

STUDY VISIT ON COMMUNITY MENTAL HEALTH IN JAPAN

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EXECUTIVE SUMMARY

This report is based on a 2-week study visit programme on community mental health in Japan by the international consultant. The aims were to identify strengths and opportunities for further development of best practice community mental health care models. Discussion also took place on current and future service delivery with mental health leaders in government, clinical services, community and other stakeholders.

The progress in community mental health care in Japan and the commitment shown by the mental health leaders and staff were significant. While initiatives in community based mental health services are promising and commendable, the overall community mental health development appeared to be limited and there are significant challenges facing the mental health system in Japan. There is a need to expand the scope, quantity and distribution of best practice community mental health services. The available funding and staff (nursing and medical) resource could be diverted to the spectrum of community based services that are shown to be cost-effective and culturally appropriate.

To achieve this, a policy and strategy framework is needed for the planning and implementation which can provide clear directions for the re-development of mental health system, expansion of community mental health services, re-structuring of mental health funding and stronger partnership between government departments especially with the Welfare Department. Investment in aged care in mental health services, with alternative placement options is considerably needed. Gradual reform that builds on the current strengths and achievements would lead to progressive development of a community based service system. Increased leadership capacity and confidence in the mental health workforce including the policy makers, hospital owners, psychiatrists, nurses, allied health staff, community workers and NGOs should be addressed effectively .

Aims of Visit

- To understand the state of the mental health system in particular community mental health care in Japan from multi-sectoral points of view
- To identify shared learning from various site visits to inform future community mental health development in Japan
- To discuss with various stakeholders including Ministry of Health, Labour and Welfare, Japanese Society of Psychiatry and Neurology, Japanese Association of Psychiatric Hospitals, National Centre for Neurology and Psychiatry, private psychiatric facilities, non-government organisations (NGOs) and mental health professionals
- To provide a report for the mental health reform in Japan outlining the strengths, strategies for future development and areas to be explored further

Introduction

To provide a background to this report, a brief description of mental health care in Japan is outlined. As this study visit was not a data gathering exercise, detailed facts and figures will not be provided in this report, and more accurate statistics are currently available at the Ministry of Health, Labour and Welfare than what the author can provide.

Japan has about 128 million people with a life expectancy of 78.5 years for male and 85.5 for female. It had been estimated in 2005 that there were over 3 million sufferers of mental illness, and of these about 326,125 were inpatients (with nearly 40% of the inpatients over 65 years of age) and about 2,675,000 were outpatients. Of the inpatients there were nearly 196,500 sufferers of schizophrenia and related disorders and 52,100 patients with dementia. Of the 360,000 newly admitted inpatients per year, the vast majority were discharged within 12 months; hence most of the inpatients were a result of long stay patients.

Funding structure

Japan has a universal health care insurance system. Health cost is paid on a pre-determined cost on a fee for service system, and the national fee schedule is reviewed every 2 years. The other system of funding is the social welfare services which are undergoing a comprehensive reform since the enactment of the Act on Support for Persons with Disabilities in 2006. About 6.1% (in 2004) of the total health budget is spent on mental health as compared to other countries like in Australia (about 7%).

Legislation

The first law covering people with mental illness is the Confinement and Protection for Lunatics Act enacted in 1900. The Mental Hygiene Law in 1950 which required medical treatment in hospital for the mental ill ended the previous practice of home confinement. After that, the Mental Hygiene Law had been revised several times and the name was changed to “Mental Health Law” in 1987 and “Mental Health and Welfare Law” since 1995. Under the Mental Health and Welfare Law, each prefecture and designated cities have to establish and run a mental health centre with governmental subsidies to enhance mental health and welfare of people with mental

disorder. In 1995, the Mental Health and Welfare Law established that mental illness is a disability. Therefore, the current Mental Health and Welfare Law has been revised many times (most recently on 2005).

The legal statuses of mental hospital admissions include: voluntary admission with patient consent (63.2% of admissions in 2004); involuntary admission with consent of the family or guardian by order of a psychiatrist (35.4% of total admissions in 2004); and involuntary admission due to risk of harm to self or others by order of prefecture governor (0.7% in 2004).

