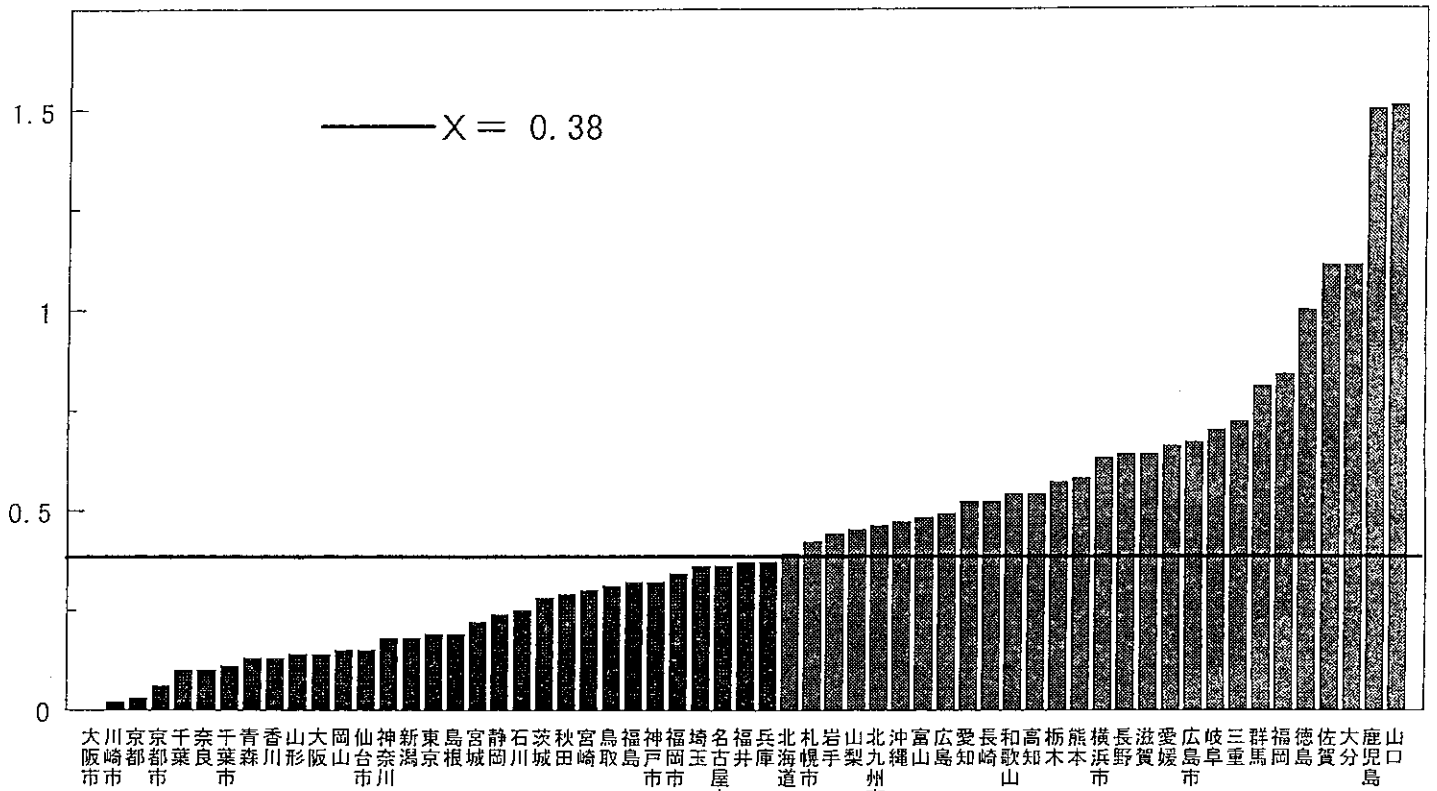
(Source : Ministry of Health and Welfare, June 30, 1997)

Ratio of voluntary Admission



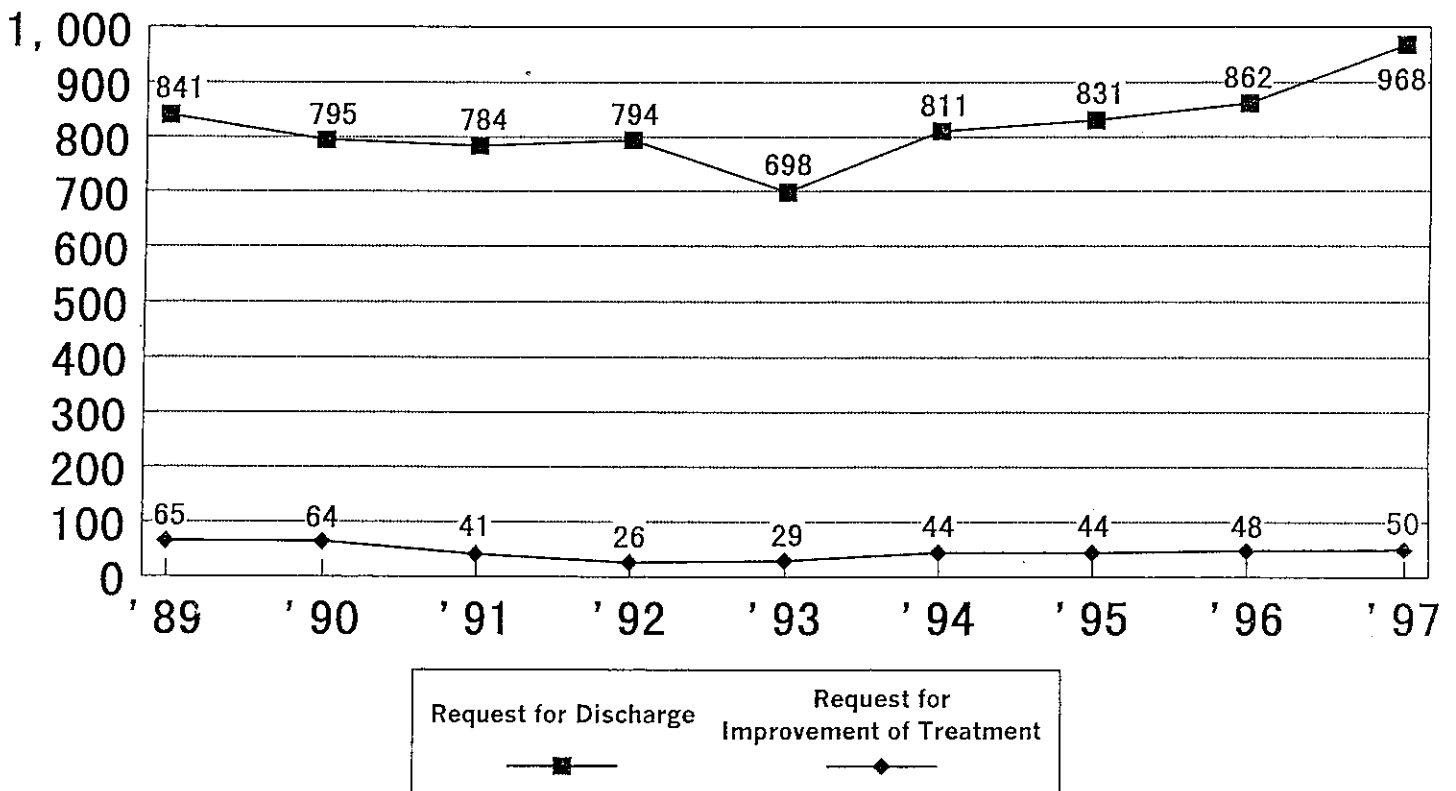
(Source : Ministry of Health and Welfare, Jun.30.1997)

