Japanese Mental Health System Reform Process and Comparisons with Australia

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Japan

- Population:
  128M (Australia 20M)
- Area:
  378,000 sq km (Australia 7,687,000)
- GDP per capita:
  29,400US$ (Australia 28,900US$)

High population density.

About the same GDP per capita

Comparing the data, divide by six to know the equivalent size in Australia

Current Situation of Mental Health Services in Japan

Difference of health system Aus &Jpn

In Japan there is…

- No GP
- No catchment area. Patient can choose wherever they want to go
- Universal health insurance with copayment
- Fee for service scheme for medical service
- Private and public hospital on same scheme, with same price

Mental Health Services in Japan

Medical

- Mental Hospitals (80% private)
- Out patient clinics (private practice)
- Home visit by nurse
- Daycare center
- Pt. and Family Psychoeducation/Social Skills Training/Occupational therapy…

Social Welfare

- Half-way homes (rehabilitation facilities)
- Group Home
- Home help
- Job coaching/supported employment
- Care management

Mental Hospitals

- Mental hospitals: 1,669. No of Beds: 350,000.
  28.1 beds per 10,000 people. (No of pt. 330,000)
- Forms of the establishment:
  University hospitals 5%
  Public hospitals 15%
  Private hospitals 80%.
- 40% of the inpatients are over 65 years old, and more than 70% are staying longer than one year.

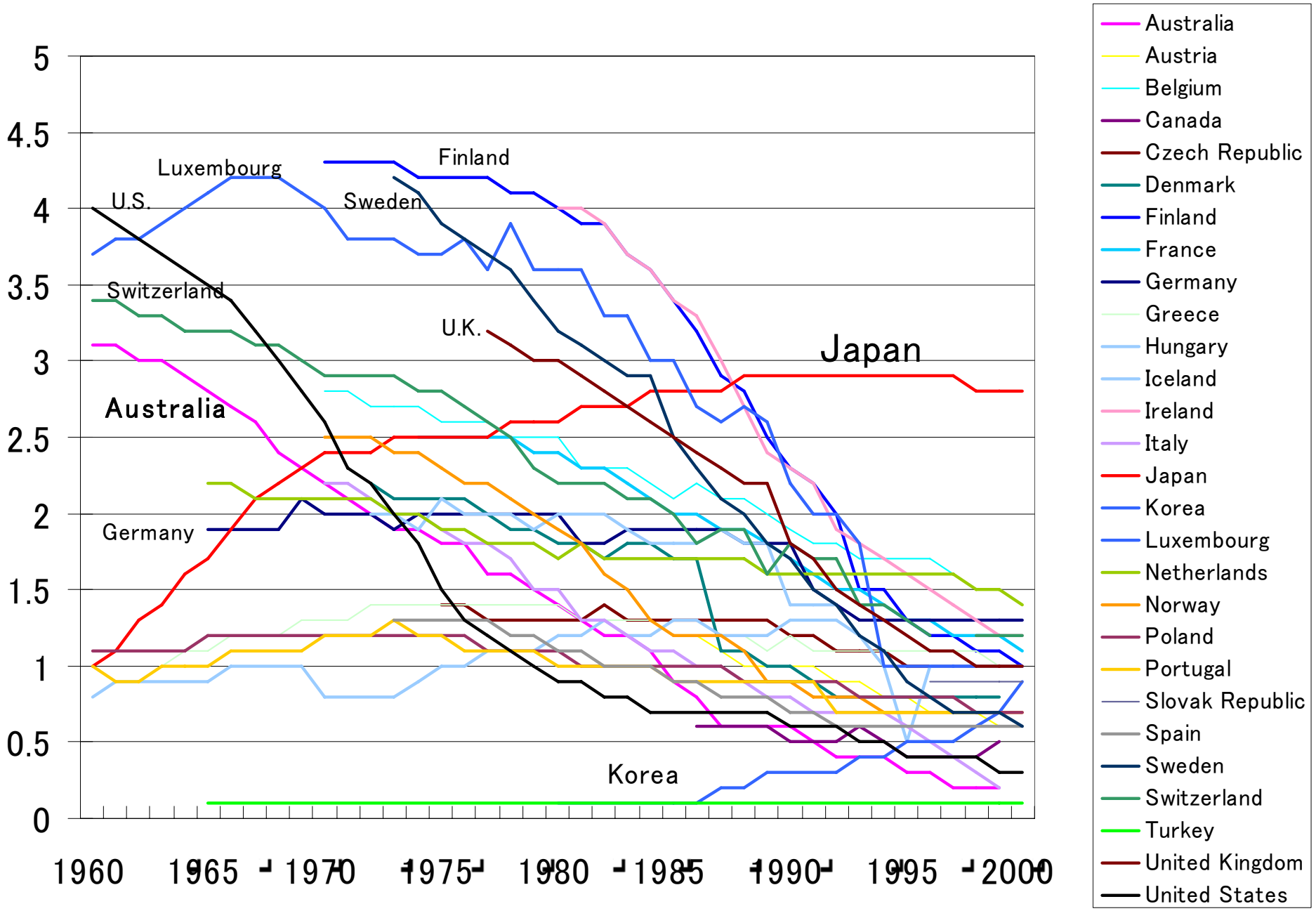
Mental Hospitals cont.

- All beds of national and public mental hospitals accepts involuntary hospitalization.
- 68% of the private mental hospitals also have beds for involuntary hospitalization.
- In Japanese mental health services, private facilities are playing a central role.
- Co-payment of medical services are 30%, same in public or private. For chronic mental ill patient, co-payment is 10% or less, depending on income.
- Most of the fund goes to Mental hospital. We must allocate more fund to community mental health.

Other Medical services

- No. of mental clinics 3,682. Almost all of the clinics are private.
- About 800 mental hospitals and 300 mental clinics provide psychiatric day care.
- Home-visit nursing by mental hospitals: total number of about 43,000 cases per month.
- Group therapy, Occupational therapy, and other programs are conducted at hospital
- Family psychoeducation is also widely conducted.

Psychitric beds per 1,000 people (OECD Health Data 2002



Mental Health Personnel（Full time）at Mental Hospital

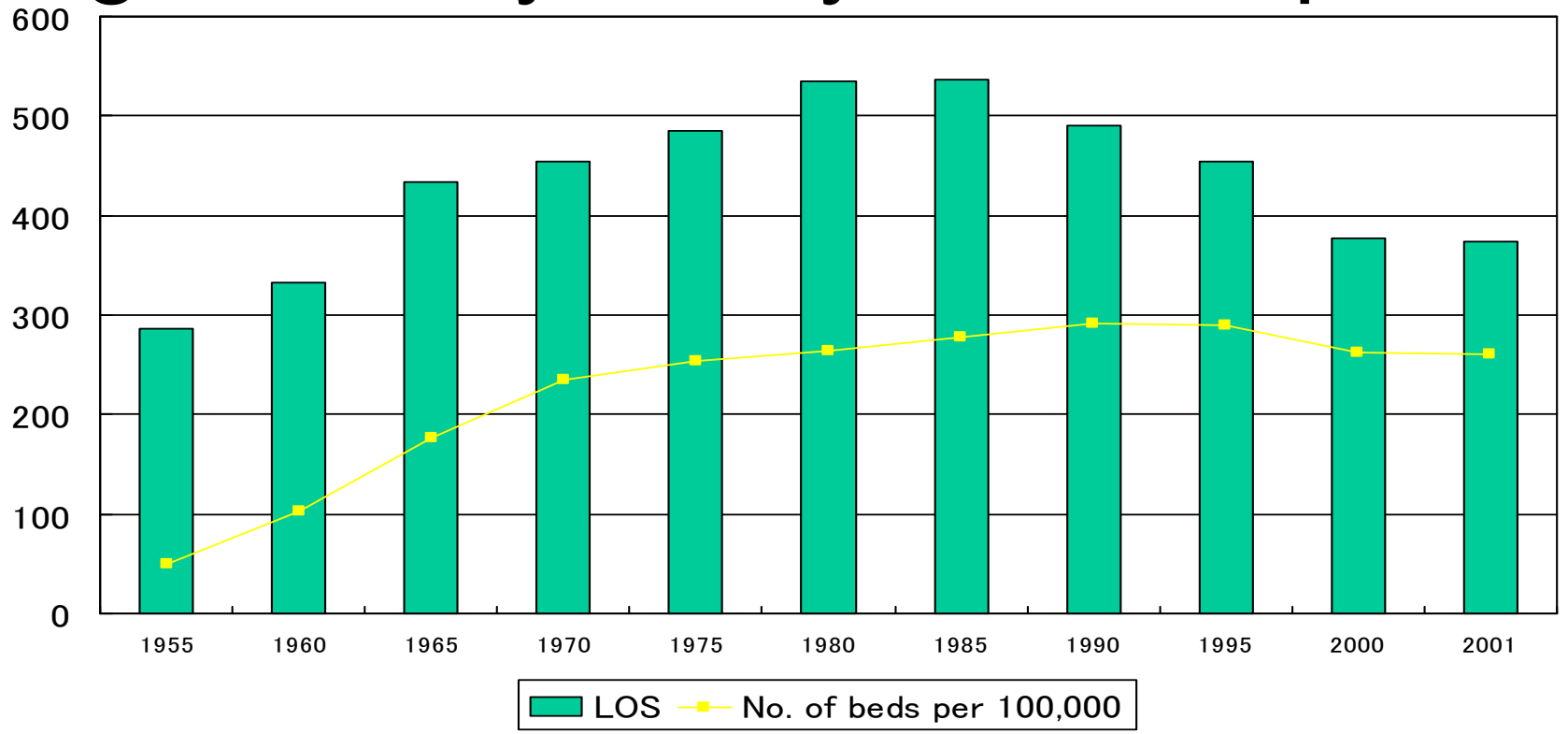
	No. of person	No. of beds per person
Psychiatrists	9,527	37.2
Nurses	53,378	6.6
Assistance Nurses	49,554	7.2
Nursing aids	35,604	10.0
OTs	3,832	92.6
PSWs	4,503	78.8
Clinical Psychologists	1,496	237.1

2002 No. of beds 354,721

We have many staff working at hospital.

