

## Japan's Country Report

### Asia-Pacific Community Mental Health Development Project

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#### Country background and mental health system:

Japan is an island country in East Asia. It has an area of 377,915 kilometres<sup>2</sup> with a population of nearly 127.7 million people. People of Japanese origin form 99% of the population. Japan has the world's second largest economy by GDP. Life expectancy at birth is among the longest in the world: 78.5 years for males and 85.5 for females. On the other hand, Japan's total fertility rate is steadily declining reaching 1.26, and in 2005 the population declined for the first time in 60 years. As a result, the society is rapidly aging. Urbanization has progressed and more women are working, increasing the trend towards nuclear families.

Japan's culture today is a mix of outside influences and internal developments. Western culture has blended with Japanese culture. Though Buddhism and Shinto are the most common religions, most people are not religious, especially the younger generation.

The health care system in Japan is divided into two systems- medical and welfare. Medical expenditure is covered by a universal insurance system. The funding system under universal health insurance is mostly fee for service. Service prices are set by government and adjusted every two years. Some inpatient units, such as psychiatric emergency units and acute psychiatric units have adopted a comprehensive payment per bed-day.

Social welfare services for those who are under 65 are provided by a government fund (through taxation). As a result of the enactment of the Act on Support for Persons with Disabilities in 2006, this service system is undergoing a comprehensive reform. Social welfare for the elderly is covered by a long-term care insurance fund established in 2000. Japan spends 5% of its total health budget on mental health.

The first Japanese law relating to people with mental illness was the Confinement and Protection for Lunatics Act enacted in 1900. Since then, many laws have been enacted and revised. The current Mental Health and Welfare Law has been revised many times (most recently in 2005) since its initial enactment as the Mental Hygiene Law in 1950.

Japan has the largest number of psychiatric beds and highest ratio of beds per capita in the world (Figure 1). In 2004 Japan had 1,661 hospitals with psychiatric units, with a total of 353,319 psychiatric beds. Bed occupancy rate was 92.3% with 326,125 patients according to a one day survey. The ratio of beds per 10,000 population is 27.9. Out of the 1,661 hospitals, 1,086 are stand-alone psychiatric hospitals and 1,379 are privately owned. These figures are inflated by the number of patients with dementia, who are treated in psychiatric units.

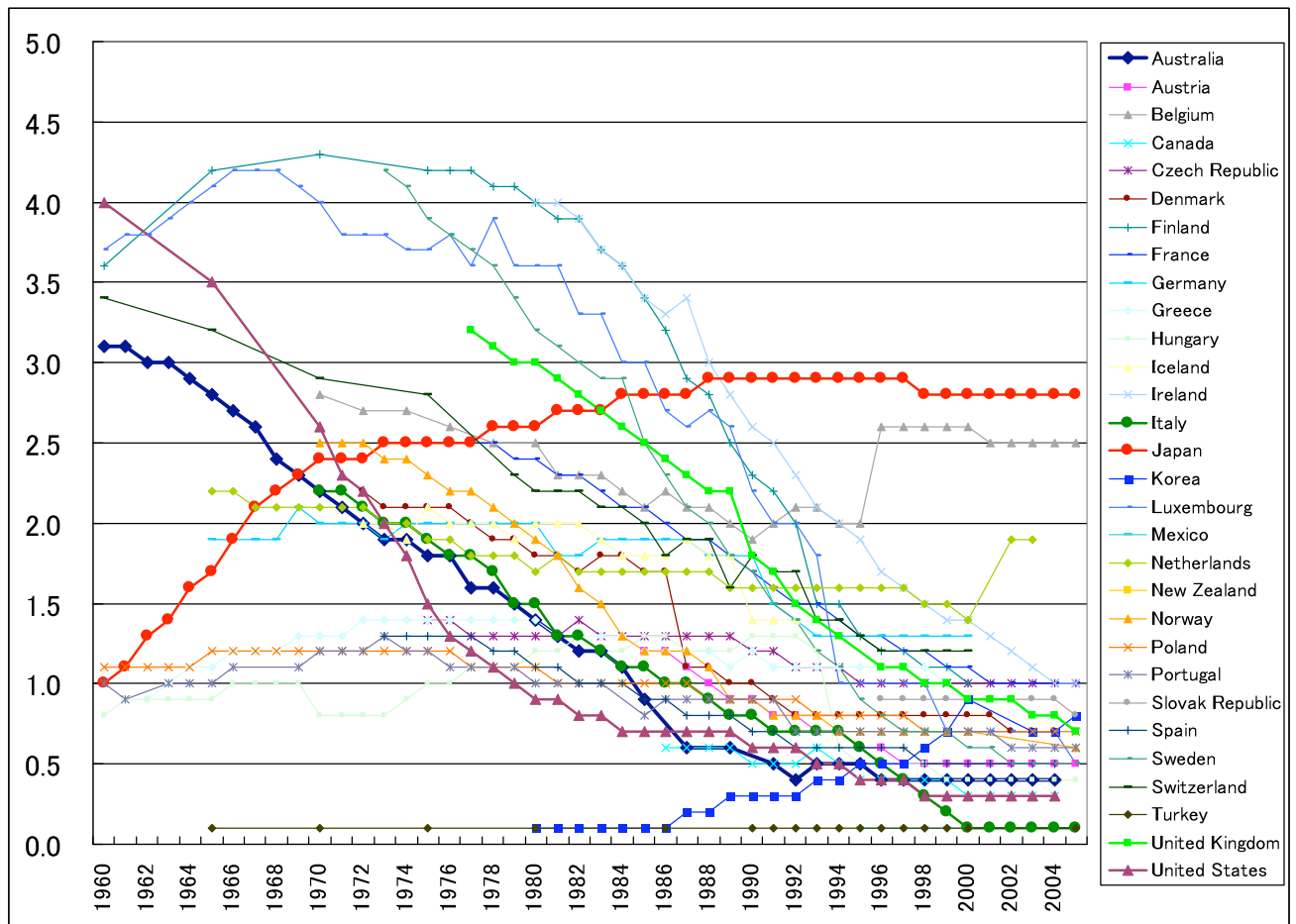


Figure 1 Psychiatric beds per 1,000 population  
 Note: Data cited from OECD health data 2002 and 2007

The number of psychiatric clinics (without beds) have recently rapidly increased to 2,470 places in 2004. Most of these clinics are private. Most hospitals also have outpatient facilities, and patients who are discharged from hospital usually attend the outpatient clinic in the same hospital.