Mental health services

Based on the year 2004 figures, there were 1,671 hospitals with 354,923 psychiatric beds and a bed occupancy rate of over 90%, giving rise to 27.8 beds per 10,000 population. Of the hospitals, 1,086 were stand alone psychiatric hospital and 1,379 were privately owned. Although the private sector provides the large majority of mental health service there is no distinction in clinical practice between the public and private sectors. Hence, the private hospitals which are by law not-for-profit organisations, in a way provide public service. There is increasing number of private psychiatric clinics, over 2,470 in 2005. There are also 1,274 psychiatric day care facilities operating under the universal health care insurance system.

Psychiatrists, 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. Japan has 9.4 psychiatrists, 59 psychiatric nurses (not all accredited), and 15.7 psychiatric social workers per 100,000 populations (WHO Atlas, 2005).

Social rehabilitation facilities are mostly provided by private social welfare corporation, private health care corporations, or non profit organizations. There are 590 vocational facilities (12198 users), 17 welfare factories (462 users) and 452 community life support centers in 2004. Social residential rehabilitation facilities include 309 daily life training facilities with 6,490 beds, 223 welfare homes with 3165 beds, and 1201 group homes with 6,404 beds.

Mental health care reform

Although the shift from hospital-based to community-based mental health care began in the 1960's, significant process of deinstitutionalisation has not occurred in Japan. Of note, as far back as 40 years ago, the Government of Japan has had clear intentions of moving to a community mental health care system with integration into general health and community resources. This resulted in the WHO Report by Clark (see textbox). Many reasons for the lack of progress have been cited in the literature. These include: high prevalence of psychiatric stigma; low public acceptance of the mentally ill to return to society; the lack of alternative facilities for the elderly patients who have been chronically institutionalised, payment system that provides disincentives to reduce admissions or to increase discharge rates; lack of differentiation into specialty care; lack of community services to support discharged patients; and inadequate trained personnel to treat patients in the community. However, there have been many developments and signs of change occurring in the last 10 years with length of stay of newly admitted patients significantly decreasing,

community facilities and programs are being built, greater financial incentives for reform are provided, changes made in the mental health laws and quality control being instituted. Much remains to be done to achieve more widespread and consolidated reform in Japan, which is one of the key rationales for this study visit.

Nearly 40 years ago the Government of Japan requested a WHO consultation (Clark Report) on “Community Mental Health in Japan” because
“Community mental health care program and rehabilitation of ...mentally disordered is one of the urgent social and public health problems.... We have not yet achieved integration of community mental health program into general health services...or sufficient cooperation between public health facilities and mental hospitals, GPs and other community resources.....”

Government of Japan 1968

Scope of Report on the Community Mental Health Care Models

This report is based on the author’s knowledge gained and observations made during the 2-week study visit programme. The sites were selected presumably because they represent some of the best practice models of hospital and community mental health services in Japan. However, it is noted that these sites are only some examples of ‘best practice’ and there are many other best practice sites that could not be included due to practical reasons. See Attachment for full program.

- Sudachikai Discharge Facilitation Programme
- Chiba Hospital in Funabashi city, Chiba prefecture
- Kanagawa Prefecture Mental Health and Welfare Centre
- Forensic Unit at National Centre of Neurology and Psychiatry
- Sawa Hospital in Toyonaka city, Osaka prefecture
- Matsubara Hospital in Kanazawa city, Ishikawa prefecture
- E-JAN (NGO), Dada Mental Clinic and Peer Clinic in west Shizuoka
- Hamamatsu Mental Health and Welfare Centre
- Meetings and presentations at:
 - Division of Mental Health, Ministry of Health, Labour and Welfare
 - Japanese Association of Psychiatric Hospitals
 - Japanese Society of Psychiatry and Neurology
 - National Centre of Neurology and Psychiatry

Limitations

This study visit was done for specific purposes and not to review the whole mental health system in Japan. The visit was intentionally short only for 2 weeks (unlike the Clark report which was a 3 month study), and the site visits were highly targeted. As a result, this report does not aim to provide a comprehensive report covering all aspects

of the mental health services in Japan. The study visit was too brief and there was insufficient opportunity to review other important areas relevant to the mental health service system in Japan. This included the Mental Health Law, Mental Health Promotional programme, and Suicide Prevention programme, and the graduate and post graduate training for psychiatrists and allied health staff, the medical insurance system, the university and general hospitals, services quality and accreditation and the public hospital system.