We must move this workforce into community practice

Length of Stay of Psychiatric Inpatients

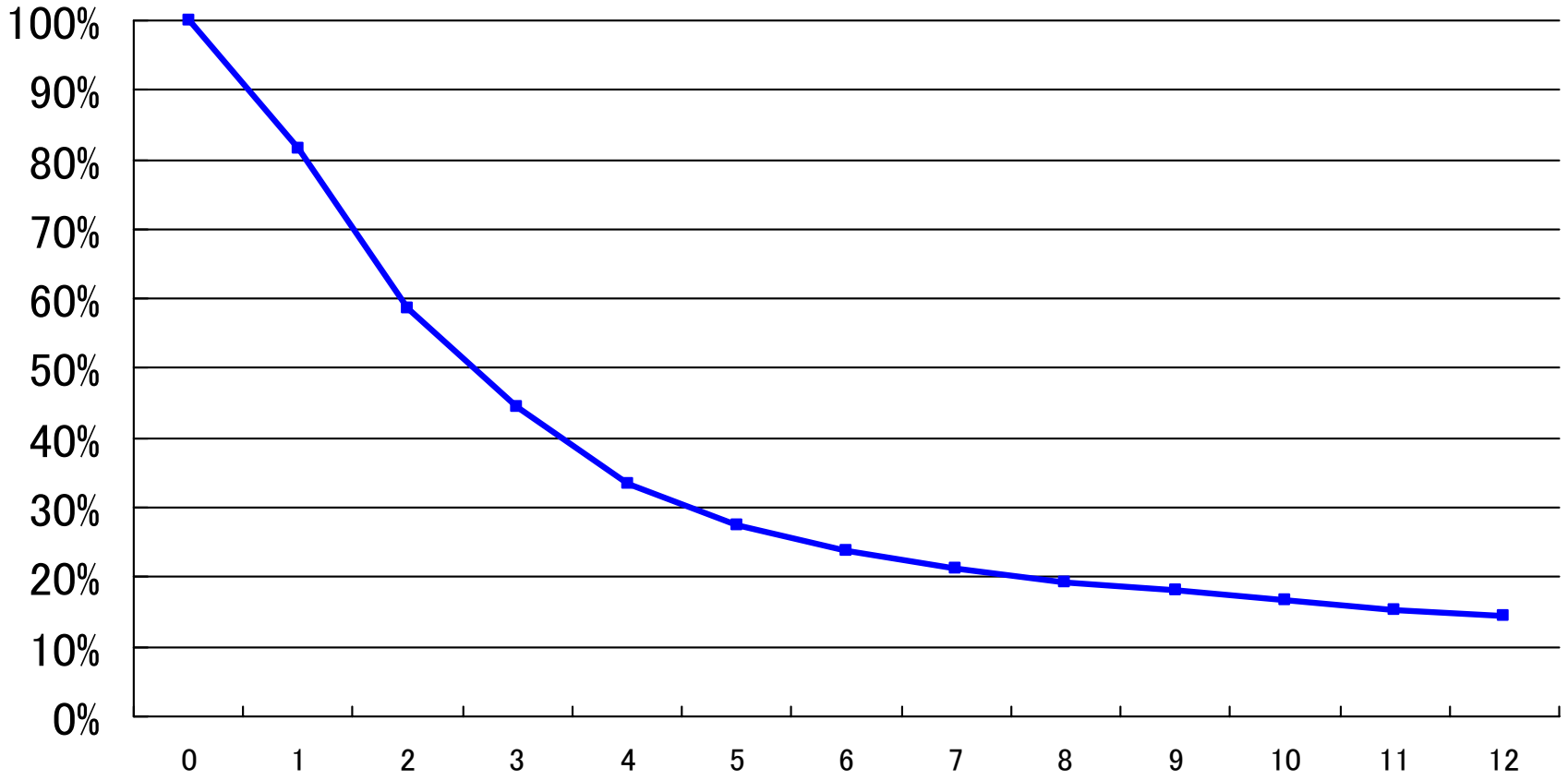


$$\text{Length of stay} = \frac{\text{inpatient person-day}}{\text{1/2 (No. of admission + No. of discharge)}}$$

Length of stay is gradually becoming shorter since 1985.

However, it is still long due to long stay patients.