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



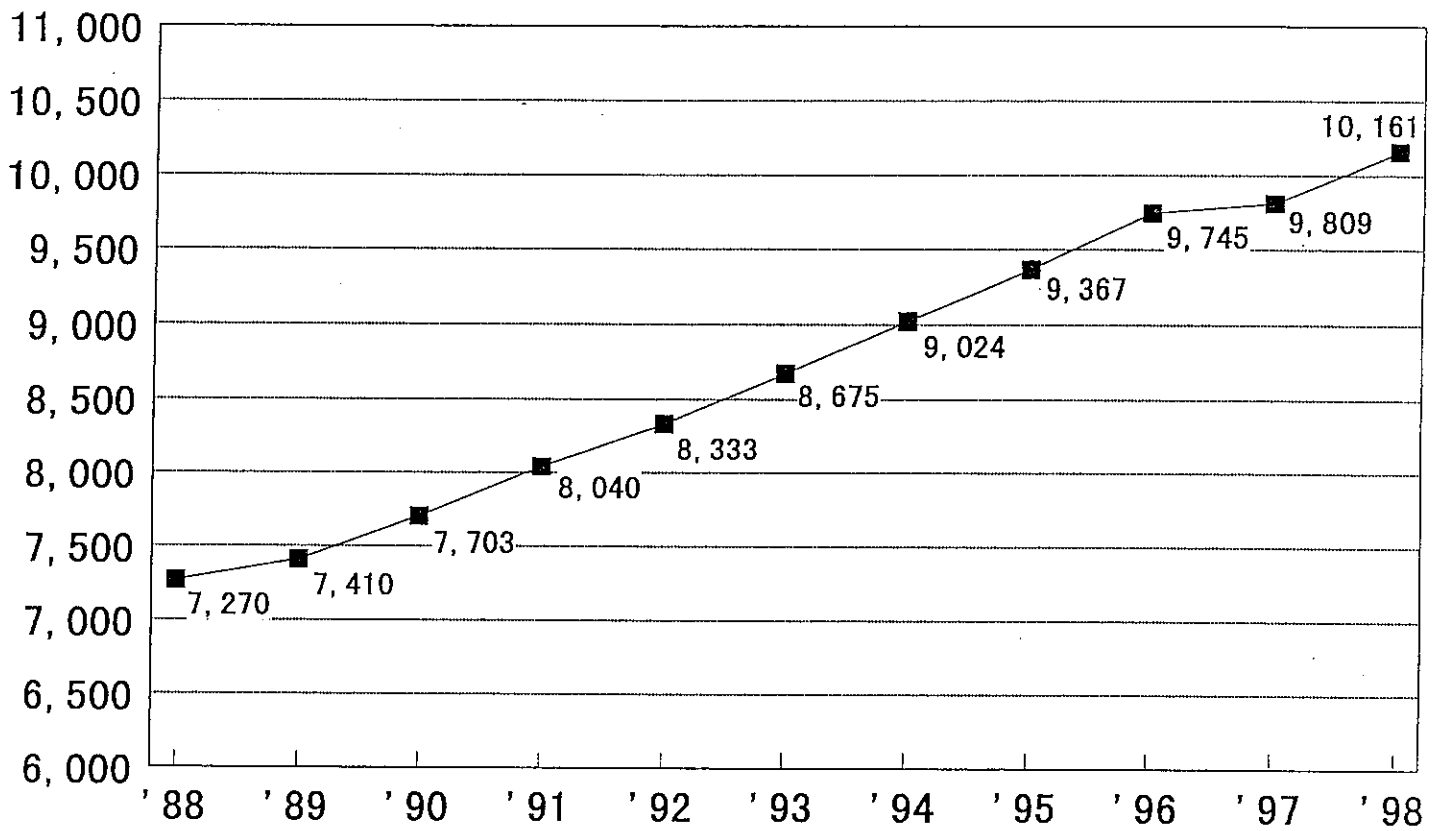
(Source: Ministry of Health and Welfare, Jun. 30. 1997)

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



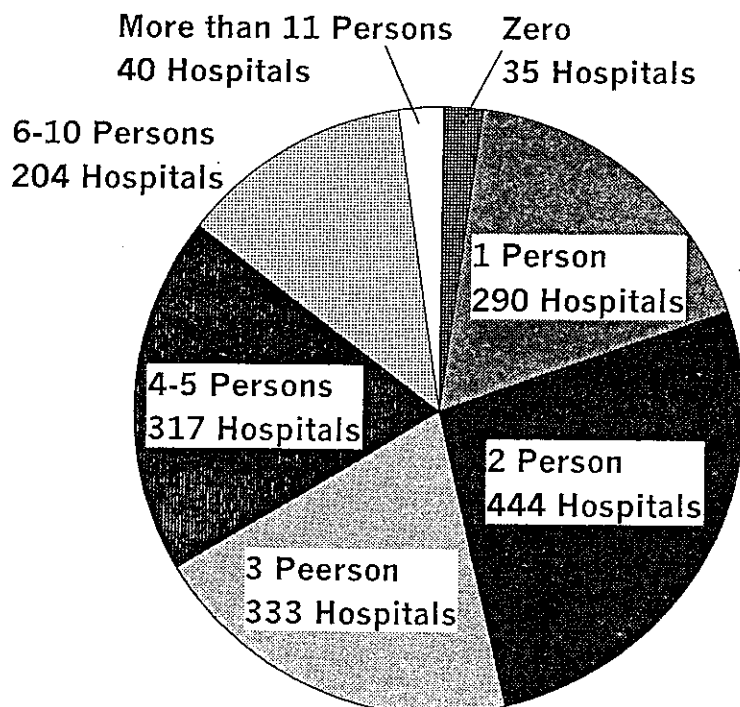
(Source : Ministry of Health and Welfare)