In 2004, a total of 571 public health centres provided primary community mental health services. In addition, under the Mental Health and Welfare Law, each prefecture and designated city is required to establish a mental health and welfare centre in order to enhance mental health and improve the welfare of people with a mental disorder. These centres disseminate knowledge, conduct investigations and research, and offer guidance, and specialist counselling for people with complex or difficult problems.

Although community mental health services have recently increased, they are still not extensive enough. Within the national fee schedule, classification of psychiatric treatment includes ambulatory services such as visiting nurses and psychiatric day-care. There are 1,380 psychiatric day-care centres in Japan.

Until the enactment of the Act on Support for Persons with Disabilities in 2006, social rehabilitation facilities were defined under the Mental Health and Welfare Law. Five types of social rehabilitation facilities were defined: facilities for training in daily life, vocational facilities, welfare homes, welfare factories and community life support centres, and three

types of support services for living at home – home-help, short-stay, and group homes. Definition of the new categories in accord with the new law is still in transition, so the data in this report relates to the previous categories. Social rehabilitation facilities are mainly provided by private social welfare corporations, private healthcare corporations, or non-profit organisations (NPOs). In Japan, both social welfare corporations and private healthcare corporations are also not-for-profit. In 2004, there were 1,530 social rehabilitation facilities under the Mental Health Act, with 20,977 users. There were 515 social rehabilitation facilities with 9,405 beds. These figures do not include group homes, which had 5,884 users.

Physicians, nurses, psychiatric social workers, and occupational therapists are licensed by the Ministry of Health, Labour and Welfare, and clinical psychologists are licensed by the Japanese Certification Board for Clinical Psychologists. According to the WHO Mental Health Atlas 2005 project, Japan has 9.4 psychiatrists, 59 psychiatric nurses, and 15.7 social workers per 100,000 population. However accreditation for psychiatric nurses is not widely available, although a Clinical Nurse Specialist accreditation system has recently started in some universities. Therefore these figures may under-represent the number of nurses working in psychiatry.

Certified mental health physicians are designated under the Mental Health and Welfare Law. Only a certified physician can decide whether involuntary admission, restraint, and seclusion are necessary.

The private sector plays the main role in the Japanese mental health system. They are part of the universal health insurance system and there is little clinical distinction between the public and private sectors. Fees are the same wherever you go. As the private sector cannot generate profit, the privately owned hospital is undertaking a public service as a not-for-profit provider.

### **Country mental health strategy and principles**

Many acts and policies related to mental health have been released recently. In 2004, two reports from the Ministry of Health, Labour and Welfare (MHLW) were released. These reports declared the need for reform of mental health and public health services. In response, the Japanese Diet enacted the Act for Support for Persons with Disabilities in 2005. Preceding and following this law, many changes in the mental health system have taken place, such as the enactment of the Act for the Medical Treatment and Supervision of Insane Persons Who Caused Serious Harm, revision of the Law for Promoting Employment of the Disabled, and revision of the national fee schedule in relation to community mental health. The overall aim of this reform is to realise the transition “from institution-based medical treatment to community-based care”. In general, ‘community care’ means treatment or services not provided on an inpatient basis.

This reform process started in 2002 with the report ‘Future Direction of Mental Health and Welfare Policy’ submitted by the Sub-Committee on Mental Health to the Social Security Council. The Social Security Council is an advisory board of the Minister of Health, Labour and Welfare. The Sub-committee on Mental Health is under the Committee on Disability, and comprises representatives of various stakeholders, such as consumer groups, family groups, professional groups, private and public hospital associations, local government, and lawyers and researchers. In this report, the current situation and needs of mental health and welfare services in Japan were described and the

strategic direction and action plan were stated. Its fundamental message was 'Shifting from hospital-based medical treatment to community-centred health care and welfare'. Immediately after this report in December 2002, the Headquarters for Mental Health and Welfare, headed by the Minister of Health was established in the Ministry of Health, Labour and Welfare (MHLW).

The time-chart for the reform is shown in Table 1.

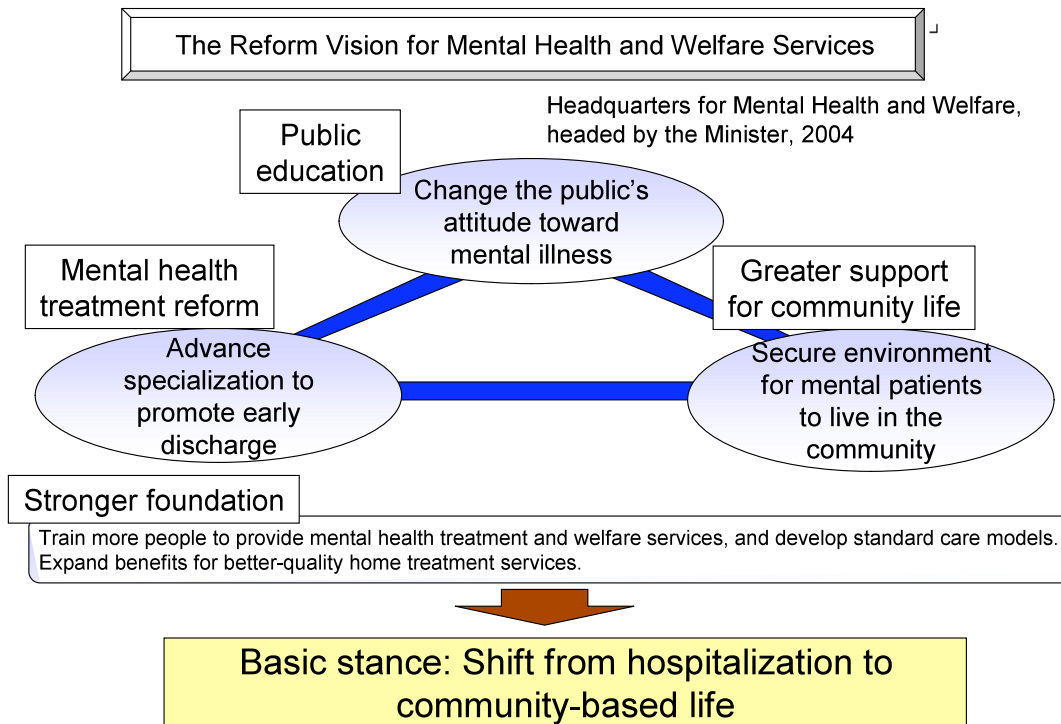
*Table 1 Recent reform in Mental Health*