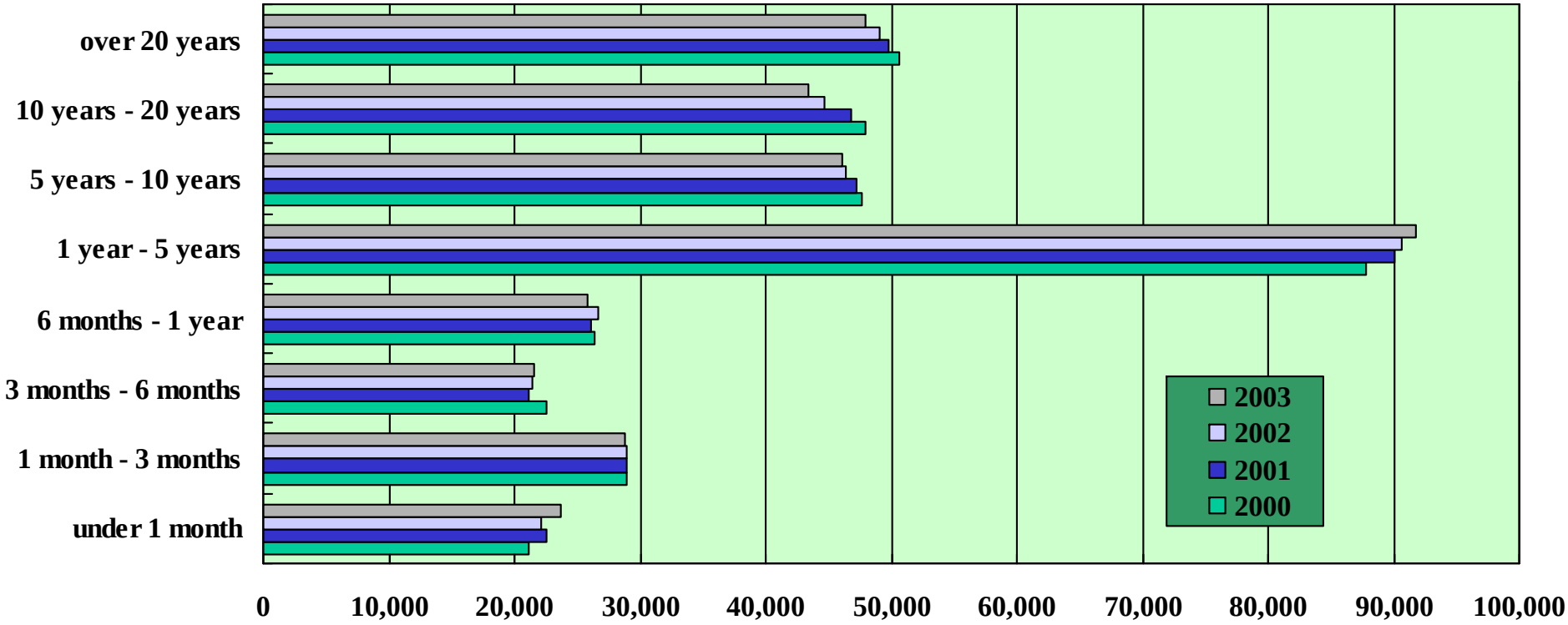
Survival Curves of Inpatients Admitted



When seeing the inpatients admitted,

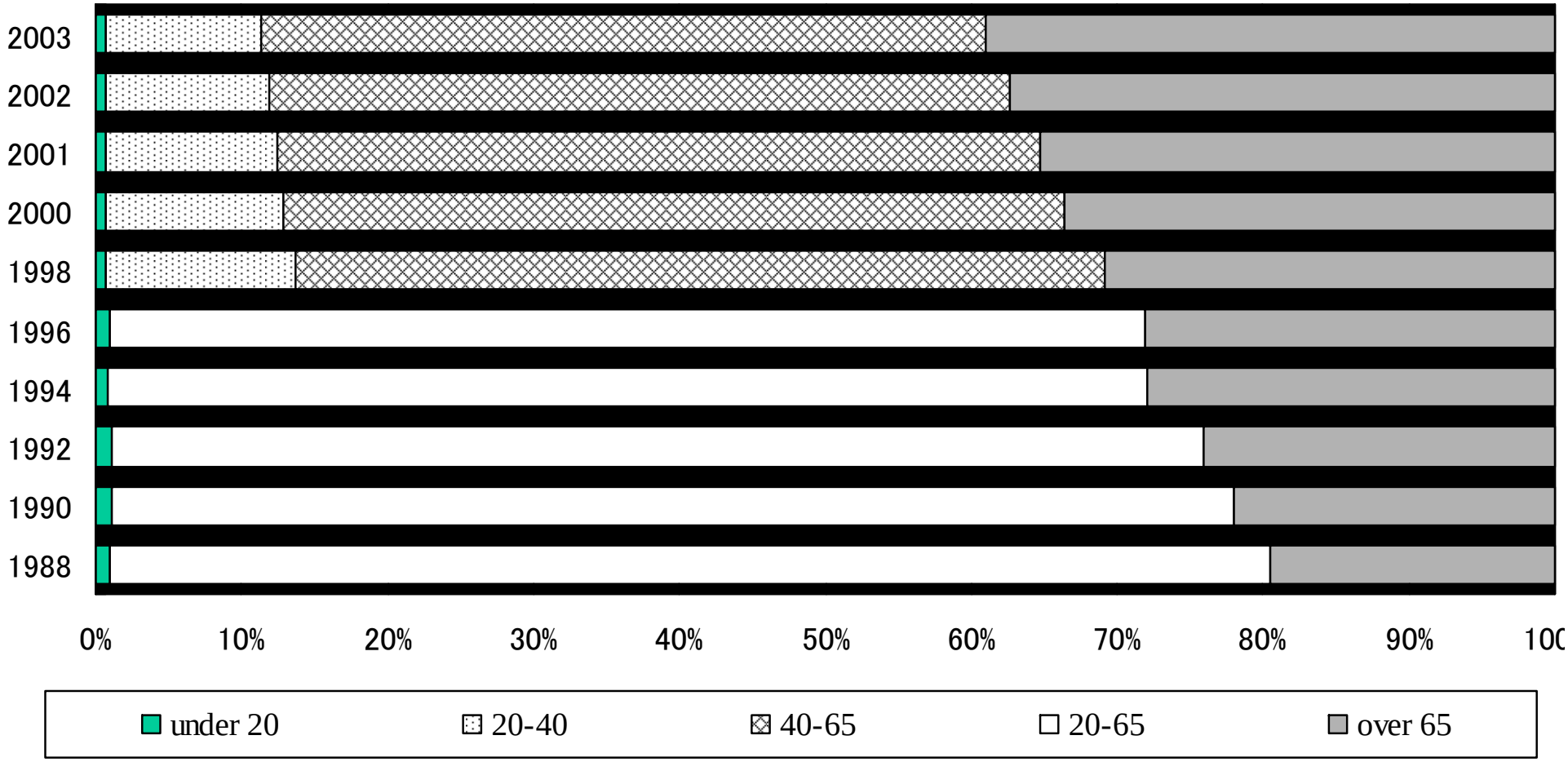
- Half of the newly admitted patients are discharged within 2 months.
- About 15% of the patients are still staying after a year.

No. of Inpatients by Length of Stay



Length of stay varies; 30% stays less than a year, and remaining 70% are staying longer.

Age of Inpatients



- About 40% of the inpatients are over 65 years old.
- Aging of psychiatric inpatients are advancing.

Number of Psychiatric Inpatients and Length of Stay (Summary)

- Among the newly hospitalized patients at psychiatric hospitals, 50% discharged within about 2 months, 14% stayed longer than 1 year.
- Of the inpatients staying at mental hospitals, 30% are staying for less than a year, and 40% are over 65 years old. This is because the patients who cannot get discharged from the psychiatric hospital and move to the other rehabilitation facilities are aging.

Community care

Rehabilitation and Residential Facilities in Community

- Welfare facilities are mostly private owned (social welfare corporations, medical corporations, NPOs).
- Administrating finance is from public funds.
- Users can choose the facility, and are registered to the facility. Usually the database of each facility is not linked with others.
- Entering the facilities, users must be assessed and have a care plan.

Rehabilitation facilities

- Half-way homes with limit for stay (e.g.6months, 2years)
- Units varies by function, from 10 to 30 users
- Place to gather from home
- Offers psychosocial rehabilitation, such as ability for daily living (e.g. cooking, buying, telephone use, public transport…)
- Some offers opportunity to work

Group Homes

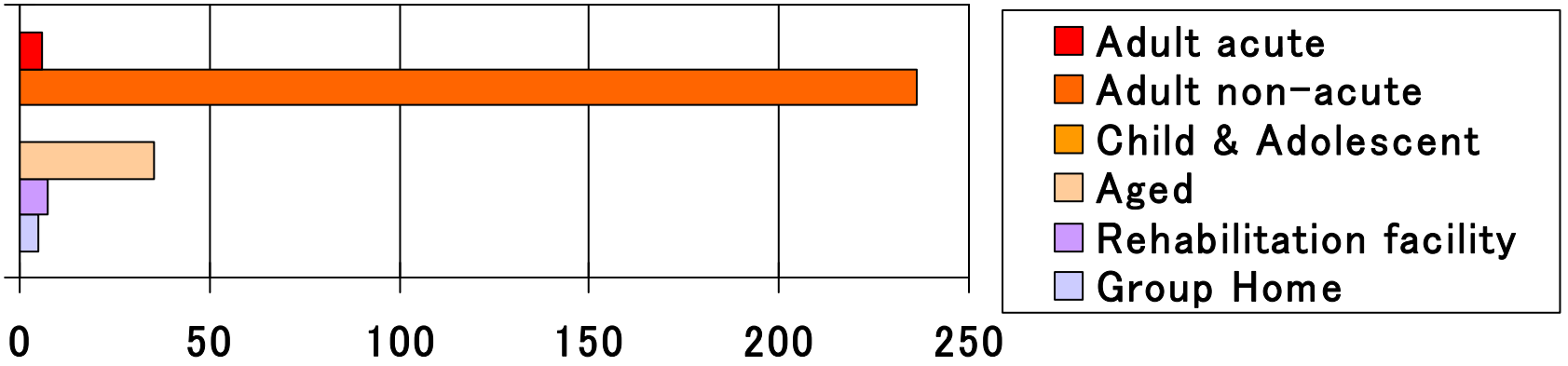
- Place to stay for long term, for those whom they can live on their own
- Units are about 5-6 users
- Some is a big house with many rooms, some are apartments
- One staff comes on daytime

Community Rehabilitation Facilities

	Target	No of capacity
Facility for training in daily life*	Person without home and can not live independently	5,684
Welfare home*	Person without home	3,165
Residential vocational facility*	Person without home and needs vocational training	806
Outpatient vocational facility	Person who needs vocational training	6,271
Welfare factory	Person who can not work because of interpersonal reasons	462
Community life support center	Provides consultation and liaison with other facilities	452 places
Group home*	Person who can live communally	6,404

*residential facilities

No. of Beds in Hospital and Facilities



Per 10,000 person

No. of beds for mentally ill people per 100,000 population are 28.1 in mental hospitals, 0.7 in rehabilitation facilities and 0.4 in group home.

Though there are many beds in psychiatric hospitals, most of the beds are used by long staying and aged patients.

Promotion of discharge, changing hospital beds to community facilities, and securing beds for acute care is an urgent issue.

Home-visiting (Outreach) support

- The importance of visiting support has been emphasized. Home-visiting services done by mental hospitals and clinics are increasing.
- Forms of home-visiting services
  - -home visit by nurse/SW/OT/Dr
  - -home visit by nurse before discharge
  - -home help service by home helper

Care Management

- Needs of integration of care is increasing especially in community mental health.
- However, because of the insufficient liaison between hospitals and welfare facilities, and lack of budget to support, it was not introduced to routine care.
- In 2006, new Law (Law to Support the Independence of People with Disabilities) was enacted. It provides funding for making care plans, so it may increase the no. of care management done.

Recent effort in Japan:

Assertive Community Treatment

- Intensive form of care management. Case load about 10
- Treatment offered directly from the multidisciplinary team.
- The pilot study of ACT has begun in 2003.
- However, the main administration body and funding resource for ACT is not decided.

Supported employment

- “Place, then train” approach
- Traditionally, patient were trained in special settings.
- This approach, assign the patient to a actual work place, and job coach train them on the spot.
- Still in the research phase

Current Limitation (Before the reform)

- Too many psychiatric beds/ lack of community support services.

  Inpatients due to the lack of support in the community = 70,000
- Difference between disorders. Mental disorders not included to funding/service provision system for physical and intellectual disorders.
- Difference of service quantity and quality between areas.
- Lack of vocational rehabilitation.
- High stigma and lack of understanding of mental health among the community.
- Increase of the use of both social welfare services and medical expenses for outpatient/ambulatory services led to scarcity of the funding. The system is not sustainable.