Number of Designated Physician for Mental Health



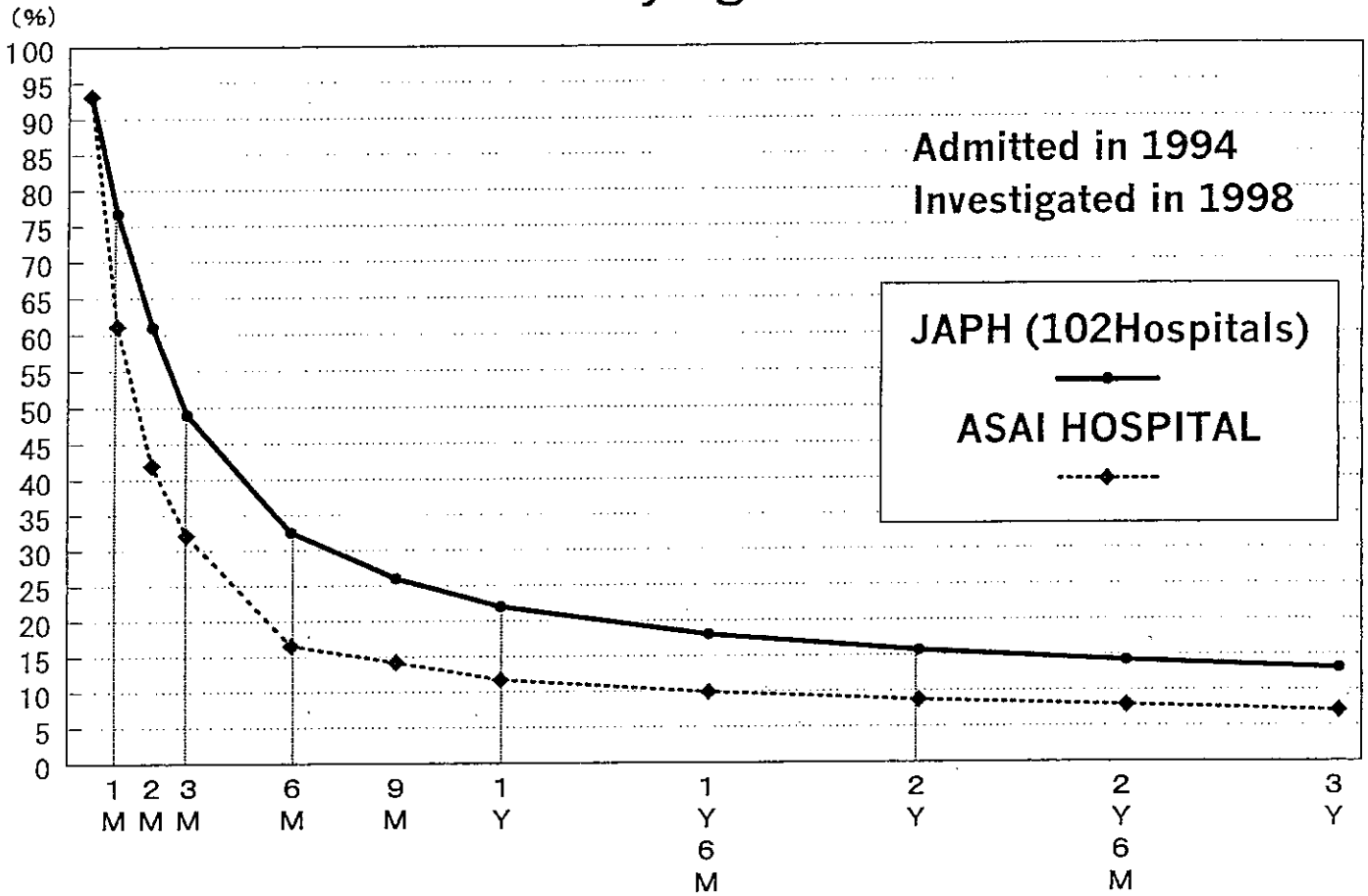
(Source : Ministry of Health and Welfare)

Number of Designated Psysician for Mental Health



(Source : Ministry of Health and Welfare)

Staying Rate



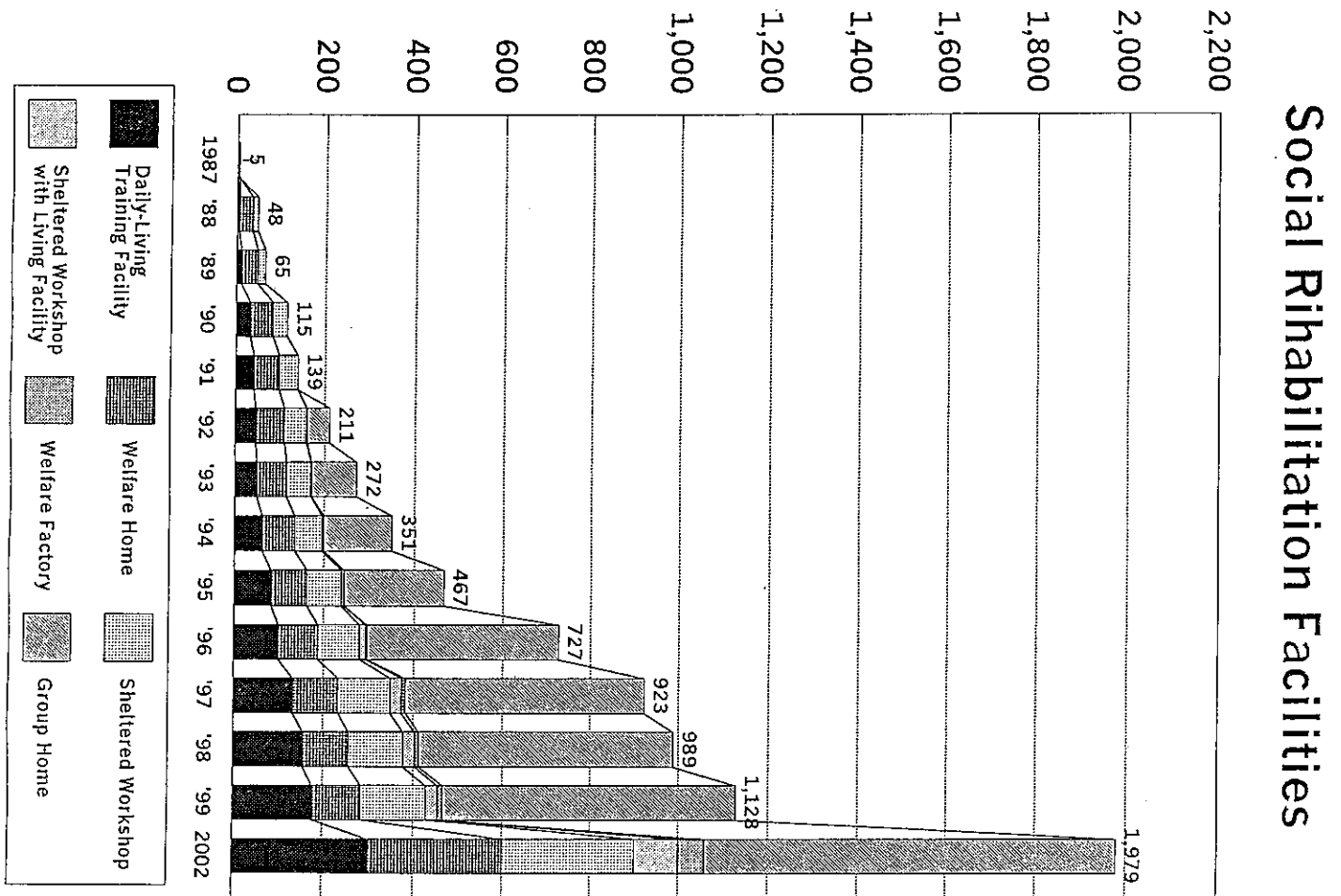
**The Government Action Plan
for Persons with Disabilities:
- A Seven-Year Strategy
to Achieve Normalization -
(1996 → 2002)**

- (1) To Live Together in the Community
- (2) To Promote Social Self-sufficiency
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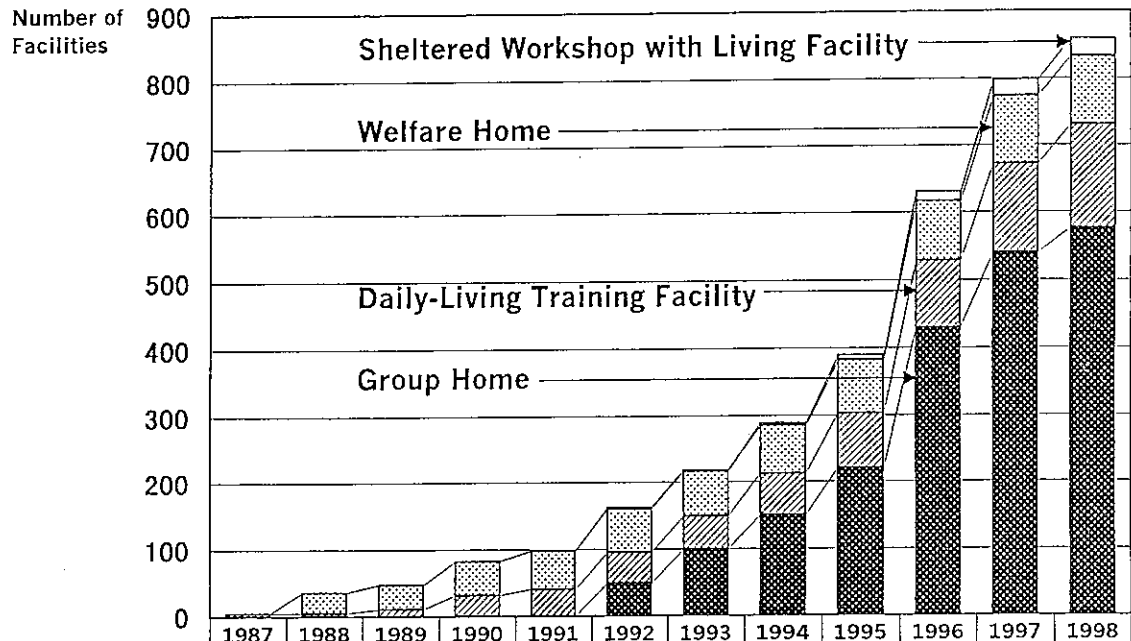
Mental Health Community Programs as of FY2002