2002	Future Direction of Mental Health and Welfare Policy
2003	The Act for the Medical Treatment and Supervision of Insane Persons Who Caused Serious Harm
2004	Reform Vision for Mental Health and Welfare Services
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
2006	Revision of the National Fee Schedule

Each component will be briefly explained below.

### ***1) Reform Vision for Mental Health and Welfare Services***

The overall aim of the Reform Vision submitted from MHLW is to realise the transition "from institution-based medical treatment to community-based care." This involves three main themes (Figure 2). Firstly, "educating the public" to achieve better understanding of mental disorders and of patients in the community. Secondly, "reforming psychiatric treatment" by enhancing specialised psychiatric units and promoting earlier discharge. Thirdly, "strengthening community support systems" to secure the community environment for persons with mental disorder.



Reduce the number of psychiatric hospital beds by about 70,000 over the next 10 years

Figure 2 The framework of the Reform Vision for Mental Health and Welfare Services

To achieve the objectives of the Reform Vision, definitive goals for the next 10 years have been set for public education and the reform of psychiatric treatment. The goal for public education is to raise public awareness that ‘mental disorders are common diseases similar to lifestyle diseases and anyone can develop them’ to over 90% of the population. In the area of psychiatric treatment, the target is to bring down the ‘average residual rate of one year’ to 24% or less, and to increase the rate of discharge to 29% or more for patients hospitalised for over one year. These are targets for each prefecture. By achieving these goals, the Reform Vision aims to reduce the number of hospital beds by 70,000 within the next 10 years.

### 2) Future Policies for People with Disabilities and Community Welfare (Grand Design for Reform)

The Grand Design for Reform has three main aims: firstly, to unify health and welfare policy and services across three types of disabilities - physical disabilities, intellectual disabilities, and psychiatric disabilities. Secondly, to transform the system to support the independence of people with disability. Thirdly, to ascertain the sustainability of the health and welfare service system (Yajima 2005).

### 3) The Act for Support of Persons with Disabilities (2005)

This new law contains the key elements of the above two reports and has five main aims:

- (1) to streamline services in order to provide the same level of care to people with physical, intellectual, or mental disorders
- (2) to put greater emphasis on user-oriented services
- (3) to enhance support for employment
- (4) to clarify the benefit supply process
- (5) to secure financial sources.

The funding system for both medical and welfare services has been changed by this law. For welfare services, co-payment was introduced, block funding changed to individual (per user) funding, and price and service were unified across physical, intellectual and mental disabilities. For medical treatment, co-payment for psychiatric patients was increased from 5% to 10%.

Through enactment of this Law, responsibility for community care has moved to local governments. Each municipality (city, town and village) has to establish an Independence Promoting Council either on their own or in conjunction with other municipalities. This council is responsible for the development of the area's welfare system, including mental health. The needs of social welfare facilities are discussed at this level.

Funding essential welfare services has become a duty of the national government, and it is expected more services will be developed.

#### ***4) The Act for the Medical Treatment and Supervision of Insane Persons Who Caused Serious Harm***

This Act was approved in 2003 following an incident in June 2001 when a mentally ill ex-patient entered a school and killed eight children. Its aim is to provide legal judgment in relation to insanity of serious offenders (such as those who commit homicide, manslaughter, robbery, rape, arson, and assault), and to treat them at designated inpatient units and outpatient clinics.

#### ***5) Revision of the Law on Promoting Employment of the Disabled***

This law aims to promote the employment of persons with disability by making it obligatory for companies to employ at least 1.8% people with disabilities in their workforce. In 2005, the revision of the law meant that people with a mental disability were included in the definition of a person with a disability as well as those with physical or intellectual disabilities.

#### ***6) Recent change on the national fee schedule***

The National fee schedule is revised every two years. In 2006, the mental health section was revised to include a more community- oriented payment.

Some of the main features are as follows. Fees for inpatient stays in emergency and acute psychiatric units have been increased for those who staying less than 30 days. Fees for inpatient stays for standard psychiatric units have been increased for those staying less than 15 days and reduced for those staying more than 90 days. Nurse visits used to be limited to three times a week, however this has been changed to five times a week for people in the first three months post-discharge from hospital. Psychotherapy for the family of the inpatient has been included to the schedule. Short-term (three hours) psychiatric day-care was introduced for the first time.

These rapid and successive reforms have dramatically changed the Japanese mental health system. However there has been some opposition to these reforms, and there are areas which require further consideration. The full effect of these reforms on the mental health system is yet to eventuate, however it is good that the reforms emphasise a more community-oriented mental health system.

We think that even when Japan decreases the number of psychiatric beds, it will not be to such a low number as in other developed countries. Our current aim is to decrease psychiatric beds by 70,000. When this is accomplished, the number of beds in Japan will still be around 280,000, or 2.2 per 1,000 population, although this includes beds for

patients with dementia. This is still more than twice the number compared to other countries. When this is achieved, we will review at that point whether or not this is the best balance for Japan.