Mental Health System Reform in Japan

Reform of Mental Health and Welfare Services
- Recent Developments -

- 2002 Future Direction of Mental Health and Welfare Policy Report from the Sub Committee on Mental Health in the Social Security Council (advisory board to Minister of Health)
- 2002 Establishment of Headquarters for Mental Health and Welfare, headed by the Minister
- 2004 Reform Vision for Health, Medical Care and Mental Health Welfare
- 2004 Future Policies for People with Disabilities and Community Welfare (Grand Design for Reform)
- 2005 Law to Support the Independence of People with Disabilities
- 2005 Revision of the Mental Health and Welfare Law
- 2005 Revision of the Law on Promoting Employment of the Disabled

Reform Vision for Mental Health and Welfare Services

Headquarters for Mental Health and Welfare, headed by the Minister

“From Institution-based Care to Community-based Care”

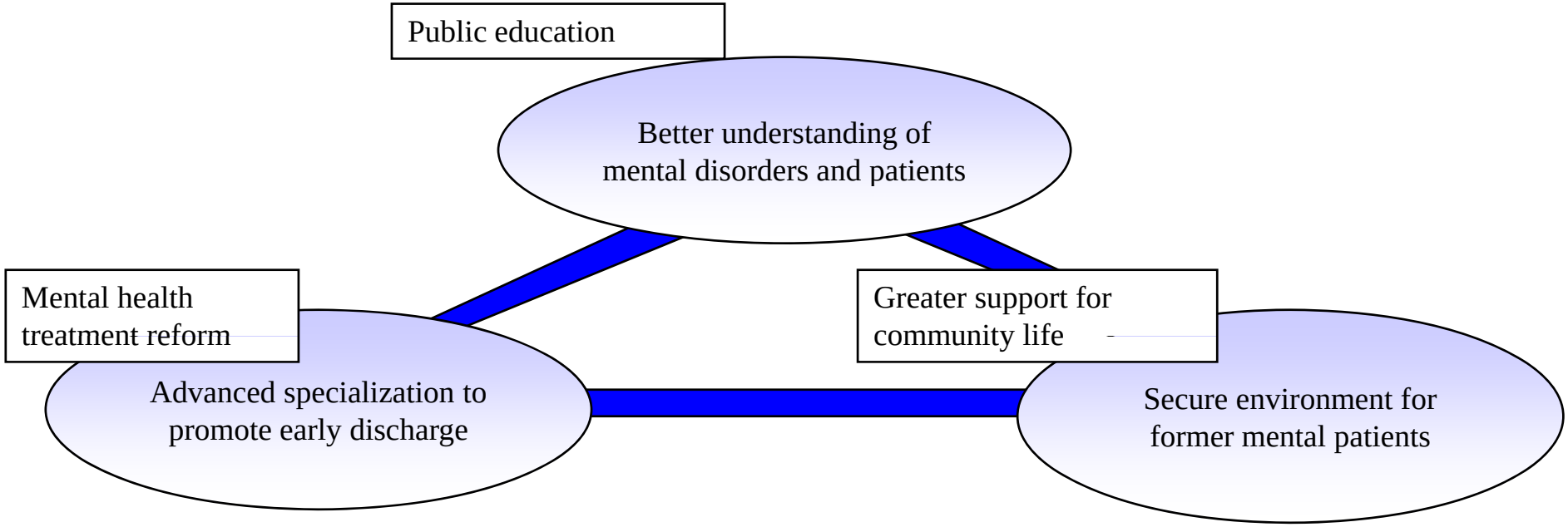
Three main aims

- Change the public’s attitude toward mental illness
- Reorganize and reinforce psychiatric medical services
- Reorganize and reinforce community support systems

After hearing the opinions of local governments and related councils, etc., the MHLW revised the Mental Health Welfare Law in 2005.

Framework of Reform Vision for Mental Health and Welfare Services

Implement the following to promote change from hospitalization to community life over the next 10 years:
(1) Better public education (2) Reform of mental health treatment (3) Greater support for community life.



Stronger foundation

- Train more people to provide mental health treatment and welfare services, and develop standard care models.
- Expand benefits for better-quality home treatment services.

Basic stance: Shift from hospitalization to community-based life

The aim is to reduce the number of psychiatric hospital beds by about 70,000 over the next 10 years

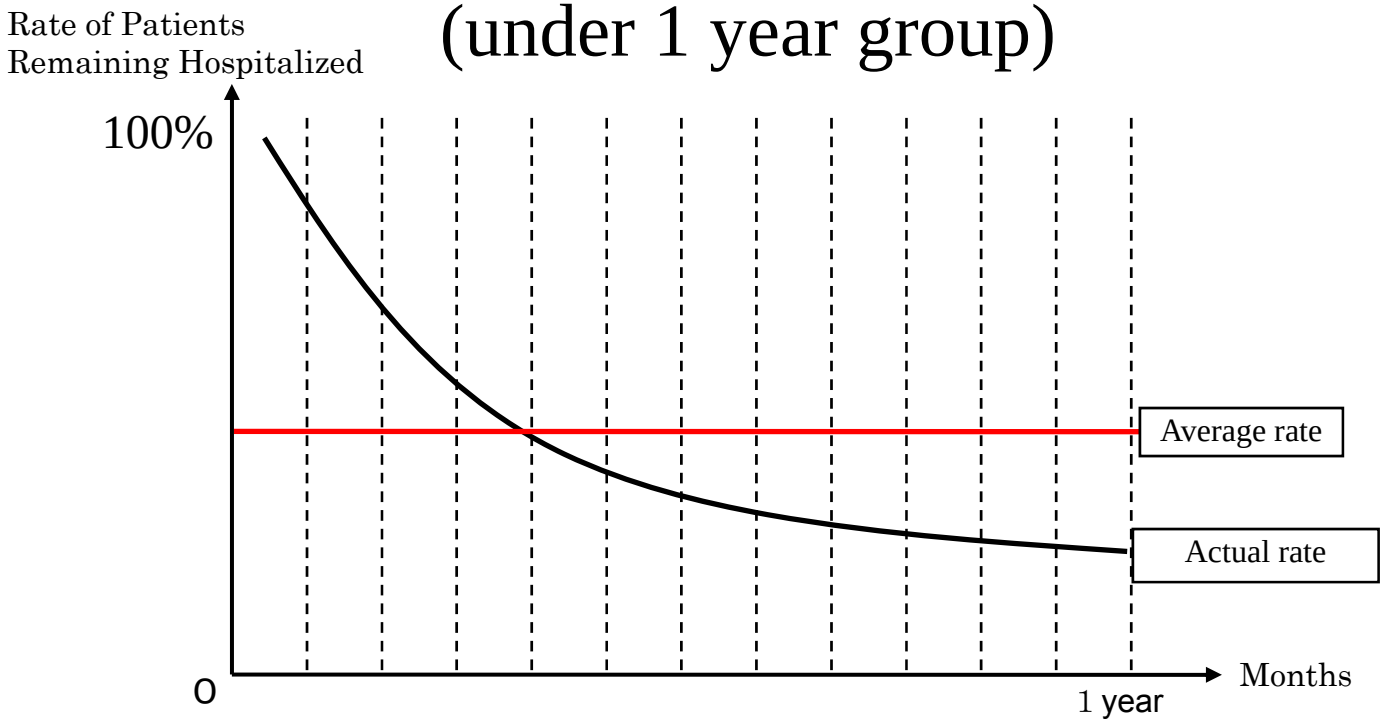
(1) Goal of Public Education Reform

- Like any life-style related disease, mental disorders also affect the general public. The goal is to raise public awareness to over 90%.

(2) Goal of Medical Treatment Reform

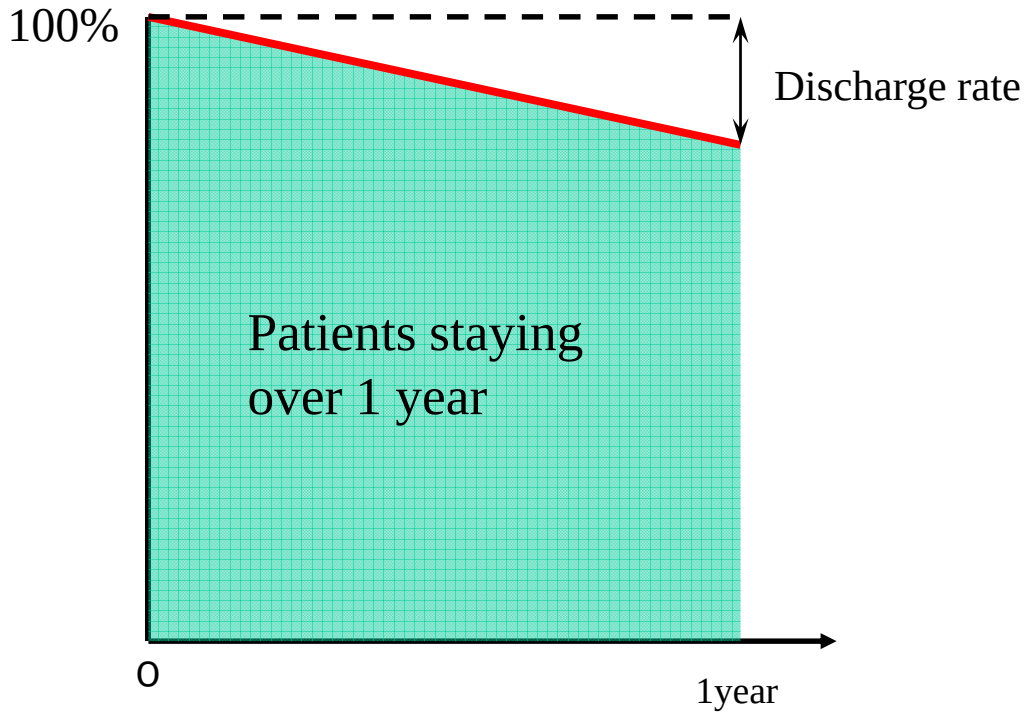
- Efficient treatment to promote patient discharge within a year of hospitalization.
  Lower the average number of patients who remain hospitalized to below 24% (less than 1 year group) in each prefecture.
- Promote the return to community life of the patients hospitalized over a year.
  Raise the discharge rate (over 1 year group) to over 29% in each prefecture.