Facility		FY 1998		FY 2002	
		number of facilities	number of service recipients	number of facilities	number of service recipients
Rehabilitation Facilities	Daily-Living Training Facility	172	3,440	300	6,000
	Welfare Homes	155	1,550	300	3,000
	Group Homes	576	3,168	920	5,060
	Sheltered Workshops with accomodation	15	450	100	3,000
	Sheltered Workshops without accomodation	113	2,260	300	6,000
	Welfare Workshops	23	690	59	1,770
Community-Living Support Center		115	—	650	—
Social Adjustment Training Programs (Outpatient Rehabilitation Programs)		2,691	4,306	3,300	5,280
Day Care Facilities		658	32,900	1,000	50,000

(Source : Ministry of Health and Welfare)



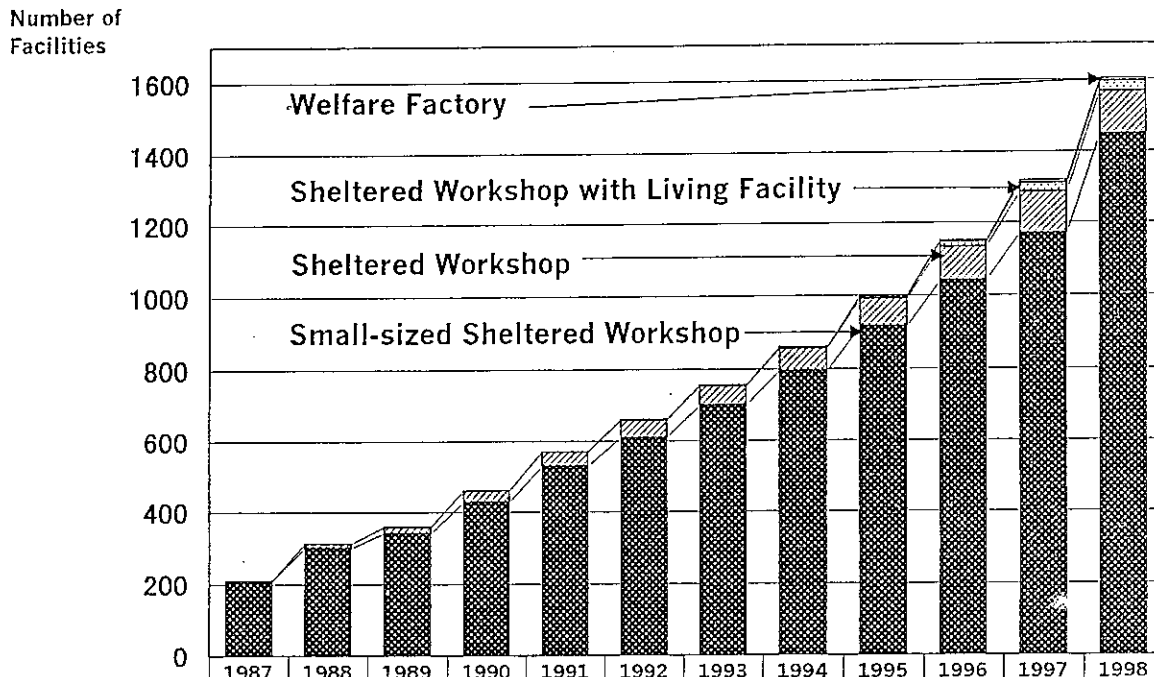
Rehabilitation Facilities for Living



Sheltered Workshop with Living Facility	0	0	0	0	0	2	2	4	7	14	24	26
Welfare Home	0	31	37	51	57	64	67	73	80	88	102	102
Daily-Living Training Facility	5	5	11	32	41	46	49	62	83	99	132	155
Group Home	0	0	0	0	0	50	100	150	220	430	540	576

(Source: Ministry of Health and Welfare)

Rehabilitation Facilities for Working

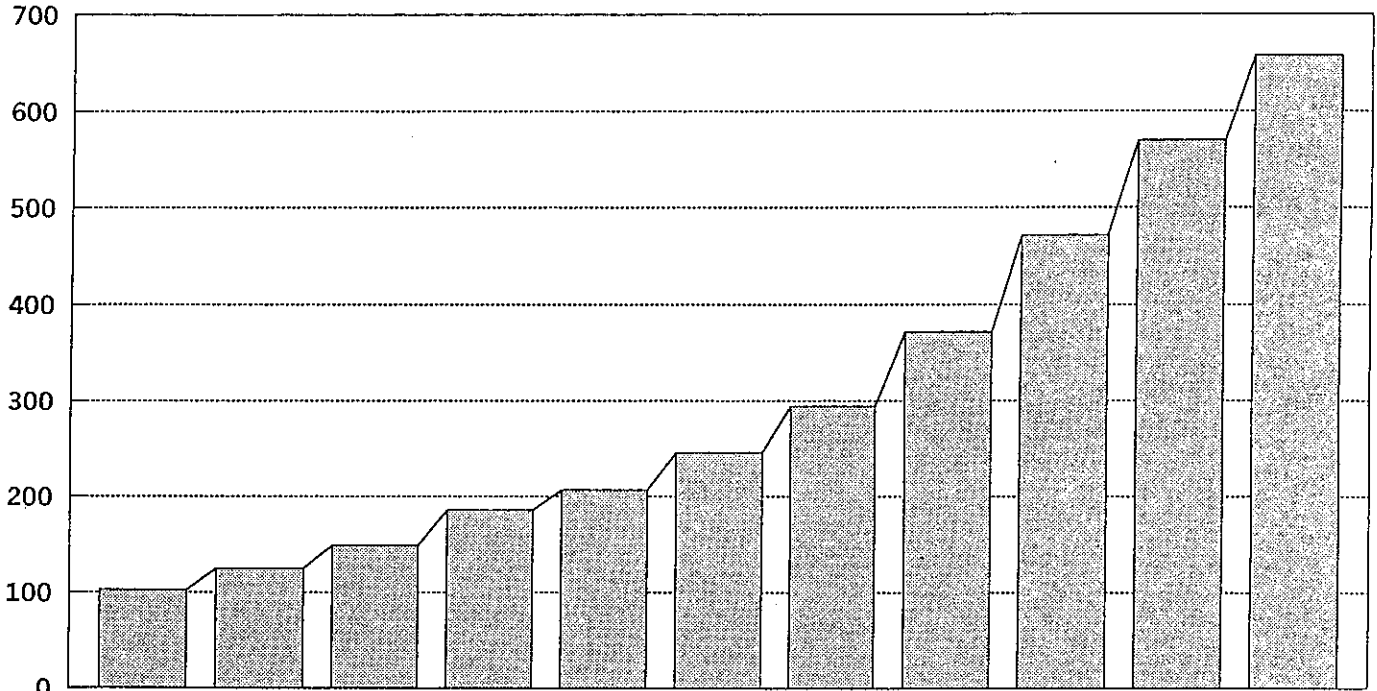


Welfare Factory	0	0	0	0	0	0	0	1	1	3	9	9
Sheltered Workshop with Living Facility	0	0	0	0	0	2	2	4	7	14	24	26
Sheltered Workshop	0	12	17	32	41	49	54	61	76	93	116	121
Small-sized Sheltered Workshop	210	300	342	428	529	610	700	795	916	1040	1169	1447