### **Examples of best practice models of community-based services or care**

Examples of best practices in community mental health were selected by mental health experts in this field. The examples were considered in relation to four criteria – consumer-centred services, practices initiated by the hospital, practices initiated by welfare services, and practices which combined medical and welfare services. There were many other examples of best practice, however in consultation with MHLW, only one practice from each category was selected. The location of these practices is shown in Figure 3.

#### **Example One: Urakawa, Hokkaido: The House of Bethel**

The House of Bethel conducts a unique activity program mostly run by consumers. The program has an interesting philosophy illustrated by slogans such as “Descending life rather than climbing up life”, “Change weakness into bonding”, “Many problems -that’s what expected!”. The House is always filled with smiles and laughter (and many problems as would be expected). Each year, more than 2,000 people visit the House of Bethel to find out about their secret for success.

The House of Bethel is located in the rural town of Urakawa, on the south coast of Hokkaido Island in the northern part of Japan. Urakawa’s population is about 15,000 and the population is decreasing. Urakawa is known as the hometown of thoroughbreds and produces some of Japan's top racehorses. This area is also known as the producer of choice dried kelp.

The House of Bethel first started in 1978 when some members of the “Recovery Club Donguri-no-Kai” started to live together at the Urakawa church. After some time, many consumers gathered and met at this church. In 1983, some consumers started to sub-contract work to pack dried kelp in a corner of the church. In 1984, the priest named the place the ‘House of Bethel’. Bethel started to sell its dried kelp nationally and to spread their activities. They established a social welfare corporation called ‘Urakawa House of Bethel’. They continued to develop and now they have many group homes and communal dwellings, vocational activities, shops selling items they produce, and so on. They have even established some private firms. The House of Bethel is not one service, but a complex of services, self-help groups, and private firms.

They are keen to convey their message and have produced many books about Bethel; they also deliver lecture all around Japan. Some TV stations, including the national broadcast company, have even broadcasted feature programs about them. Now not only people with mental disorders but many other people with disabilities from around Japan have joined the activities of Bethel.

Each day, the House of Bethel activities start with a morning meeting, and many meetings are attended during the day. They call this “Having more meetings than eating”. They try to solve problems by meetings. The meetings are mostly facilitated by consumers themselves, and they are encouraged to show their weaknesses – “Disclosure of weakness”, as they say. For example, at the morning meeting, all the attending members report their current state and feelings, and decide how long they can work that day – for example, “I have recovered

from a fever but still feel depressed. I would only like to work until two o'clock." Other meetings include group home meetings, couples meeting, Friday meeting, hallucination meeting, social skills training, schizophrenic anonymous, consumer study ("Tojisha Kenkyu" in Japanese), and so on.

In consumer study meetings, people try to understand and analyse their problems. Usually in a group, they discuss one person's problem. The most important thing in consumer study is to "enjoy" and to "share" with other members. Firstly, they separate the people from the problem ("From Hallucination to Mr. Hallucination"). In a second step, the person, with help from others, diagnose themselves with a diagnosis which fits their feelings and problems ("Let's diagnose yourself"). Some example of diagnoses are "Schizophrenia-explosion type", "People allergy", "Schizophrenia-co-dependence with Mr. Hallucination type", etc. Thirdly, they analyse the pattern and process of the problem to understand what is happening and how they are coping with it. They do this by talking with members, using charts and graphs, and role-playing. Next, they think about how to protect themselves and how to cope with the problem. They predict difficulties they will face, and think about specific ways to handle the problem. Then they practice by role-playing. Finally, they record the study and put it into practice. In the next meeting, the person reports about the outcome and they discuss the good points and ways to improve ways of handling the problem. In this way, people understand and develop ways to cope with their problems.

The other important aspect of Bethel is the entrepreneurial spirit. They still sell dried kelp around Japan and are producing new products such as Hallucination candy through members' planning meetings. They also encourage starting new business, and some members of Bethel have started new businesses, such as a shop selling and delivering welfare materials and a company transmitting information about Bethel through websites and books. The annual sales of the House of Bethel are around 1 million dollars.

I will introduce some unique sayings of the House of Bethel to finish this section- "Descending life rather than climbing up life", "Change weakness into bonding", "From Hallucination to Mr. Hallucination", "Having more meetings than eating", "Disclosure of weakness", "Let's diagnose yourself", "Build an easy to goof workplace", "Many problems-that's what expected!".

### **Example Two: Obihiro, Tokachi, Hokkaido -Community care network system**

Obihiro -Tokachi area's comprehensive community care network has more than 30 years of history. It is seen as a model for development of community networks in other areas in Japan. This is especially important now since the enactment of the Act on Support for Persons with Disabilities, as each municipality, either on their own or with other municipalities must create their own council, called the 'Council to support the independence (of people with disability)'.

Sub-prefecture Tokachi sits in the central to southern part of Hokkaido prefecture. It has an area of 10,831 kilometres<sup>2</sup> and the population is about 360,000. It has a low population density for Japan. Obihiro is the only city in the Tokachi sub-prefecture and has a population of 170,000. This area developed only about 120 years ago through land reclamation, and there is a mix of many people and cultures from across Japan in this area. Now, Obihiro, along with most of Tokachi, has a large agricultural sector that revolves around large scale farming operations.

The community care network in Obihiro -Tokachi started in 1969, when five psychiatric social workers of three hospitals in the Tokachi area started a Tokachi Psychiatric Social Worker study group. As well as studying and discussing community care, they started outreach services in the area. Soon they developed a case conference attended by many service providers, such as social workers from hospitals, psychiatrists, public health nurses from the municipalities, staff of health centres and child guidance centres. They also discussed the development of the area's mental health resources. The psychiatric rehabilitation facilities in the community were almost non-existent at that time. In 1982, they established a communal dwelling for sixteen people, which can be used by any person in need. As there was no care-taker, hospital social workers made outreach visits to support residents in daily living. Over the next 25 years, they have developed many community facilities and the network has grown into its current configuration and is continuing to improve. They also made policy recommendations and funding submissions to governments, both nationally and locally. They cooperate well with local governments.