In providing an evaluation of the community health services in Japan, there are also a number of qualifications in the Japanese context to consider. These include:

1. the value of mental health, and status of psychiatry as well as that of community mental health services varies at different government, professional and community levels;
2. the scope of hospital functions is wide and the expected roles of hospitals also varies in different parts of the country;
3. the concept of '*community mental health*' is not uniform and has broad meaning; it ranges from a community hospital, to a hospital-based community services, or to a fully integrated community mental health service.

Differences between Japan and Australia Mental Health Systems

There are a number of significant differences between the mental health systems found in Japan and Australia. Users of Japanese mental health services are covered by the universal health and welfare insurance which provides funds on a fee for service basis leaving only a small patient co-insurance or out-of-pocket expense (about 10 %). State governments in Australia fund public mental health services, which are managed by health services directly and provided free of charge to the patients. The health and welfare departments of the Japanese health system are under separate administration, but in several state in Australia both health and community and housing services are under the administration of one department. Further, more than 80% of the psychiatric services are provided by the private psychiatric sector in Japan whereas the reverse is true in Australia where more than 80% of specialist mental health services (excluding primary care) are provided by the public sector. No formal catchment areas are found in Japan and patients can choose any facility or to see any doctor at any time with the same amount of payment. In Australia, most public mental health services are administered via an area-based service system where each service area generally overlaps with local municipal administrative area to allow better service coordination. However, public-based services are restricted to the most severely ill patients usually suffering from schizophrenia and other severe mental disorders. Less severely ill patients with private insurance can access the services through the private mental health sector or through the primary care system.

The roles of the psychiatric hospitals in Japan are usually mixed with a propensity for high numbers of long stay chronic beds. In Australia, psychiatric hospitals or units usually perform specific functions in relation to targeted clinical needs, with a high proportion of short term acute beds for these purposes and a low proportion of long stay inpatient beds. In Japan, psychiatrists provide the main direct clinical care with other disciplines inside the hospital systems. Outside the hospital, although community services are provided under the mutual effort of public and private sectors,

there is limited input from other disciplines. In Australia the general practitioners, allied health staff, psychologists, social workers, family, and NGOs compliment the role of psychiatrists to provide significant support and care for the mentally ill in the community. Japanese mental health legislation appears to emphasise the right of mentally ill patients to receive medical and hospital treatment, whereas in Australia, the mental health laws stress that patients have a right to receive treatment in the community in “the least restrictive setting”. There are also other differences which are evident in the Japanese system relative to the Australian system in terms of high bed ratio numbers, low supportive housing facilities numbers, high emphasis on physical treatments rather than psychosocial treatments, low levels of staff and community confidence in managing patients in the community (see Table).

	Japan	Australia
Funding	Universal health and welfare insurance; ~10% out-of-pocket	State funds the public service directly free of charge for patients
Infra-structure	Health and Welfare departments are separated financially and administratively	Health, Community and Housing services all under one government department in several states
Psychiatric services	>80% provided by the private sector	>80% specialist service provided by the public sector
Catchment Area	None. Patient can choose any facility or doctor with same payment	Area-based but public service restricted to the most severely ill. Less severely ill can see GPs or private sector
Roles of hospitals	Mixed roles with high number of long stay chronic beds	Specific functions with high number of short term acute beds
Service providers	Mainly psychiatrists. Limited care by other disciplines	GPs, psychologists, NGOs and families provide significant community care
Mental Health Law	Patient has a right to receive medical and hospital treatment	Patient has right to receive treatment in the community in 'least restrictive setting'
Others	<ul style="list-style-type: none"> ↑ bed ratio ↓ supported housing ↑ use of physical treatment Low confidence of staff and families to care for patients in community 	<ul style="list-style-type: none"> ↓ bed ratio reasonable supported housing ↑ use of psychosocial treatments Good capacity of staff and carers to care for patients in community

Observations of Examples of Best Practice Sites

Sudachikai Discharge Facilitation Programme

(7 January 2008)

This mental health NGO situated in Mitaka Tokyo began 15 years ago, and consists of 3 day vocational workshop facilities (with 169 users) and 8 supported group homes facilities (with nearly 90 users). Mitaka city sits in the middle of Tokyo Prefecture and has a population of 178 000 with a large number of psychiatric patients because of high numbers of psychiatric hospitals concentrated in this area. Most of the users of this programme are previously long term psychiatric hospitalised patients (on average 10 years) although some referrals also come from private homes and families. The facilities and group homes are rented but are government approved and designed for workshops or group housing. The owners are respected members of the community and are sympathetic towards the mentally ill. The funding for this programme partly comes from fee for service from the Welfare insurance using a combination of national government and local government sources. With the recent Act on Support for Persons with Disabilities, the system is shifting to user-based funding, creating opportunities for expanding the programme.