(Source: Ministry of Health and Welfare)

Day Care Facilities

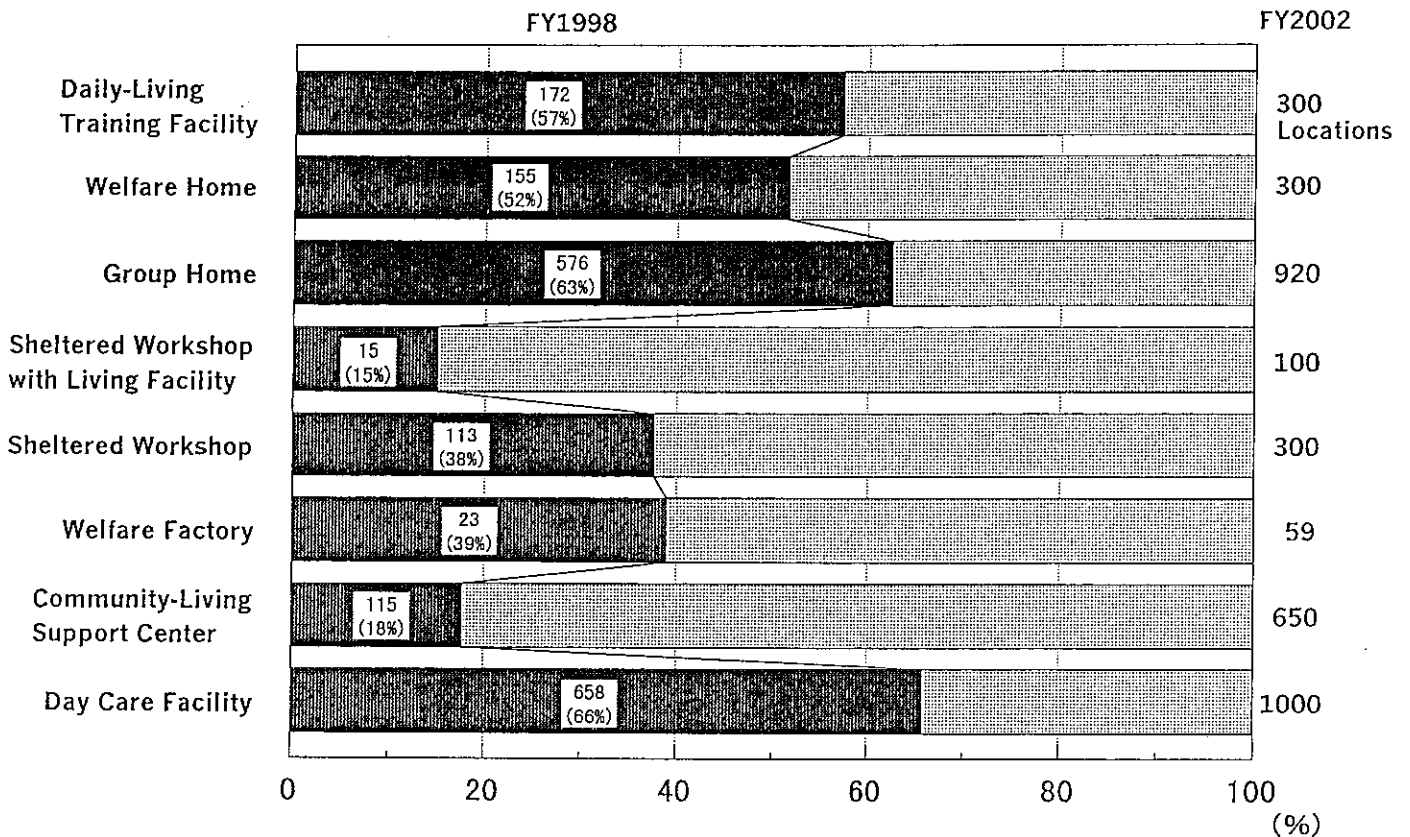
Number of Facilities



1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
103	125	149	186	207	246	294	372	471	570	658

(Source: Ministry of Health and Welfare)

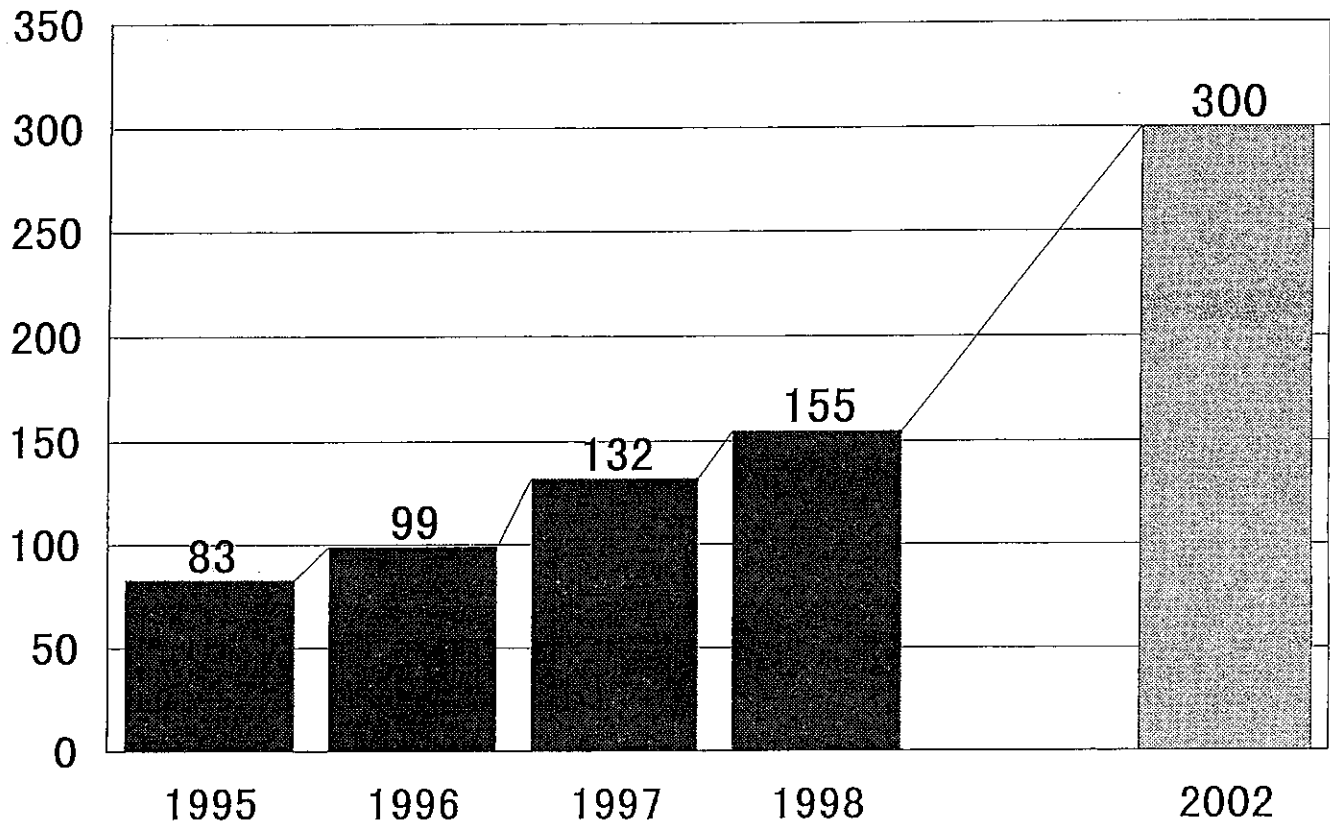
Social Rehabilitation Facilities for Living and Working — A Seven-year Normalization Strategy —