The important concept of the Obihiro-Tokachi's community care network is the "Open system", in which any person, regardless of which hospital they consult, can use any community resources if in need. It may sound a matter of course, however in Japan, some hospitals keep their patients even after discharge to their affiliated group facilities. Another example is that it is sometimes difficult for people to attend another hospital's daycare without changing their primary psychiatrist. Sometimes patients using one service (such as a group home) in the social welfare corporation tend to use other services (such as sheltered workshops, home help service, etc) in the same corporation. In Obihiro's system each community resource is open to the public and it is usual for patients to use multiple services from multiple agencies. To coordinate the services, a care management approach is used, and there are two network meetings to share information: a care management meeting and a living support meeting.

The care management meeting started in 1999. Twice each month, care managers (about 20-30 people) in the Tokachi area gather and meet about their clients. They exchange information, and care plans are discussed. In the living support meeting, which started in 1991, all the mental health service providers and staff from municipalities in the Tokachi region gather each month and discuss the needs of the community and the development of new services. From these networks, interchange between agencies, facilities, and people are facilitated to form a closely-knit community network. These two meetings became a part of the "Council to support the independence" of Obihiro city in 2007.

The development of housing is the other key issue for Obihiro's care network. Housing was placed as the first priority for community living, and many types of housing were developed. In relation to administration, group homes and welfare homes are governed by law, and 'managed homes' are not. Managed homes are apartments managed by a contract between landlord and the NPO. When there is a vacancy, the NPO finds the tenant and helps them sign the lease agreement with the landlord. The NPO supports the tenant in daily living. In relation to services, some places have residential staff and meal services, in others a caretaker comes to prepare the meals, others utilise a meal delivery service, and some are self-catering. The caretakers of the homes are mostly housewives who live in the neighbourhood. Their responsibility is to provide food and to clean the communal area. Supports for daily living are provided by professionals from social rehabilitation facilities and hospitals on an outreach basis. Rental rates for the rooms are set under the limit of the welfare payment.

In the Tokachi area, there are more than 250 beds in the community where people with mental disorder can stay. Through developing these houses, Obihiro has succeeded in decreasing the number of beds in the area. In 1982, there were 987 beds in six hospitals (2.7 per 1,000 population), but in 2007, there were only 540 beds in four hospitals (1.5 per 1,000 population).

Other important services to support daily living of people with mental disorder were also developed to meet current needs, such as day-care or other day programs, consultation services, employment services, and self-help groups. This flexibility and the commitment to fulfil needs resulted in a comprehensive network of care systems including public and private, and hospital and community services.

### **Example Three: Mitaka, Tokyo: Sudachi-kai (Flight from the Nest)**

Sudachi-kai (Flight from the Nest-group in Japanese) is a social welfare corporation in Mitaka city, Tokyo. They are very active in discharge promotion and in their 15 years of history have helped more than 120 long stay patients to be discharged from the hospital. They currently have eight housing facilities and three vocational facilities to support people with mental disorder to live in the community.

The housing and vocational facilities of Sudachi-kai are located in Mitaka city and Chofu city. Both cities lie in the middle of the Tokyo prefecture, just beside the special wards of Tokyo (Tokyo has 23 special wards that together make up the core and the most populous area of Tokyo). Mitaka city has a population of 178,000 (area 16.50 km<sup>2</sup>), and Chofu city has a population of 21,600 (area 21.53 km<sup>2</sup>). Many patients in hospitals in Mitaka and Chofu cities are from the special wards of Tokyo, where the number of psychiatric beds is scarce. Therefore in fact the catchment area of Sudachi-kai is much greater than those two cities.

Sudachi-kai started in 1992 when a psychiatric social worker from a mental hospital in Mitaka met an understanding apartment house landlord who agreed to rent several rooms to form a group home. At that time in Japan, there was still great stigma against people with mental disorders and it was difficult to rent a room without a guarantor, or even with a guarantor. At the same time, the Tokyo prefecture started a bounty system for group homes for people with mental disorders. The first group home, “Sudachi home” was established in this way, with cooperation between the landlord, hospital staff and families. After the initial establishment, many patients were discharged not only to the group home but to the other neighbouring rooms of the apartment house. Soon there was a need for a place to spend time during the day, and in 1993, the ‘Sudachi sheltered workshop’ was opened. From these two facilities, the basic concept of Sudachi-kai was formed: to have a place to live and a place to work, with support offered by both staff and consumers. As they did not have enough staff, the consumers needed to help each other to some extent.

In the following years, Sudachi-kai expanded their activities and opened more group homes and vocational facilities, trying to meet the needs of patients who were not able to be discharged from hospital because of the lack of social facilities in the community. They now have eight housing facilities (capacity 61) and three vocational facilities (capacity 90), with about 20 staff.

From their 15 years of experience, Sudachi-kai has developed a model pathway for discharge. The model of Sudachi-kai’s discharge promotion program is shown below:

1. First, the staff and peer supporters of Sudachi-kai provide services to the hospital. They deliver lectures for inpatients about the discharge promotion program. They build relationships with them and identify candidates for discharge. They also talk with families and the staff of the hospital in order to coordinate care. The fact that peer supporters are living in the community and can tell stories about their life outside the hospital conveys a strong message to the inpatients, and motivates them toward discharge.
2. Next they consult with the candidates and their families to motivate them toward discharge and develop support plans with them.
3. When the candidate is motivated, discharge training is provided. First while still in hospital, they start to attend the vocational facility during the day-time.. Going out of the hospital, using trains and buses, is a new experience for them, and many problems are solved with the support of staff and peers. With the aim of living an independent life outside the hospital, this training takes about three months, depending on the ability of the consumer. The consumer gains confidence by regular attendance at the vocational facility and also makes friends there.
4. After the consumer becomes stable, Sudachi-kai helps him/her find housing. It could be a Sudachi-kai group home, affiliated rooms rented by Sudachi-kai, or usually an apartment room. Overnight training utilising a short-stay facility starts.
5. Then they prepare for discharge, such as self-managing medications and money, going together to buy necessities and accompanying various applications.
6. After discharge and commencement of the new life in the community, many problems occur. Staff and peers help them overcome those problems. Support by the staff is provided 24/7, so the consumer can call and consult any time if there is a problem. Support is also provided on unlimited basis.