Average Rate of Patients Who Remain Hospitalized (under 1 year group)



Average rate of patients remaining hospitalized (under 1 year group) = $\dfrac{\text{Sum of remaining patients every month}}{\text{Number of hospitalized patients in previous June x 12}}$

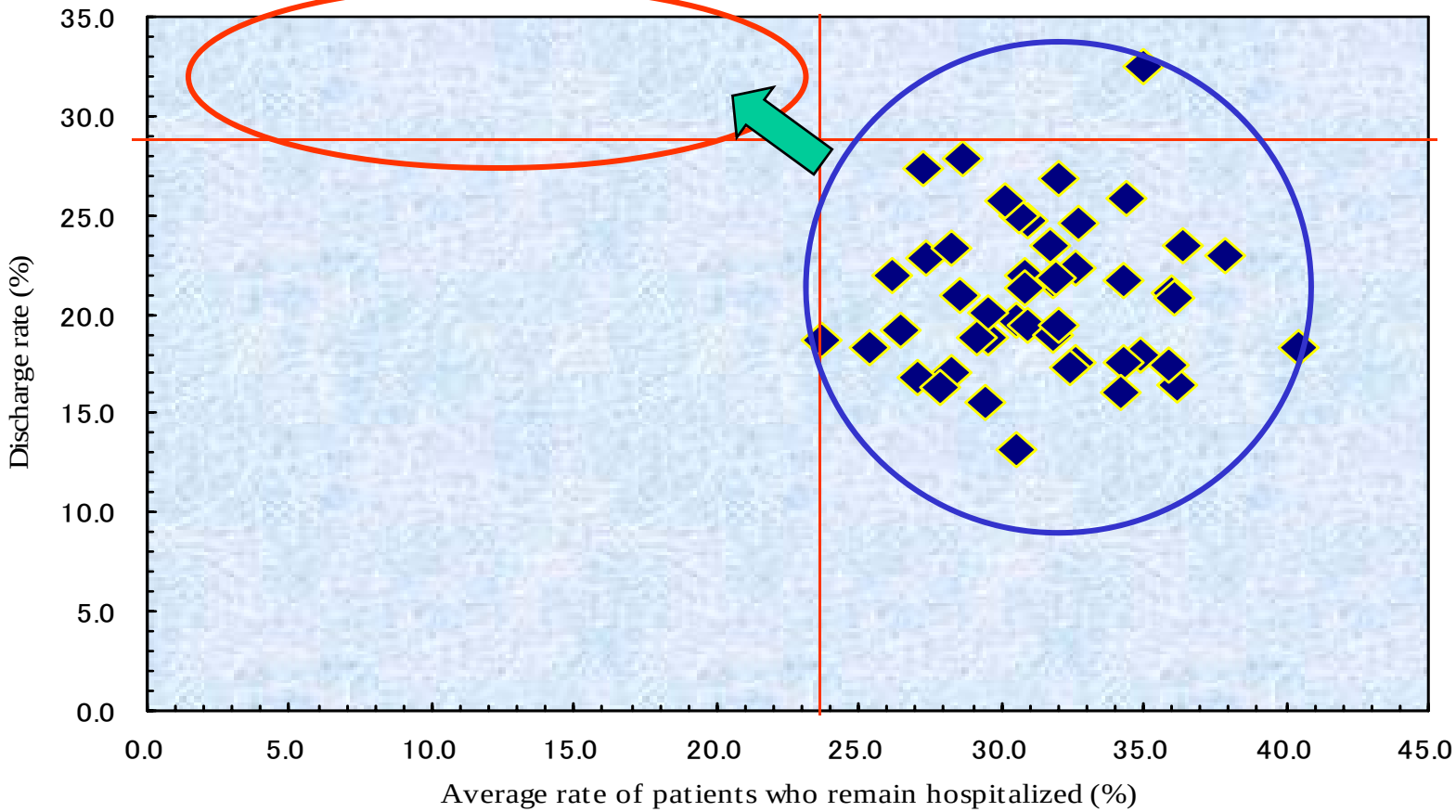
Discharge Rate (over 1 year group)



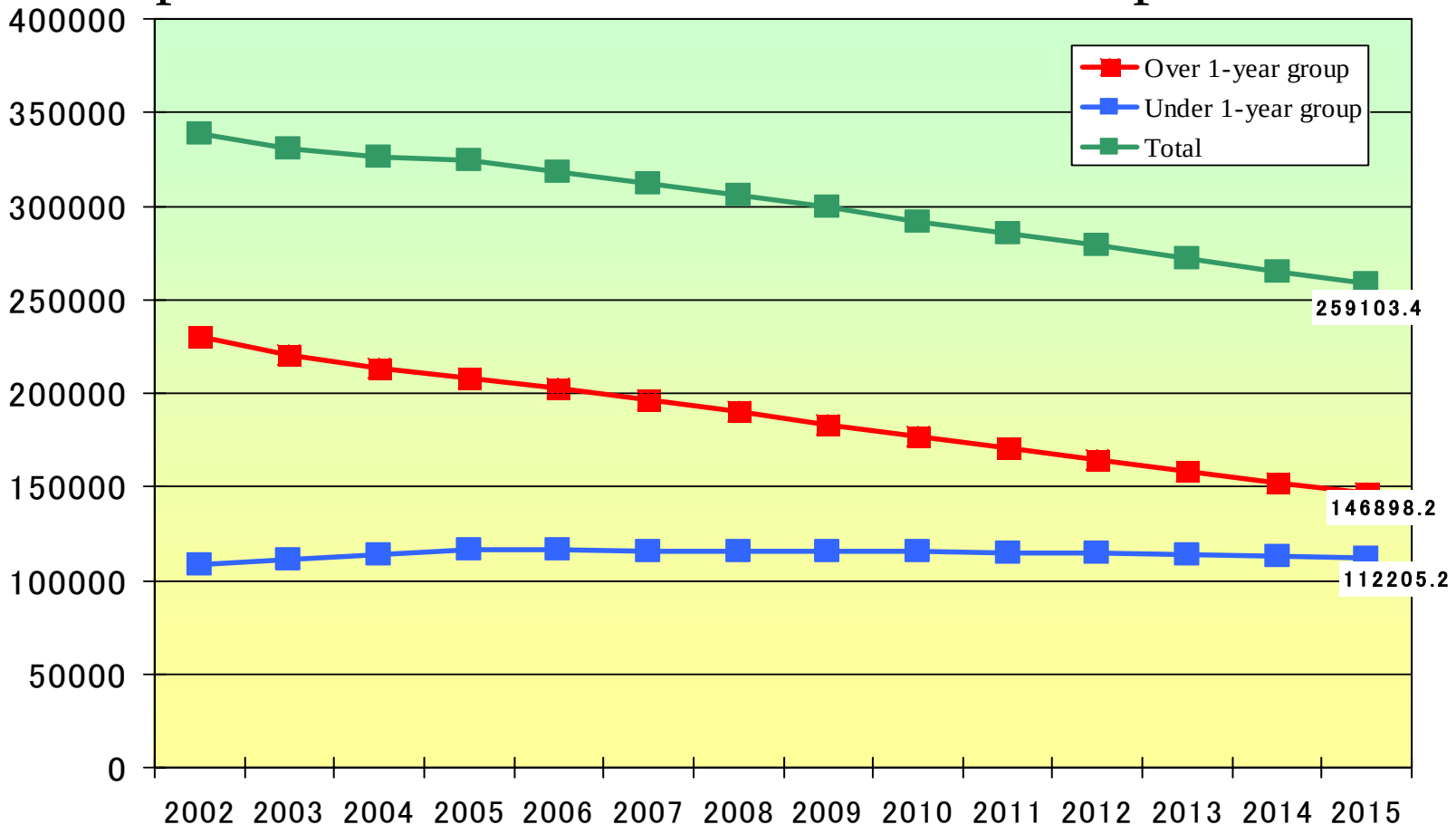
$$\text{Discharge rate (over 1 year group)} = \frac{\text{Number of discharged patients (hospitalized over 1 year) by month x 12}}{\text{Number of hospitalized patients (over 1 year) in the year}}$$

Dispersion of Average Rate of Patients Remaining Hospitalized and Discharge Rate (each prefecture)

The dots express the average rate of patients remaining hospitalized (under 1 year group) and the discharge rate (over 1 year group), calculated from 2000–2002 figures, by prefecture.