Source: Ministry of Health and Welfare

Number of
Facilities

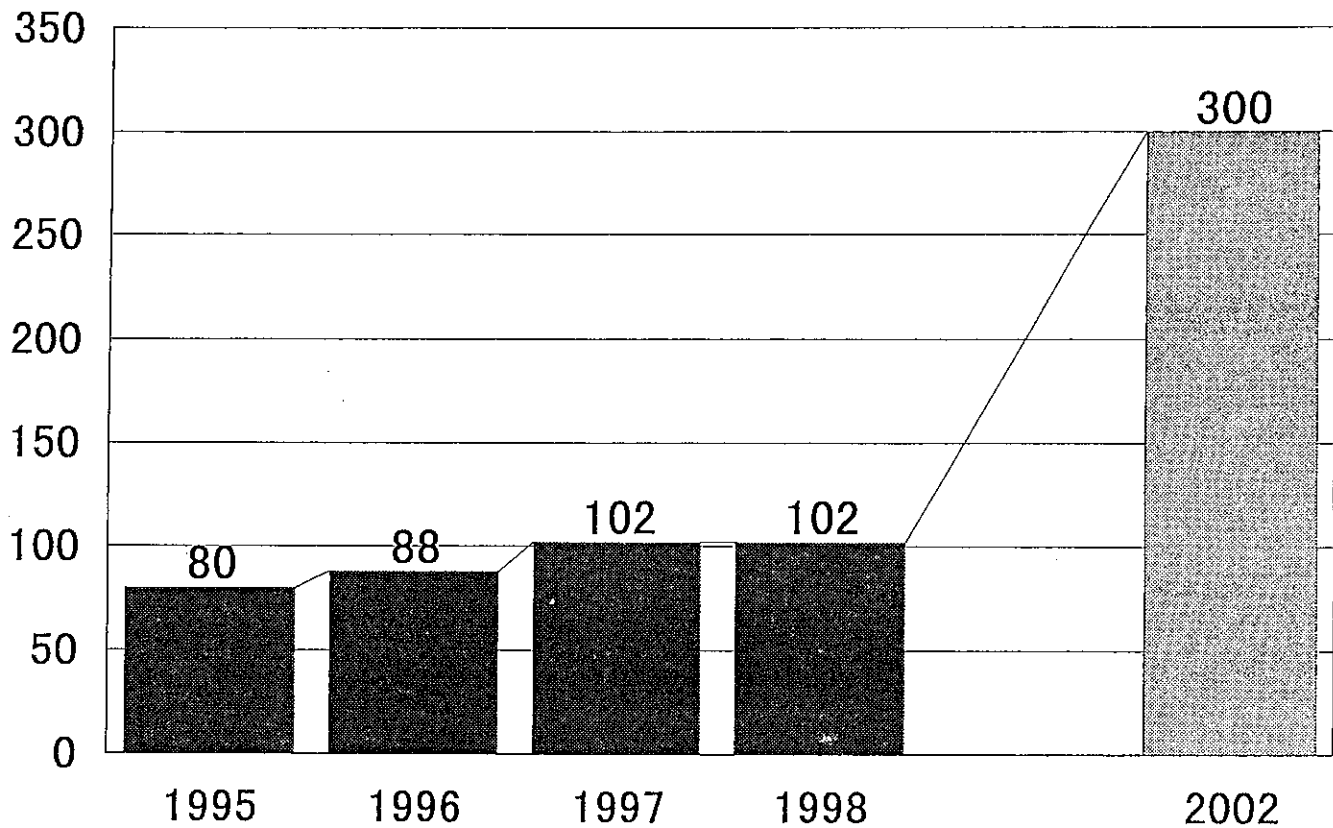
Daily-Living Training Facility



(Source : Ministry of Health and Welfare)

Number of
Facilities

Welfare Home



(Source : Ministry of Health and Welfare)

Group Home

Number of
Facilities

1000

900

800

700

600

500

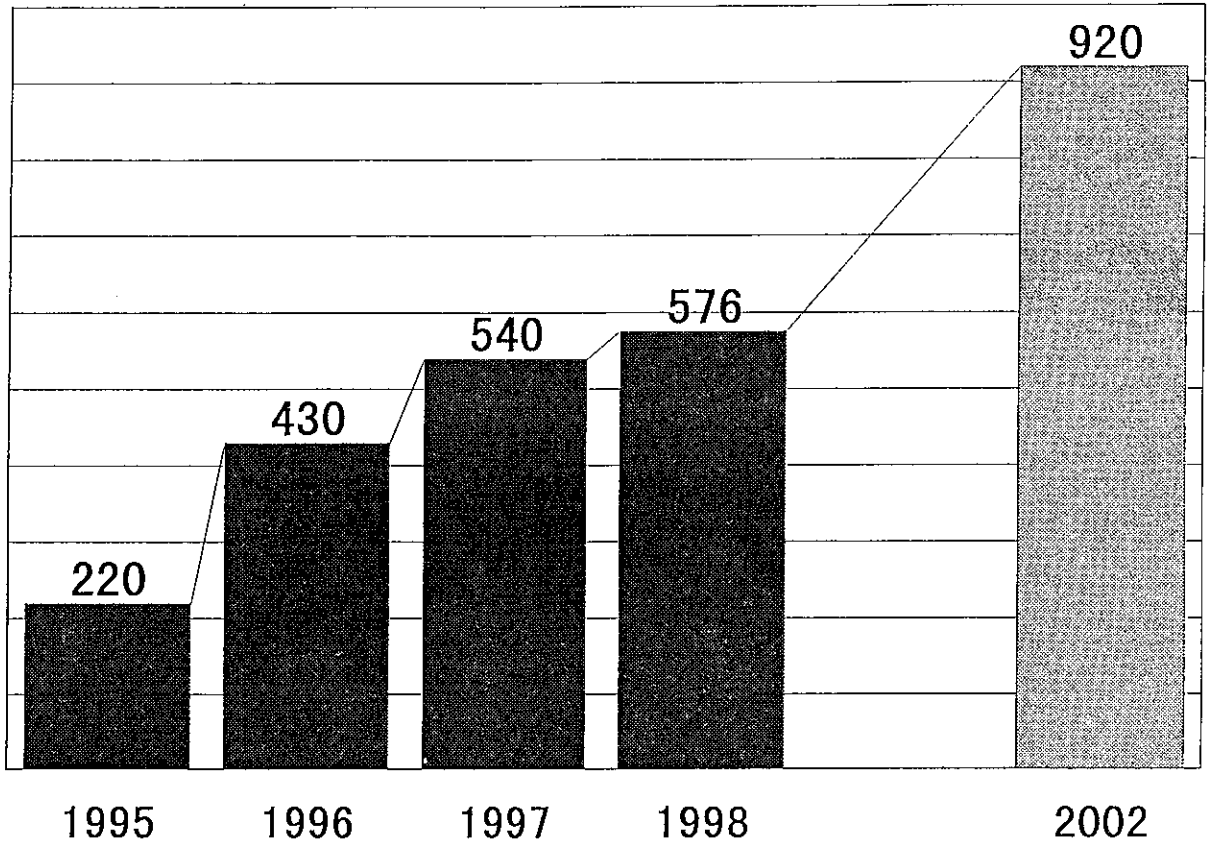
400

300

200

100

0



(Source : Ministry of Health and Welfare)