Data has been collected for 126 patients discharged from hospital with the support of Sudachi-kai. The average length of stay was 11.5 years and the longest stay was 42.2 years. 59 patients (46%) were in their 50s when support started, 39 patients (31%) were in their 40s, and 17 patients (13%) were in their 60s. The rest were in their 20s or 30s. 82 (65%) were men. The majority had the diagnosis of Schizophrenia (110 patients: 88%). 61 (48%) were discharged to group homes, 48 (38%) to affiliated rooms rented by Sudachi-kai, 10 (8%) to their own room and 7 (6%) went to other residential facilities. The outcomes were as follows; continuing to offer services 85 (68%), termination of services due to moving to other rooms or facilities 17 (13%), admission 10 (8%), decease 11(9%), discontinued 3 (2%).

The initiatives of Sudachi-kai show that there are many patients who can be discharged if there are places to stay during day-time and night-time. If there are continuous supports after discharge, consumers can lead a stable and full life. This is proven by the big smiles on the faces of residents of the Sudachi-kai, who say it is a lot better to live in the community.

### Example Four: Toyonaka, Osaka: Sawa Hospital

Japan has the largest number of psychiatric beds and highest ratio of beds per capita in the world. We have more than 350,000 beds and at least 80% of these are in private hospitals. Japan is facing the big challenge of reducing the number of beds and providing more community services. Sawa hospital has been making an effort to accomplish this change, and is a good model for other private psychiatric hospitals.

Sawa Hospital in Toyonaka is a private psychiatric hospital with a history going back for more than fifty years. Toyonaka city lies just north of Osaka, and has a population of about 390,000. The population of the catchment area of Sawa hospital is more than one million. The hospital is also famous for its psychiatric emergency treatment, and has two psychiatric emergency units (114 beds), as well as five psychiatric units (343 beds) and one dementia unit (48 beds). The total number of beds is currently 505, reduced from 604 in 1986 (Figure 4). The length of stay has also reduced from around 600 days in 1980s to 108 days in 2006.

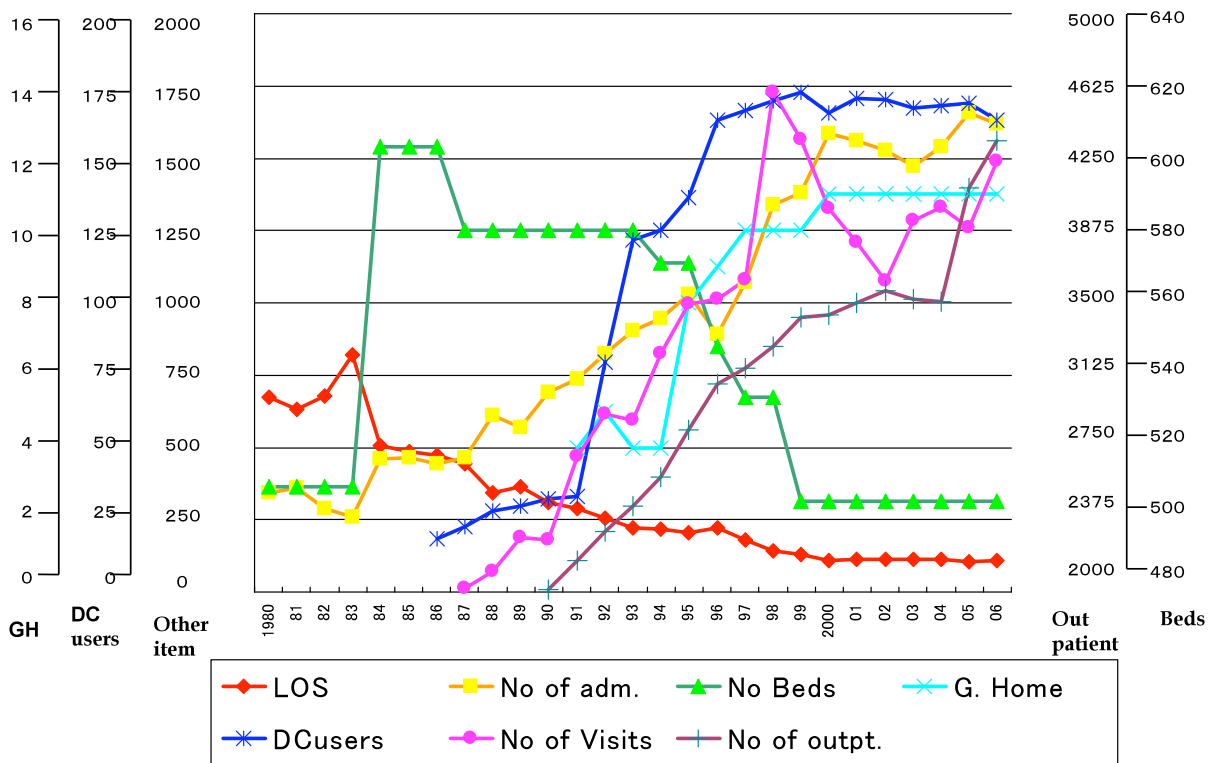


Figure 4 System change in Sawa hospital

The director of Sawa Hospital has focussed on the move towards community mental health for a long time. He believes that four components are indispensable to support people with mental disorder in the community. The first is residential facilities, which includes group homes, apartments etc. The second is activity programs, including day-care, night-care as treatment programs, sheltered workshops, coaching for employment and

welfare services. The third is the specialist workforce working as a team, consisting of doctors, nurses, psychiatric social workers, occupational therapists, clinical psychologists, and volunteers, etc. The fourth is being understood and accepted by people in the community, which includes movements against stigma for local inhabitants (Sawa, 2004).