The programme has 23 full time staff and 20 part time staff, and the total number of users is limited by the minimum staff to user ratio. Although most staff are young and may not have sufficient knowledge and experience in rehabilitation, many of the nursing and social work staff are skilled in screening and intake procedures. The components of the discharge programme usually require 6-12 month transition and include outreach intake interview, preliminary training out of hospital, housing support preparation, final discharge and aftercare. The programme emphasises key criteria which include adherence to medication, participation in vocational workshops, developing partnership with staff, and living in independent housing. Hospital staff may lack time to organise appropriate housing and vocational activities so the programme helps patients to learn ways of managing medication, budgeting, establishing interpersonal relationship with family, preparing meals, shopping, paying bills and also attending hospital appointments.

Discussion with the director of Sudachikai, Ms Tao and staff identified the following key factors that promote the discharge process:

- Adequate preparation to live in the community before discharge
- Engagement with patient and family
- Coordination between hospital and community
- Strong liaison with housing providers in the community
- Establishing good relationship with the community through participation in community committees and meeting.
- Prompt 24 hours crisis response from the staff using mobile phones.
- Developing patients' confidence with support of co-users and staff as well as visits from hospital staff weekly after discharge
- The contribution of the rental money into the local community economy

Comments

In summary, the Sudachikai model is a commendable community based discharge programme run by a NGO in Japan that has discharged over 126 people. It runs a non-clinical vocational rehabilitation programme and community living support with each user having an individual plan but continuing their hospital outpatient medical treatment. It thus extends the concept of the community mental health beyond the use of a medical model and provides rehabilitation outside the hospital setting. One concern is the throughput of entry into the programme and more attention needs to be

given to graduation of users to other options to ensure better sustainability. The programme also optimally utilises skills of the non-medical workforce. However, systematic training and better remuneration strategies need to be provided for staff career incentives. This programme has demonstrated that it is possible to change staff and community perception that mentally ill patients can be discharged out of hospital and can live independently in the community. Lack of ready access to housing options has been a key factor in limiting appropriate discharge of patients into the community which contribute to longer than necessary hospital admissions.

Although such impressive initiative has demonstrated sustainability, it lacks support from other institutional and association structures. It also needs to create greater advocacy and voice for the mentally ill users both at the local and national levels. With greater support and encouragement, similar NGO's could provide greater optimism about patients returning to the community.

Chiba Hospital in Funabashi City, Chiba Prefecture

(8th January 2008)

Founded in 1956, Chiba Hospital is operated on several key principles including short term hospital stay, integration mental health care into the community, and multidisciplinary approaches, and partnerships with patient and family in planning discharge. Currently, it has a total of 346 beds: 55 emergency and acute beds, 60 locked male beds, 60 locked female beds, 60 open ward beds, 51 open rehabilitation ward beds and 60 beds for elderly patients. Attention to cleanliness, safety, quality care and personal space was evident in the inpatient services visited. Community oriented care is demonstrated in the day-care facilities, including a social club known as the Phoenix House where patients work in a coffee house and group houses are located within the hospital site. The hospital also has a family and community support centre located in the hospital foyer to provide pre- and post-discharge planning for patients returning back into the community. The centre has 8 staff, with each looking after a caseload of 60. Nearer the town area, there is a community activity support centre for over 200 users known as Oasis and a tele-counselling service receiving more than 1600 calls per year.

Dr Tsuneo Semba, the hospital honorary president gave a presentation on the hospital and also discussed about key obstacles in trying to reduce hospital beds. The need to consider the social demographic characteristics in Japan were highlighted especially the increasing elderly inpatients and their future care needs. Cultural factors with regards to the paternalistic approach to patient care in Japan were emphasized as well as the need to develop a permanent living arrangement supported by staff within the hospital vicinity. Other key factors to consider include the largely private based mental health system and the lack of community mental health facilities necessitating a gradual and considered approach to reduce beds rather than rapid closure of hospital beds.