Expected Transition in Number of Hospital Beds



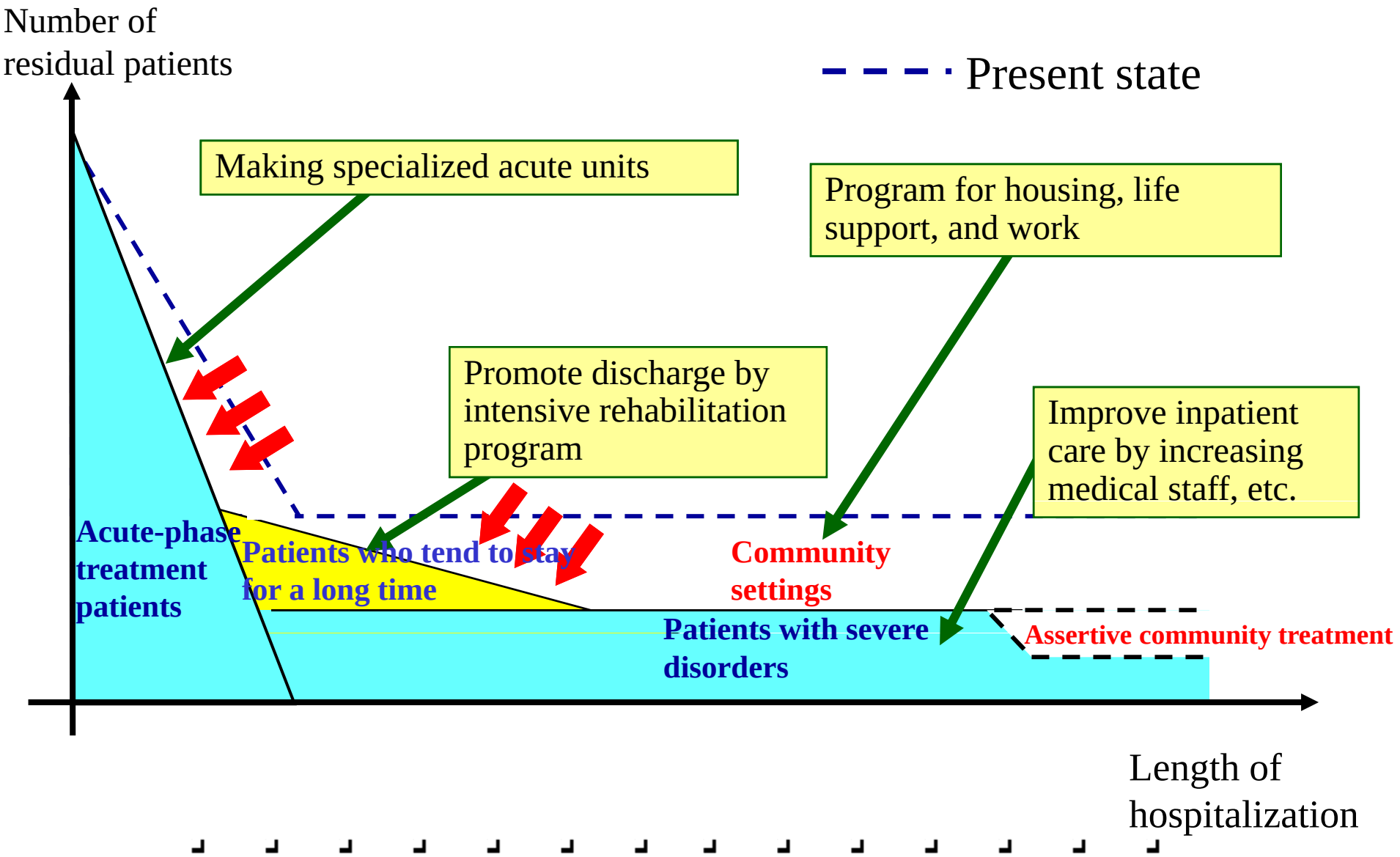
Assumption: Number of admitted patients grows by 2.0%

(3) Enhancement of Community Support Systems

1. Reorganize support system for housing, living and activities, suited to each life stage
2. Establish a multi-layered counseling support system (care management)
3. Improve the structure to supply systematic services by municipalities

→ Revisions to laws supporting the independence of people with disabilities and promoting their employment

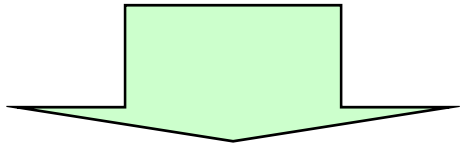
Function Differentiation of Hospital Bed



Law to Support the Independence of People with Disabilities

Challenges to People with Disabilities and Community Welfare

- Growing difficulty in maintaining the system as the number of users continues rising.
- Wide regional gaps (no nationwide rules; different service supply systems from one area to another, discrepancy in municipal financial capacity).
- Broad gaps in service quality and systems by type of disability.
- Obstacles to people with disabilities willing to work.



Inadequate systems for people with disabilities to lead normal lives in the community.

Points of Law to Support the Independence of People with Disabilities

- Streamline three disorders
- Service integration to more user-oriented services
- Enhance support for employment
- Clarify benefit supply process
- Secure financial source

Streamline three disorders

Current situation

- Haphazard approach to 3 disorders (physical, intellectual, mental).
- Implementation by two sectors – prefectures and municipalities.

Law aims to

- Streamline the approach to 3 disorders.
- Allow the municipalities to handle the services.

Service integration to more user-oriented services

Current situation

- Highly complex by disorder type.
- Gap between aim of the facility and reality.

Law aims to

- Reorganize facility systems. Create services to support employment and help severely handicapped.
- Use available social resources while promoting deregulation.

Enhance support for employment

Current situation

- Few users graduate facilities by getting job

Law aims to

- Create more job support services.
- Strengthen connection to employment policies

Clarify benefit supply process

Current situation

- No objective criteria to judge need for support
- Unclear benefit supply process

Law aims to

- Use a scale (to check disorder level) to measure the level of support needed.
- Clarify the process of supply decision making.

Secure financial source

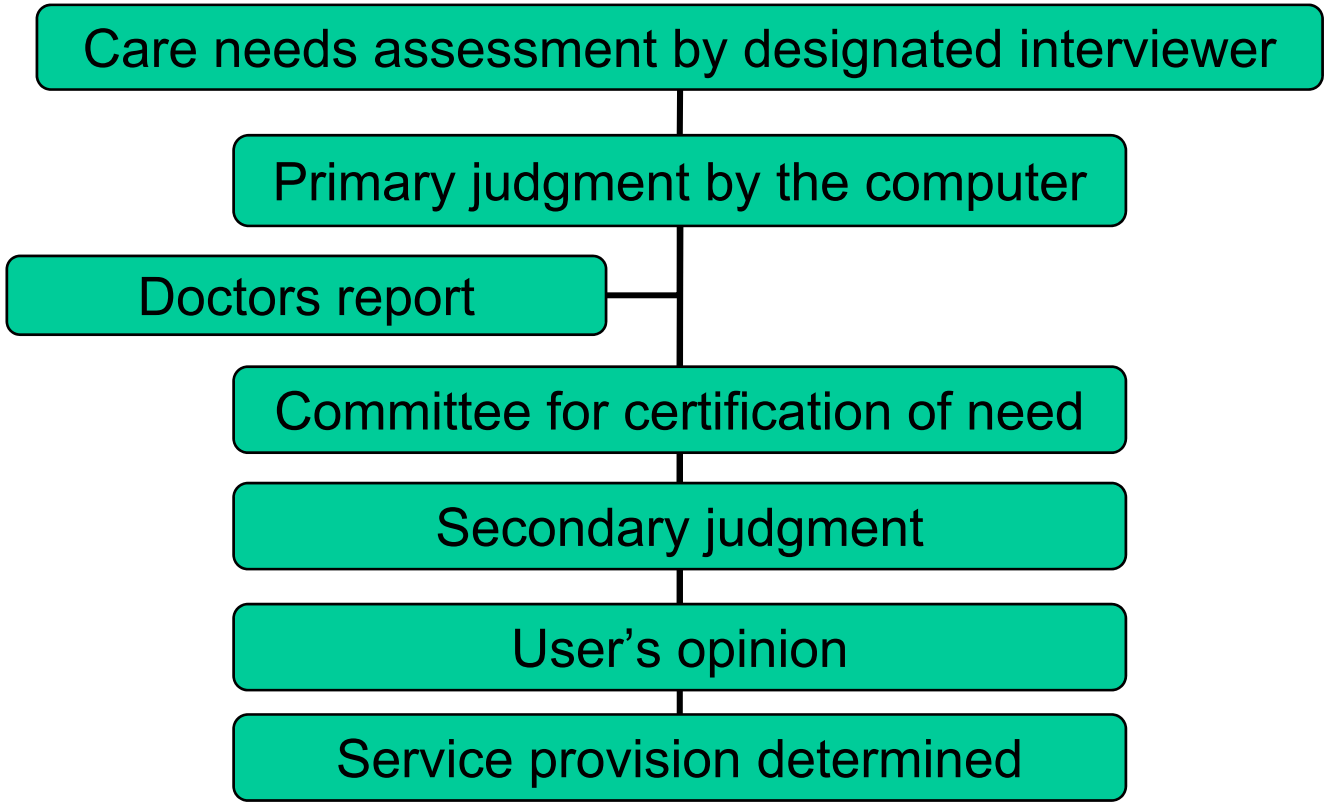
Current situation

- Expected rise in number of users.
- Unstable government financial support.

Law aims to

- Increase the government's financial burden (1/2 the cost).
- Stabilize the government finance
- Clarify users' share of the cost.