Sheltered Workshop with Living Facility

Number of
Facilities

120

100

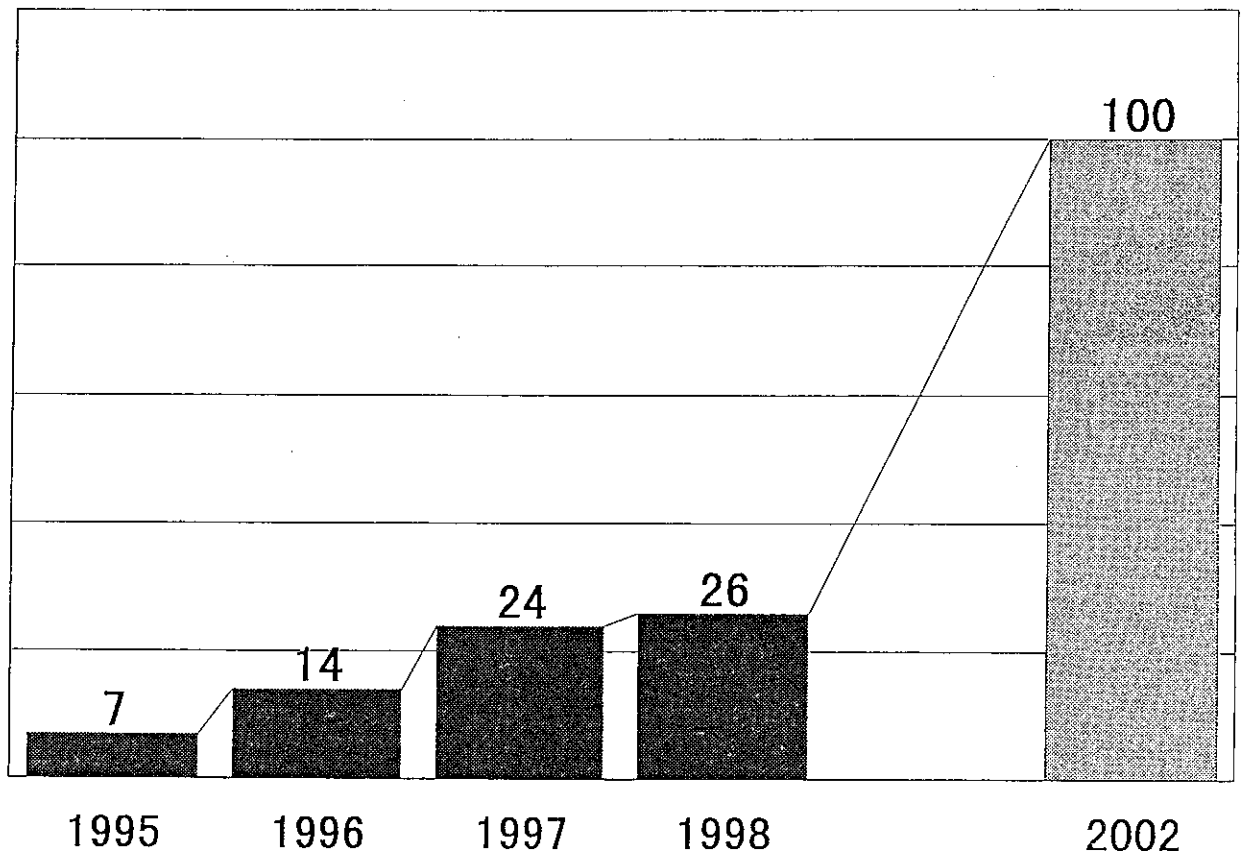
80

60

40

20

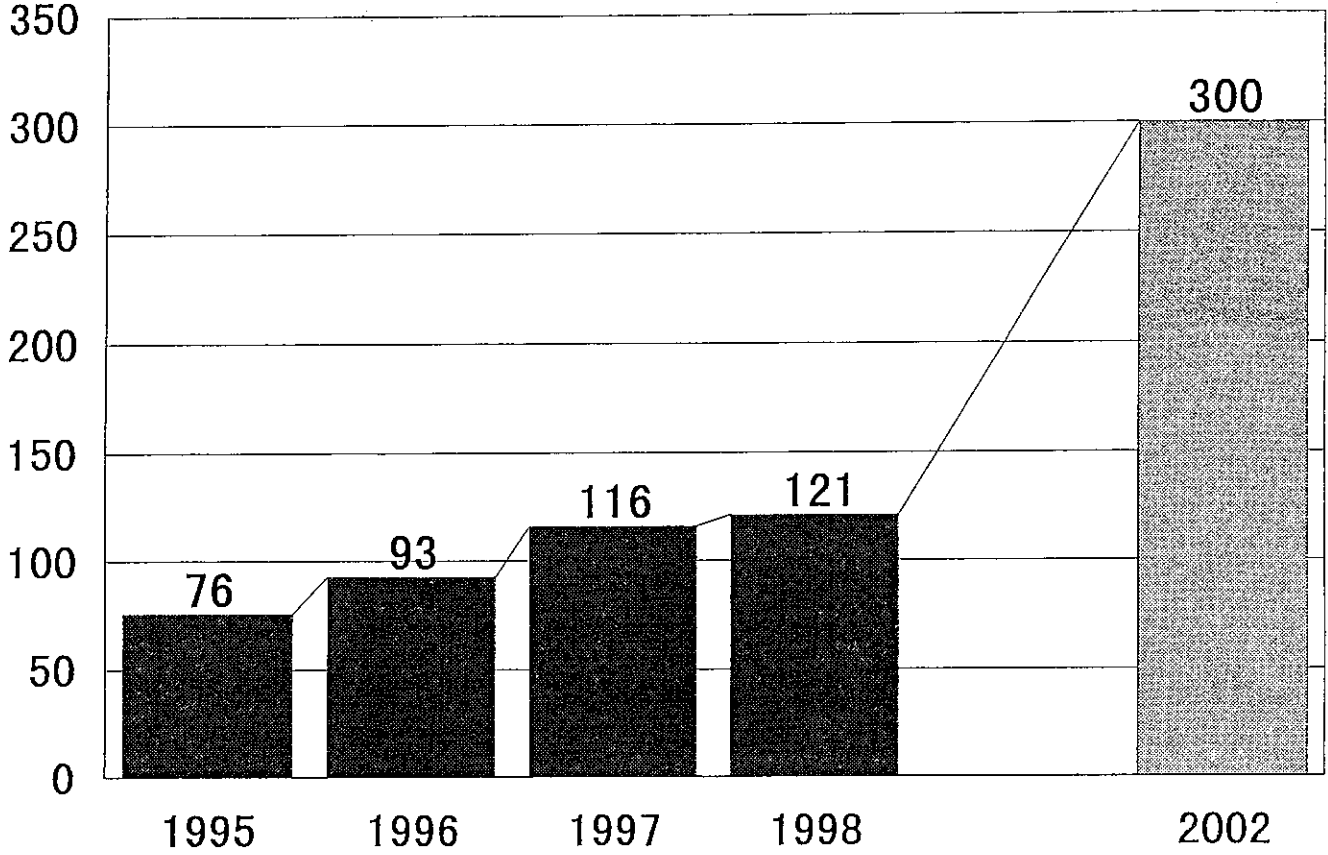
0



(Source : Ministry of Health and Welfare)