Comments

Chiba Hospital is an example of a hospital-based community mental health service that has attempted to implement a number of community-based clinical practices from the hospital infrastructure. The physical environment in Chiba Hospital in creating private space for each inpatient and ensuring respect for patient's rights and needs is

praiseworthy. This was one of the first hospitals that removed grills from the window and made wards made to be more home-like. A greater emphasis on reducing the restrictiveness of the inpatient environment through making more open wards and promoting patients rights would assist the normalisation process for patients. The function and role for the private hospital can also be shaped to provide more community oriented mental health services.

There may be opportunities to increase the use of day care facilities to prevent admissions, assist discharge planning, prevent relapses and maximise functional living skills. The role of the day hospital could hence be more specifically used for interventional purposes for individual patients. While psycho-education, family support, social activities and family respite are important roles of a rehabilitation facility, there are better opportunities for partnerships with NGOs and community resources to provide such functions. Consideration could be given to locating the community support centre within the community vicinity to increase accessibility to community resources for the patients and family.

Kanagawa Prefecture Mental Health and Welfare Centre

(9 Jan 2008)

Under the revision of the Mental Health and Welfare Law in 1999, every prefecture and designated cities like Yokohama and Kawasaki have been required to set up a mental health and welfare centre to enhance mental health of the population who suffer from a mental disability. Amongst other functions, the role of the centre is primarily to disseminate knowledge on mental health, conduct research, and provide secondary consultation and assistance to public health centres and mental health institutions. The centre has 34 full time and 66 part time staff covering a population of 3.9 million people. The centre carries out suicide prevention strategies including education, networking, training and specific models. Kanagawa currently has 1700 suicides per year (about 19 per 100,000 persons) which is 4th lowest in Japan.

The centre has several exemplary practices

1. Since 2002, it established a 24 hour emergency mental health system that provides face to face assessment for police referrals and since 2007 telephone assessment has been provided for urgent referrals from family and friends. The service has access to doctors and mental health workers, staff for transportation and collaboration with public and private hospitals.
2. The prefecture has one of the lowest beds to population ratio of 15.8 per 10,000 compared to 27.8 per 10 000 in Japan. Previously, research on long-term inpatients found that around 2500 patients were suitable for discharge. A programme targeting hospital discharges, bed numbers reduction and increased emphasis on the acute service system was carried out. The factors that promoted reduction of bed numbers were the empowerment of the public, the high level of community activities in mental health, and the public promotion campaigns to increase patient acceptance. As part of the mental health reform done by MHLW, incentives that were used to reduce length of hospital stay included the following: increase insurance revenues for day and

out patient care; early establishment of community oriented services; and the increase payments from acute-care units and revenues from the outpatient private clinics which have multiplied significantly.

3. The mental health and welfare centre is a social facilitation centre which utilises the local community to organise basic mental health service by engaging components from primary health care and other social sectors such as education, labour, welfare, and law, local residents, NGOs, users and families, thus making mental health a community concern. They have been able to provide a structure of multi-layer support and services maintained by the municipalities.

Comments

As seen in the above example, the prefectorial mental health and welfare centres can play a central role in coordinating and supporting community mental health care within a geographical area. Its greatest capacity in community mental health reform is in facilitating local ways to decrease institutional care and promote community-based mental health services. Although such approach may not produce financial advantage initially, community treatment positively results in better quality and more cost-effective care in the long term. The centres can create synergies and connections between the health and welfare sectors by developing shared responsibility for patient outcomes. Various strategies to achieve this could include introduction of care coordination mechanisms involving close collaboration of medical and welfare case management, information sharing and data collection, and joint training initiatives. Fostering relationships between sectors can be supported by means such as joint committees, work contracts and service planning activities.

Forensic Unit National Centre of Neurology and Psychiatry

(10 January 2008)

Following the implementation of the new forensic law in 2005 known as the “Medical Treatment and Supervision Act”, forensic inpatient units such as this 33-bed unit have been established. This unit has a multi-disciplinary function with 43 full time staff consisting of nurses, psychologists and social workers, occupational therapists and psychiatrists. Treatment decisions are made by the team. The positive features of this model which was borrowed from the British model, consists of open planning, bright interior, single rooms, spacious surrounding with plenty of outdoor areas, occupational therapy workshops, and gymnasium. This has led to a low level of violence, use of low medication dose and low rates of polypharmacy. The seclusion rooms have not been used because they were not needed. Each patient has an individual care plan and could be discharged earlier but is restricted by the requirements of the law.