New welfare service provision system



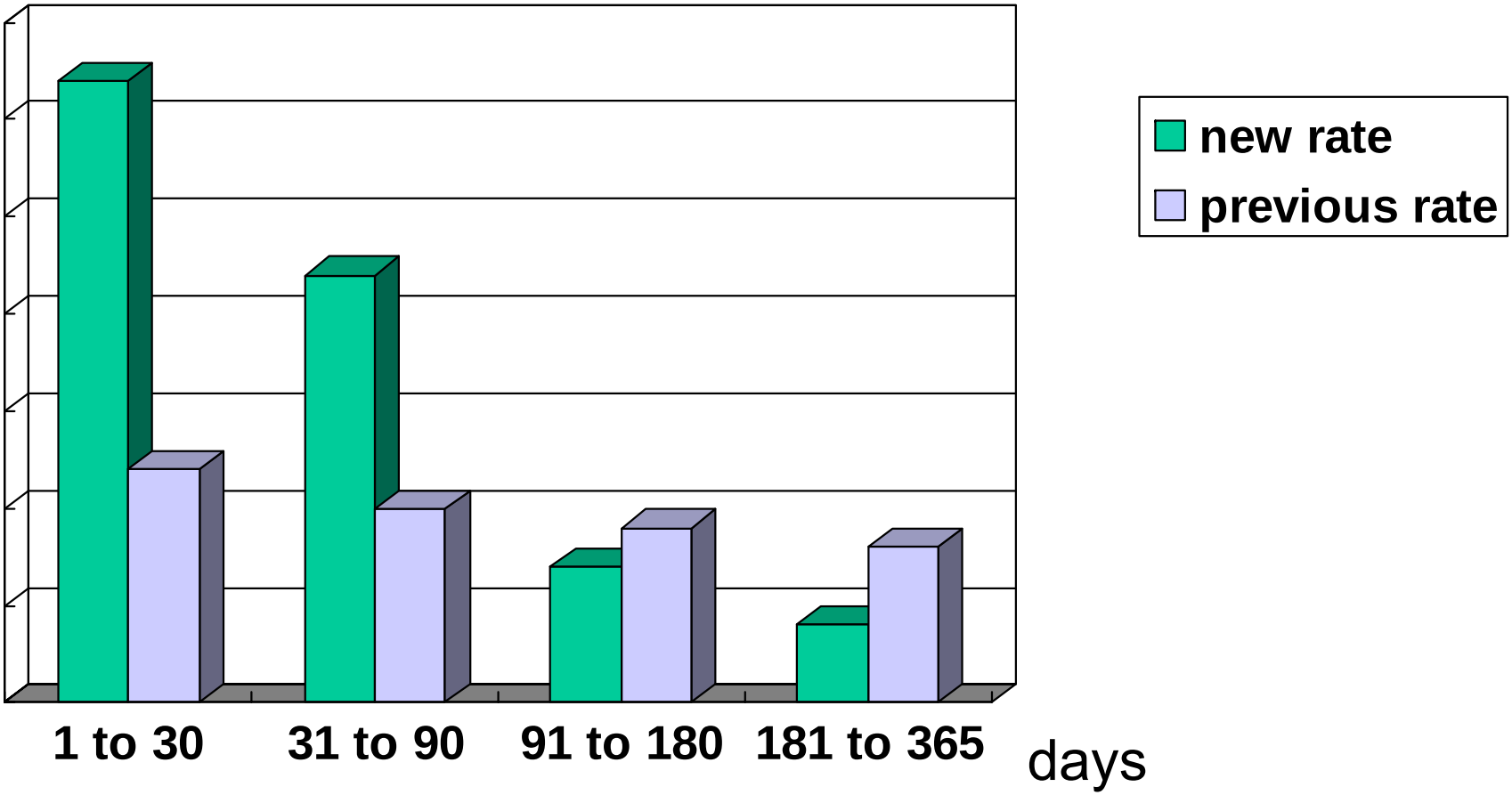
Care needs is assessed in 7 categories, no needs or care needs 1 to 6

Depending on the care needs, type of service and fund paid to service provider are decided

Recent change on the national fee schedule (2006)

- The fees paid to emergency and acute psychiatric unit are raised for those staying less than 30 days.
- Similarly, the fee usual psychiatric unit are raised for those staying <15 days and reduced for those staying more than 90 days.
- Nurse visit limited for 3 times/week but changed to 5/week for those who are less than 3 months after discharge.
- Psychotherapy for the family was included to the schedule.
- New setting of the short term (three hours) psychiatric daycare was established.

Image of changing the rate



Other recent reform

- Revision of the Law on Promoting Employment of the Disabled

  At least 1.8% of the employee must be person with disability. Mental disorder included in 2005.
- The Act for the Medical Treatment and Supervision of Insane Persons Who Caused Serious Harm

  Criminally insane treated at inpatient and outpatient of designated hospitals
- Subsidiary paid when mental hospital changes their unit into rehabilitation facility

Strategy to Reduce the Psychiatric Beds

- Difficult because most of the hospital is private
- Reduce the fee for long stay pt. while increasing the fee for shorter stay pt.
- Promote differentiation and specialization in function of the units
- Money are paid when hospital changes their bed into rehabilitation facility
- Setting medical goal (e.g. length of stay) for each district to follow
- Introduction of new antipsychotic drug
- Developing more community mental health services (home visits, half-way home…)
- Most western countries closed mental hosp. without developing community care. Many homeless, high readmission rate….

A bit about Australian Mental Health Strategy

- Three broad aims identified
  - promote mental health, prevent disorders
  - reduce impact of disorders
  - assure rights of people with mental illness
- Early effort was directed at restructuring public sector specialist mental health services to:
  - change the service mix to be more community-based
  - integrate mental health services and bring them together with general health care (‘mainstreaming’)
  - reduce reliance on stand alone psychiatric hospitals
  - improve service responsiveness and respect of consumer rights

The National Mental Health Plan 2003-08

- Four priority areas:
  - Promoting mental health and preventing mental health problems and mental illness
  - Improving service responsiveness
  - Strengthening quality
  - Fostering research, innovation and sustainability
- Continuing effort required to position mental health as a 'whole of community' matter by:
  - reducing stigma, particularly targeting the media
  - collaborating with unions and employers on prevention in the workplace
  - Health promotion programs eg Mindmatters

Outcome of the NMHS in Australia

- Funding increased/more fund to community
- High growth of community mental health services and NGO
- Closing of stand alone hospitals and non acute beds
- Rise of consumers and carers participation to services
- Development of public awareness/education programs

Comparison of key data between Australia and Japan

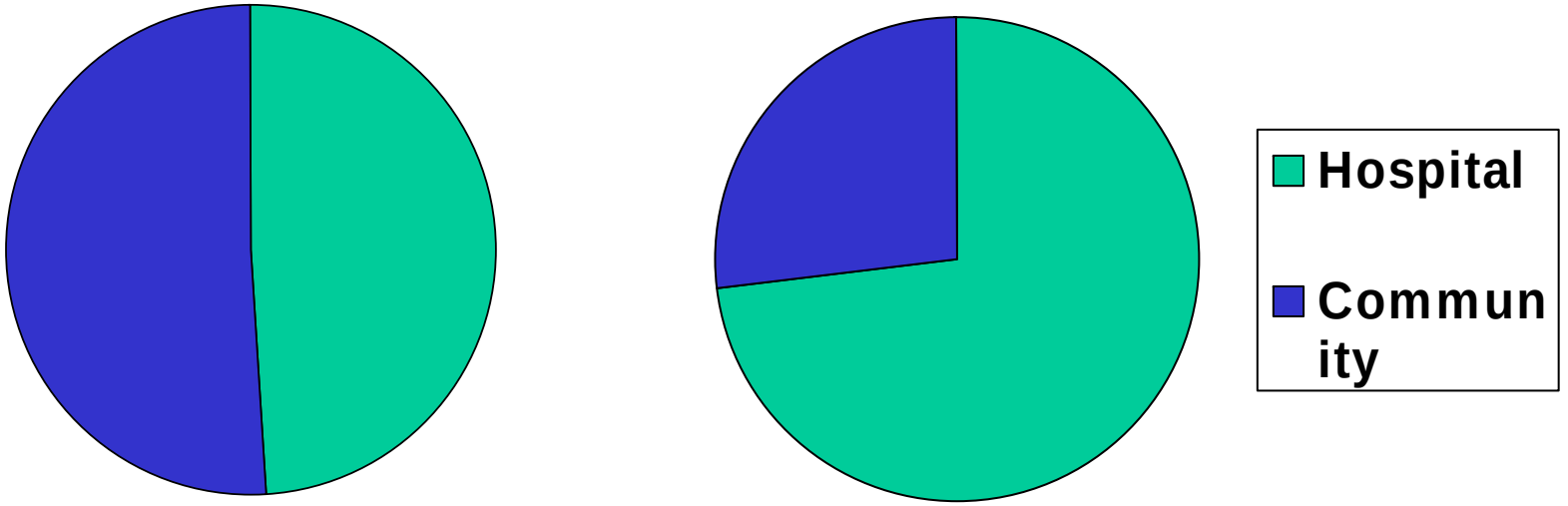
Mental Health Funding

	Australia	Japan
Total spending	3,327M A$	21,382M A$
Per capita	166.35 A$	167.05 A$

1A$=95yen

→ Almost the same spending!!