Sawa hospital started to expand their activities towards community mental health in 1986. At that time community mental health facilities were scarce in Japan, so they needed to create services themselves. They began with a specialist nurse visiting patients, and in 1987 a sheltered workshop and psychiatric day-care commenced. They started to support patients discharged from the hospital to community apartments. In 1989, they upgraded the sheltered workshop to become a vocational training centre, and started a bread factory.

In 1991, they saw the need for residential services and started three group homes. One was for a transition period of about six months before the move to more independent community living, and the other two did not limit length of stay. This was prior to legislation covering group homes which occurred with the revision of the Mental Health Law in 1993.

They started a fortnightly community care staff meeting to monitor the residents in the facilities, and this developed into a support network. In this meeting they monitored six aspects of care of the residents, and developed support plans when necessary. The six aspects were nutrition management, self-management of money, daily rhythm, cleanliness, adherence to treatment and interpersonal relationships.

They gradually developed more community services. At present, they have ten group homes, one welfare home, one vocational training centre, one welfare factory, four day-care units, occupational therapy, visiting nurse station, and home help services etc. They now have more than 100 staff working in the community service.

During this process, they transformed the hospital to take more responsibility for the emergency and acute phase of treatment of psychiatric patients. They developed the psychiatric acute unit in 1996 and two psychiatric emergency units in 2005. With these developments and the establishment of community services, they have been successful in downsizing hospital beds by about 100.

Some people criticise these developments as still retaining patients within the hospital system, saying that this change is not really integrating patients into the real community, and that the patients are still dependent on the hospital. However, when Sawa Hospital started these services, there were few community services, and in many places community services are still scarce in Japan.

Since Japan has more than 1,400 private psychiatric hospitals and reducing beds is the biggest issue in mental health, the Sawa Hospital initiatives in community mental health is a good model for hospitals to provide community services and reduce beds, while sustaining their financial viability.

## **Inspiration and the lessons learned from the best practices**

From these four examples of best practice, many lessons can be learned. Each model has unique aspects containing valuable information for others. There are five essential principles for the expansion of the capacity for community care.

The first and the most important lesson is that supporting people with severe mental illness in the community is possible. All four examples target people with severe mental illness and long-stay inpatients, who sometimes have been in hospital for more than thirty years. In Japan, there has been a long-held belief that people with severe mental illness should be treated in hospital, but these best practice examples prove that if there is enough support, patients can live a high quality life in the community.

The second principle is to believe in the strength of the consumer. The House of Bethel's unique activities and their philosophy make us aware that even if you have severe symptoms such as hallucinations and delusions, you can live a happy life in the community. In Sudachi-kai's discharge promotion practice, the consumer plays an important role. The former patient goes into the hospital and talk to inpatients about how good it is to live in the community. Only other consumers can understand the fear or anxiety about community life and can motivate the inpatients towards discharge. They have more power than the specialist in this field.

Third is the need for housing and vocational support. These four best practice examples uniformly emphasise the need for accommodation and daily activities, especially vocational support. All four provide group homes or other kinds of residential facilities. Traditionally, people with mental disorder used to live with their families. However, especially for long-term inpatients, the family cannot be expected to take them back, so there is a high need for residential facilities. Vocational services are indispensable for a high quality life. The ability of consumers to do something for others rather than only be supported by others heightens their self esteem.

Fourth is to support them on 24/7 basis. Since people with mental disorder tend to have high variation in their condition, they sometimes need acute or emergency support. 24/7 support not only in the medical service but in the welfare service is necessary to look after them in the community. Just to have a number to call when in an emergency makes consumer feel supported, and also good for supporters such as landlord to know that they have someone to ask if problem arises.

The fifth principle is to build the community network. In Japan, care management is not fully provided in many places and there are places which lack networks among hospitals and community services or between service providers in the community. Obihiro-Tokachi's community care network provides the model for a good network system. For one service to support people is much more difficult than for support to be shared by multiple services, operating as a network of services.

Sixth is that it is possible to reduce the number of hospital beds. As has been written previously, Japan has too many psychiatric beds, and to reduce these is very important. These four examples show that if you provide high quality services in the community, it will result in a reduction of hospital beds.

Another thing we learned from visiting the sites and meeting the leaders of these services, is that whatever your profession, if you have high spirits and energy, and maintain a consistent and patient attitude, you can change the community.

These lessons are especially valuable as Japan is now in the process of mental health service reform towards community-based services. We hope that these best practice examples will arouse inspiration and have a good impact on service providers and consumers throughout Japan, and in other countries.

### **Extending the current capacity of community care and the future**

Before discussing community care, it is necessary to focus on the most urgent issue in the Japanese mental health system - the downsizing of psychiatric beds. The Reform vision (2004) aims to reduce by 70,000 beds in 10 years. In Japan, more than 80% of the beds are owned by the private sector, and the responsibility for care of the psychiatric patient is shared with the public sector. It is not possible to just 'close down' the hospitals and reduce the beds immediately. We need to guide hospitals towards community mental health service provision by changing the national fee schedule, and by showing that it is possible to maintain financial viability. On the other hand, we need to be cautious about reform and not create a situation where hospitals are closed without sufficient planning. We need promotion of controlled discharge and reduction of beds with agreement by the private sector. We should view hospitals as valuable community resources and utilise these resources by changing their structures and functions.