Comments

This model although highly resource and staff intensive, has demonstrated that acute and rehabilitation inpatient units can produce excellent clinical outcomes if high international standards of care are met. Although it is not financially viable to adopt such model widely to all general psychiatric units, the good practice principles (eg multidisciplinary team approach, individual care plans, least restrictive setting, stimulating environment, prescription of effective psychotropic drugs in appropriate

doses, etc) are universally applicable and should be considered as national care standards that can benefit all inpatients with mental disorders. Evaluation of outcomes of this model compared to other models should be conducted.

Sawa Hospital in Toyonaka City, Osaka Prefecture

(11 January 2008)

Sawa Hospital is a private psychiatric hospital which provides different service components ranging from psychiatric emergency services, psychiatric day and evening care to community and rehabilitation services including activities support centre, sheltered workshops, welfare and vocational training factory and a number of supported group housing. It represents a model of a private psychiatric facility that has been able to decrease the number of beds from 603 in 1987 to 455 in 2008, and decrease the average length of hospital stay from 444 days in 1987 to an average of 97 days (all wards) and 30-35 days (acute wards) in 2007. It has established a 24 hour psychiatric emergency service in response to the needs of the community. It also delivers continuity of care with one doctor following each patient in different teams, provides outreach medical services to monitor and treat patients at home, and has converted hospital facilities into psychiatric staffed group homes. Dr Yutaka Sawa, the hospital director gave a presentation on the hospital and had discussion about community mental health service issues. The hospital appeared to be using day hospitals effectively as a strategy to discharge patients earlier. Dr Sawa has advocated that the community can function as a hospital, the home can function as a hospital room and medical services can be given at home. The hospital inpatient and day patient settings have a clear rehabilitation focus with attention to engage with community activities and to develop necessary living skills in a normalised environment.

Comments

Sawa Hospital represents the innovation of a private hospital facility in providing community treatment and rehabilitation in the financially viable way. Despite many financial and social pressures to keep psychiatric patients in private hospitals, Sawa Hospital has been able to adopt community-based approaches in the treatment of mentally ill patients partly as a result of the training and exposure of the leadership to modern models of care and concepts. It recognises the importance to provide a comprehensive psychiatric emergency service as more patients are managed in the community. As a general comment for all hospital facilities, medical outreach/ case management should work closely together with welfare case management to minimise illness relapse and rehospitalisation rate. However, financial incentive for providing medical outreach service needs to be implemented. Furthermore, for patients doing rehabilitation activities, individualised activity programs and care plans would be useful to match each patient's needs and promote greater independent living skills. Thus the vocational therapy or program can be tailor-made to each individual patient and hence be more 'patient-centred'.

Matsubara Hospital, Kanazawa city, Ishikawa prefecture

(15 January 2008)

This is a 463 bed private hospital located in Ishikawa prefecture, Kanazawa city. There are 658 admissions a year with 400 into the acute inpatient unit which has a

medium length stay of 41 days. It also has 114 admissions to the aged patients unit where the length of stay is 188 days. Matsubara Hospital works in close collaboration with Takamatsu public psychiatric hospital to provide coverage of acute psychiatric care and admissions across the region. The acute unit is usually fully occupied with a high staff to patient ratio of 1 : 2. The staffs are very committed to providing a safe, clean and caring environment in the acute unit, aged persons psychiatric unit, community centre, day care centre, community group homes and supported apartments. Users of the group homes require more intensive support and daily visits to the day care centre whereas those in the apartments are more independent and visit the support centre on a weekly to monthly intervals.

Meeting with Dr Matsubara and Dr Fujimoto, the hospital director and vice-director respectively highlighted several factors required for the development of community service. To improve outcomes, a proper 24 hours emergency care service needs to be established together with an acute unit with multidisciplinary team and a high staff to patient ratio. Assertive care team in the community will be necessary to prevent hospital admissions. To maximise the chance of community living, a care programme approach or individual care plan is necessary and should be instituted as part of mental health law and funding. Such care plan should be integrated between medical and welfare care managers. Matsubara Hospital also aims for patients to attain not just supported group home living but ultimately to live independently in apartments.

Comments

Overall Matsubara Hospital has a very high quality inpatient ward facility which has large space, bright, clean environment with adequate personal space and appropriate patient aids provided. The environment treats all patients in a humane way with a multi-disciplinary support with clearly defined team roles, high staff-patient ratios and community oriented approach aiming for short stay. It also has a unique cooperation with the public psychiatric hospital to provide a comprehensive emergency response and acute care service which is an essential part of any community based service system. Considerations given to expand medical outreach services with doctors visiting patients in the community and to extend medical case management to those not receiving case management currently will further assist in preventing readmission rates to hospital.