Mental Health Funding -Hospital and Community

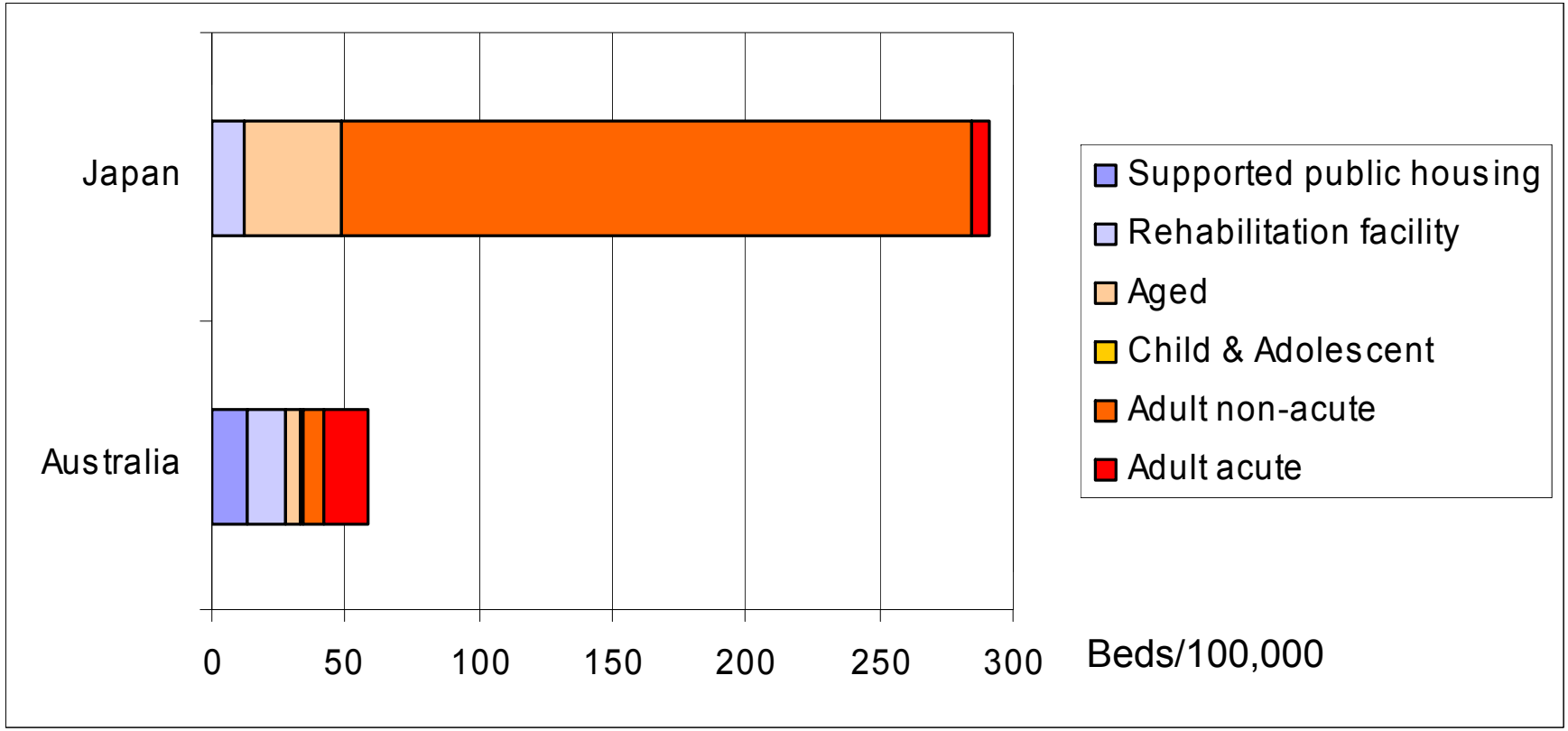


Australia

Japan

Need to allocate more fund towards community

Comparison of Psychiatric Beds

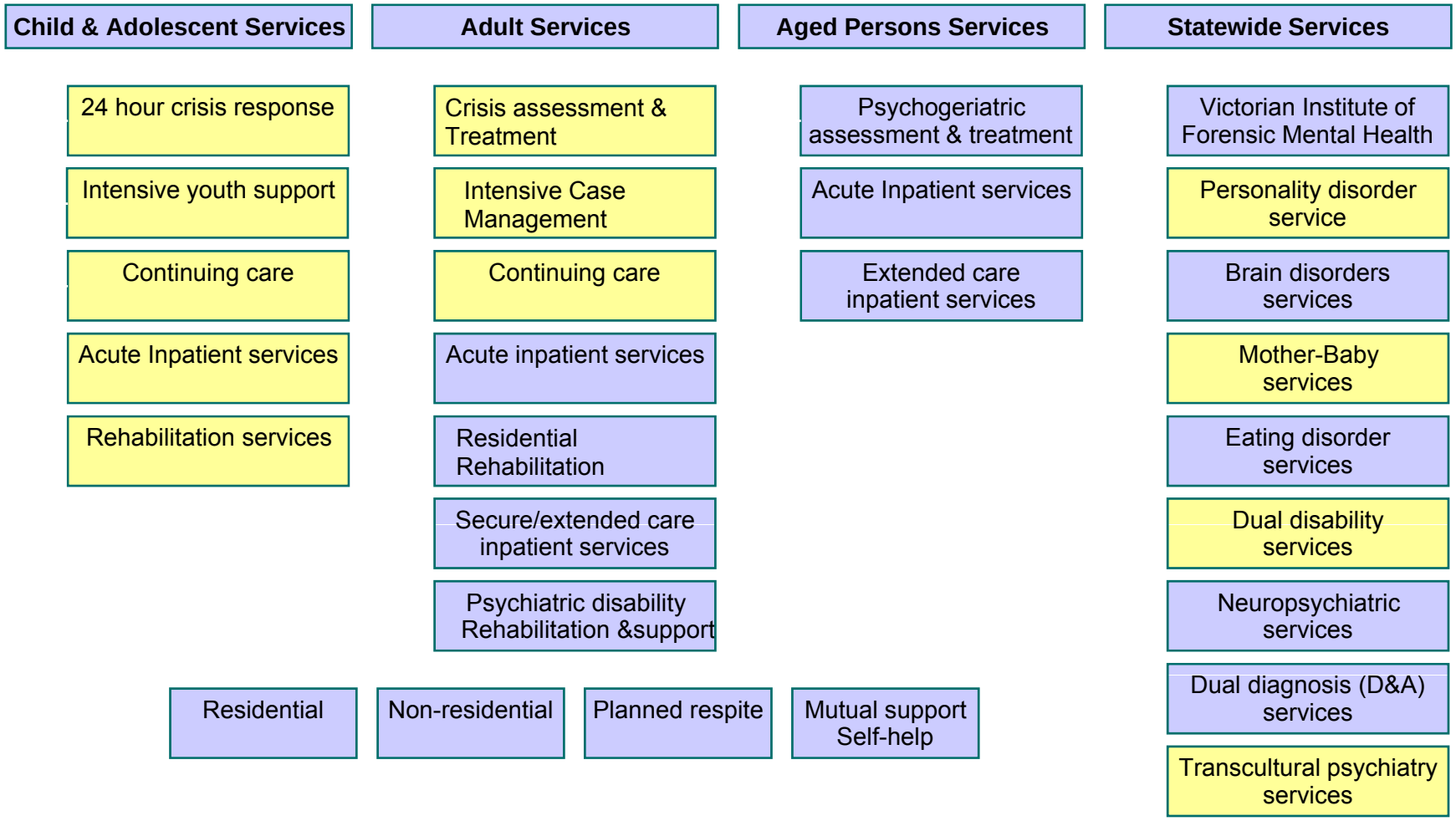


No. Professionals per 100,000 population

	Australia	Japan
Psychiatrist	14	10
Psychiatric Nurse	53	59
Psychologist	5	7
Social Workers	5	16

Source: WHO Atlas

Service difference with Victorian Service Framework



Yellow: Services not available or scarce in Japan

Implications from Australia

Implications from Australia

- Funding shift towards community
- Development of community mental health services, especially the outreach type
- Care management and Individual service plan
- Specialization in services
- Promotion and Prevention
- Quality improvement

Funding shift towards community

- Australia have shifted the fund to community in 10years, from 29.4% to 51.2%.
- Japan also needs the shift towards community.
- More outcome based funding system required

Development of community mental health services

- Outreach type of service is still scarce in Japan.
- Especially, there is no team that can assess in the crisis situation. Family must bring them to the hospital, sometime with the police.
- Also, more rehabilitation oriented residential facilities are needed
- Vocational and housing support

Case management and Individual service plan

- Introducing the new law, case management and individual service plan will be a duty for those who are living in the community
- However quality assurance of it is necessary, and those for SMI, direct care giving by the CM needed

Specialization in services

- Both inpatient service and community service needs specialization
- Areas include CAMHS, personality disorders, early psychosis, dual diagnosis, dual disability, etc

Promotion and Prevention

- High stigma among the community and the mental health knowledge is low
- We need various types of programs, such as mindmatters, Life is for everyone, beyond blue, national drug strategy in Australia

Quality improvement

- Community services framework is set, but contents are not defined
- Training of the staff
- Consumer and carer involvement
- Outcome measurement

Conclusion

- Japan is in the reform process toward community mental health
- Many policy, law and regulation are released
- However there are areas to be considered more, and lessons from Australia's reform is valuable.