Sheltered Workshop

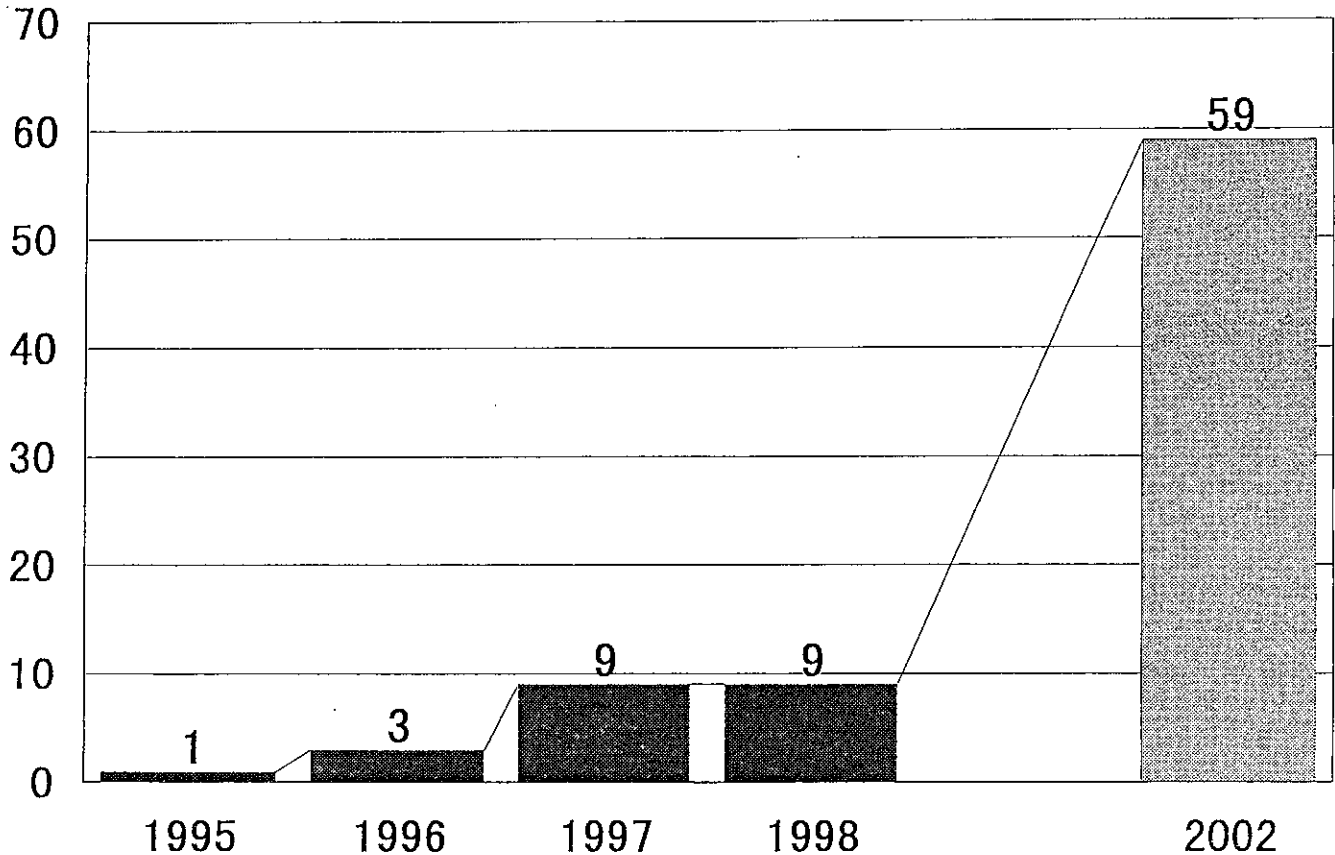
Number of
Facilities



(Source : Ministry of Health and Welfare)

Welfare Factory

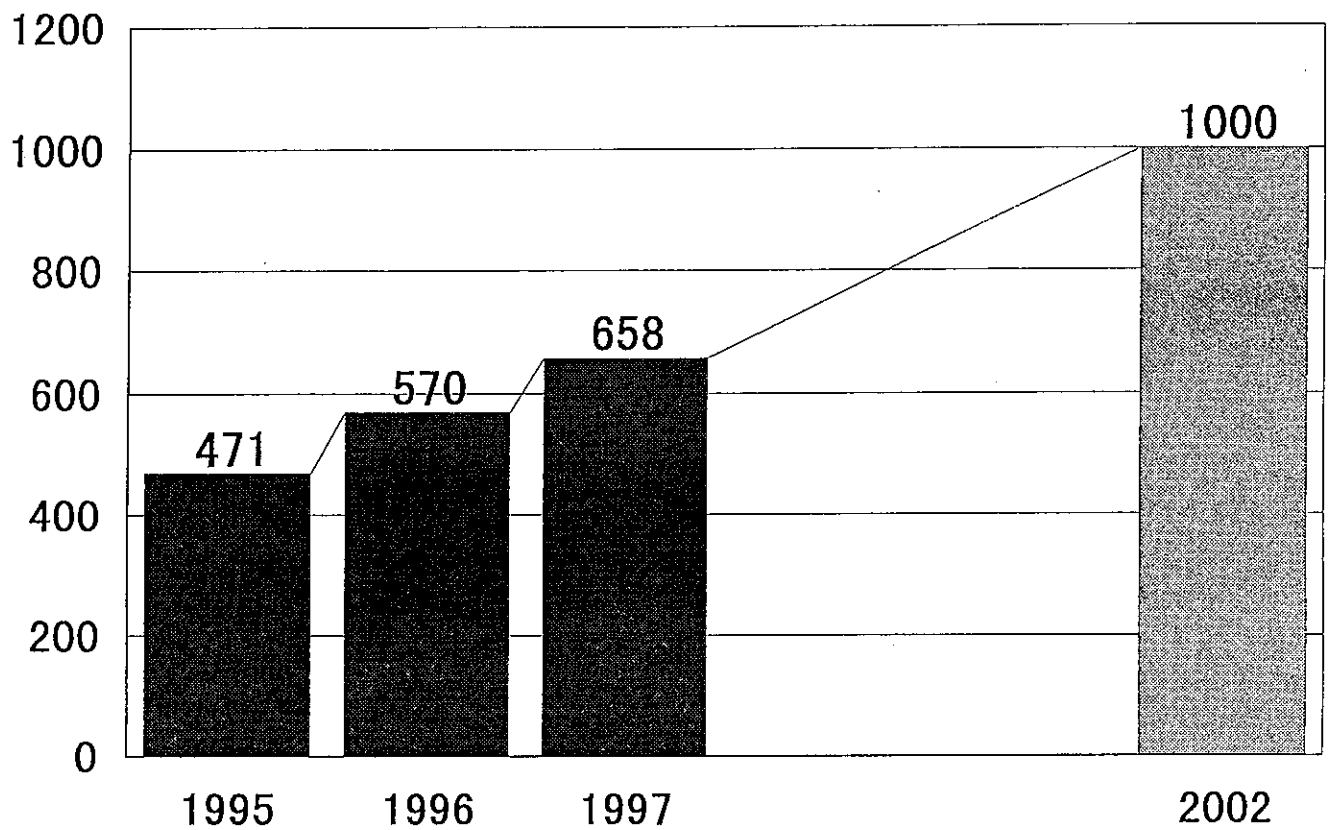
Number of
Facilities



(Source : Ministry of Health and Welfare)

Number of
Facilities

Day Care Facilities



(Source : Ministry of Health and Welfare)

International Comparison of Psychiatric beds and Residential Facilities

	U. S. A	CANADA (British Columbia)	U. K.	JAPAN
Psychiatric Beds	1.3 *	1.6 *	1.5 *	2.7
Capacity of Residential Facilities	1.5	1.1	5	0.5
Total Capacity of Facilities	2.8	2.7	2.0	2.7.5

per 10,000 population

* Psychiatric Beds
(Including Forensic Beds)