Visit to Hamamatsu Mental Health Services

(16 January 2008)

E-JAN (Enshu Joyful Action Network)

Formed in the mid 1990s, this is a non-publicly funded mental health NGO which establishes a network of community mental health resource in Hamamatsu. Currently it has over 220 members, and 20 affiliated organisations including private clinics, hospitals and community agencies. It was formed by a group of mental health professionals and volunteers in response to a lack of rehabilitation and employment opportunities in the community for mentally ill. These activities include monthly meetings and daily activities by users and volunteers, mental health awareness campaigns, and site visits for external organisations wanting to learn more about community resources. Its main role is to provide facilitation and coordination of community mental health resources by organising social events, engagement with

appropriate stake holders and forming academic links with the university. Several affiliated members of E-JAN were introduced by its director Dr Yoshitaka Oba.

Dada Mental Clinic

This facility provides psychiatric services for child and adolescent patients including private mental health clinics, day care centres, psychological therapies, consultation clinic and follow up visits in the community post discharge from hospital. Based on the developmental model, the care approach is across the lifespan, and hence the staff members are trained to provide a developmental treatment approach in the community. It was founded in 1993 by Dr Oshima in response to a lack of child and adolescent outpatients and community treatment. Revenue is generated by combination of fee for service through medical and welfare insurance. Among other facilities linked to Dada Mental Health Corporation, the Dandan transitional living facility and the community life support centre provide vocational training including farming and other jobs for about 40 users and community living in group homes or apartments. The Centre carried out several projects under the new Act on Support for Persons with Disabilities, and so has a mixture of private service and public project funding. The Dandan transitional living facility has multiple functions operated on the private premises. These include drop-in centres, day care centres, vocational training, residential rehabilitation centre and respite care, which is used by 20 residents and 20 other non-resident users. The length of stay is up to 2 years.

Comments

The challenge these facilities faced has been to recruit and develop multidisciplinary staff and provide a team based approach to the medical and welfare services. Given the broad criteria for intake of those with mental health problems, staff training will be critical to offer such a broad range of services. Another major challenge is to develop a catchment area approach where administrative and service areas can overlap which would facilitate provision of local welfare and social services. The link between NGOs and prominent community members, academics and respected professionals appear to give credentials and standing to such NGOs so that they can be trusted by psychiatric hospitals and facilities.

Peer Clinic

This private community clinic set up by Dr Arai (previously a psychiatrist and president in a general hospital), is unique in that it provides medical outreach (assertive community treatment) with a multidisciplinary team approach. It serves about 50 patients especially those with poor treatment compliance post discharge. The clinic also provides free of charge day centre and drop-in centre facilities. The key approach is to develop patient engagement and a horizontal collaborative relationship rather than a vertical authoritarian one. The challenge has been to develop a financially viable service as the cost exceeds estimated payment from universal health and welfare insurance. There is no reimbursement for travel or extended consultation time during outreach visits.

Hamamatsu Mental Health and Welfare Centre

There are many community resources in Hamamatsu comprising rehabilitation facilities and NGOs involved in mental health care. The mental health centre is also supporting the development of more self-help groups. The relationship between

municipal government mental health centres and NGOs has been to provide credentials to NGOs and to support via commissioning several related activities including training of volunteers, engagement in community activities, group activities for suicide survivors, forums for consumers, workshops on substance abuse, surveys on population needs, supervision of sheltered workshops and family sessions. Integral to the city's policy, the mental health centre has a priority in collaborating with NGO's in delivering mental health services in many areas.

Comments

Given the high need for community mental health care, it is necessary for government to collaborate with NGOs and to provide non-clinical community-based services to mentally ill patients. Non-clinical and welfare support for mentally ill patients is very important to minimise the need for re-hospitalisation and maximise the chance for community living. Hence the local government will need to find a viable mechanism to fund such services that would complement the clinical services provided by the private hospital sector. The relationship between mental health services with NGOs and primary care as well as the relevant workforce to deliver community care need to be strengthened. Secondly, although E-JAN has representation in the planning of services at the centre, it is necessary to create a formal structure whereby the key community stakeholders can provide input and advice on policy and service development at a local government level. Involvement of users and patients in the development of services is crucial to ensure their needs are met appropriately.