Japan currently expends about 75% of the mental health budget on inpatient treatment, and the key to accomplish a move to community services, is to shift funds from hospital to community by reducing beds. However, this must be accomplished by developing community services before beds can be reduced. If not, we will follow in the footsteps of the United States and other countries, where people discharged from hospital end up as homeless or in prison, or end up with numerous admissions – the 'revolving door' effect. So in the transition period, it is inevitable to some extent, that there is a double financial burden for the hospital and the community. Through enactment of the new law, the national government now has a duty to fund necessary welfare services and it is expected that this will result in more service provision.

**Future directions to expand the current community mental health capacity are as follows:**

#### ***1. Support consumers to build consumer-centred services***

It is apparent from the best practice examples that consumers can be great service providers. In Japan, however, consumer involvement is still in the developmental phase, and only places such as club houses are operated by consumers. We lack funding to support consumers other than funding for peer support or peer counselling in some cities and prefectures. Also in most services, formal consumer participation as service providers or as advisory board members is limited or nonexistent. We need to identify mechanisms to provide funding to support consumer activities.

#### ***2. Develop more community services***

Although Japan is making the transition to community mental health, we still lack community services. Community services are mostly run by social welfare corporations or non-profit organisations (or non-government organisations). Through enactment of the

new law in 2006, the funding system has changed for welfare services. A co-payment was introduced, block funding changed to individual funding, and prices and services became consistent for all disabilities - physical, intellectual and mental. Some mental health service providers say that because people with mental disorder are unstable compared to people with other disabilities, they sometimes do not comply with services (for instance, they do not attend services, or do not wait at home for outreach services), or stop if a co-payment is required. They claim that they have less funding than before, or compared to other disabilities. To develop more good quality community services, we need to modify the funding system.

The services that are most needed are supported housing, vocational rehabilitation and outreach-type services. Each is mentioned briefly below.

#### *Housing support*

We aim to reduce hospital beds by 70,000. Currently we have only about 14,000 beds in residential facilities, compared to 350,000 in hospitals. Therefore the provision of supported housing is a task of pressing urgency. However, not all supported housing needs to be in a residential facility. There are many people who can live in their own apartments with intensive or occasional outreach support. We need to increase the capacity of outreach services, and give priority to people to settle in public housing. This will also decrease the stigma about mental illness in the community.

We also need to promote information about mental health to people in the community to reduce stigma against people with a mental disorder. Though there is gradual improvement, there is still a high level of stigma in the community, and campaigns by neighbours opposing the building of residential facilities are not unusual. Similarly, many landlords are reluctant to rent a house to people with mental disorder. However, learning from our best practice examples we can be confident that if we keep looking, we will find a benefactor or an understanding landlord in the community.

#### *Vocational rehabilitation*

Traditionally, people with mental disorder were treated in a protected environment. The most protected environment is in the hospital, but even after discharge to the community, people are sometimes overprotected. Although some sheltered workshops or day-care centres provide training, in general these are places to come and gather. Of course many people do benefit, however for some people need more practical vocational rehabilitation. Employment sometimes has a greater effect on stabilising symptoms than medication.

Recent evidence about vocational rehabilitation such as supported employment and individual placement and support (IPS) shows that people with severe mental illness can work in the competitive workplace. Funding for job coaching started in 2002 and the research on individual placement and support in Japan is showing evidence of good outcomes. More services like these are needed.

#### *Outreach services*

In Japan, most services are run on-site in facilities, and outreach services are scarce. Outreach services are mainly provided by visiting nurses in medical programs and home-help services in welfare programs, but they are still insufficient and services are not coordinated between the two program areas.

Also there is no funding for intensive care management or assertive community treatment (ACT) which has become a mainstream treatment for people with severe mental illness in western countries. The research on ACT is showing good outcomes in Japan, and some ACT teams have started to provide services. We also lack mobile teams to provide assessment and treatment in crisis situations.

#### *Other services*

Other services which need to be developed or enhanced include early intervention, suicide prevention, child and adolescent mental health services, and sub-specialty services such as for personality disorders, dual diagnosis, dual disability, etc.

Dissemination of good quality care management and building close network in the community

Care management is important to coordinate services for people with mental disorder. Under the new law, Act on Support for Persons with Disabilities, care management and the individual service plan are introduced, but it is not widely used and the quality is not guaranteed. Training and dissemination of good care management and the monitoring system to assure the quality of it are necessary. And for those with SMI, direct care given by the care manager, such as ACT is needed.

To provide effective care management, it is beneficial to have a community network of service providers and local government. Under the new law, it became necessary for the municipalities to organize Independence Supporting Council, which is a formal network of service providers, care managers, consumers and families, local government and other related organization. The quality differs greatly between municipalities, and in many places it is still not started, but it is expected to promote close network in the community.

### ***3. Quality improvement***

The community services framework is mandated in the Act on Support for Persons with Disabilities, but the service contents are not defined adequately to ensure quality. There is much to do to improve quality, such as training staff, increasing consumer and carer involvement, and measuring outcomes.

#### **Overall Summary/Conclusions:**

In this article, the current situation and the future prospects of the Japanese mental health system and four examples of community mental health were described. From the four best practices in community mental health, invaluable lessons were learned. Main points are as follows: it is possible to support patients with serious mental illness in the community, we need to believe in the strength of the consumer, it is important to build community networks, housing and vocational support is needed, and support should be provided on a 24/7 basis. There are many examples of reduction of hospital beds.

Japan is currently in the process of reform toward community mental health, and many policies, laws and regulations have been developed. The most urgent issue is to reduce the 350,000 psychiatric beds and shift the funding towards community mental health. The hospitals should be utilised as community resources by changing their structure and function. We are struggling to accomplish this task by first expanding the current capacity of community mental health services.

This reform process has had a big impact on community mental health. Many service providers in the community and hospital are struggling to survive this big change, and there are many complaints against the new law, and probably more problems will arise when continuing this reform process. However it is a big step towards a more community-centred mental health system.

Service system reform cannot be done in a single process: it is important to continue the reform to create a better system. Lessons learned from local practices in Japan and in other countries are valuable to sustain the reform.

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