Meetings with Key Organisations

Presentation to the Division of Mental Health, Ministry of Health, Labour and Welfare Japan

(9 Jan 2008)

A presentation on the Australian mental health system was given. Present were the Director, Dr Yasumasa Fukushima and the Deputy Director, Dr Satoshi Ezoe. Important issues were highlighted in the current mental health system in Japan which included the rapid rise of aged inpatients particularly those suffering from dementia. The conditions of chronic inpatients have remained unchanged and significant numbers of inpatients remain hospitalised due to lack of alternative residential facilities in the community. Hence, the function of the hospital requires to be differentiated as currently they perform mixed functions covering acute care as well as placement for chronic patients. Fortunately, the numbers of psychiatric inpatients are not increasing and newly admitted patients do not have excessive length of hospital stay. There is a need to develop a strategy to deal with such high numbers chronic inpatients including the ageing patients who cannot be discharged.

Meeting with Japanese Association of Psychiatric Hospitals (JAPH)

(17 January 2008)

Presentation and meeting took place at the JAPH together with Dr Takeshi Samejima (President), Dr Takuo Nagao (Vice President), Dr Saburo Matsubara, Dr Kei Sakuma, Dr Hisomu Chiba, and other key members of JAPH. Presentation on community psychiatry reform in Australia was given and discussion that followed included the

following points. There are clear differences in the mental health systems between Japan and Australia. One of which is the separation between the medical services and welfare services thus creating a split funding schemes even though patients with mental illness require support from both services. JAPH leadership is still considering, which is the best strategy to progress forward with the community mental health reform and needs to develop consensus within the association. The main barrier to system reform has been the lack of community services and resources. Another concern is how the medical professional can maintain clinical leadership in community psychiatry service delivery. In addition, to achieve reform, funding from the government and clear leadership from the Ministry of Health would be required.

Meeting with Japanese Society of Psychiatry and Neurology

(7 January 2008)

A lecture titled “Community Mental Health Reform in Australia” was provided in the presence of Professor Takuya Kojima (President) and several executive members of JSPN. The discussion post-lecture centred upon the process of reform in Australia in terms of the closure of psychiatric hospitals, development of community facilities, staff retraining and recruitment, funding and challenges moving from an old system to a new one, and the cost of community care. A number of differences between the Australian and Japanese systems were also outlined. The principles of community mental health care were highlighted as the common goal rather than to directly copy from the Australian model and system. These principles included moving from a hospital-based to community-based service approach, extending medical model to psychosocial and rehabilitation models, broadening treatments to include case management, input from carers and users to provide treatment, and moving from medical hierarchy to a multi-disciplinary team approach. Professor Kojima and the executive members stressed that the role of JSPN in community mental health reform is currently being established. This consisted of (1) obtaining representations and views from various sectors and associations; (2) establishing a task force committee headed by Dr Okazaki to make advice and recommendation for an overall grand strategy and policy for community care; and (3) establishing an educational role for JSPN which has the responsibility in implementing the accreditation of specialists.

Meeting with National Centre of Neurology and Psychiatry

(10 January 2008)

Following the presentation to NCNP, discussion with the research staff of the NCNP examined the integration of medical case management and welfare case management system. In order for the medical services to provide comprehensive medical outreach, some level catchment area system needs to be designated otherwise it lacks practical use. Capacity building and training of the case managers are also required to deliver the mental health care system. Rehabilitation models need to be adopted widely and training provided accordingly. Restructuring of the medical finances and welfare finances would also be necessary and health payment should facilitate the assertive management and community services.

Summary of Strengths and Best Practice in Community Mental Health Care

A. National level

- MHLW is currently making significant efforts in shifting from hospital based to more community based mental health system. To achieve this goal it aims to reduce its beds by 70 000 within the next 10 years.
- The establishment of the Act on support for persons with disabilities has increased health and welfare resources.
- The fees for inpatient stay in acute units have increased while those staying for longer than 90 days have reduced, thus creating incentives for private hospitals to discharge patients earlier.
- Nursing outreach visit has increased for those discharged from hospitals and funding mechanisms established for outreach patient care
- Implementation of community oriented services in private hospitals and clinics to ensure sustainability
- The numbers of established psychiatric day care centres and private psychiatric outpatients' clinics have increased.
- Renovation and rebuilding of mental health hospitals to improve facilities.
- Functional differentiation of the psychiatric hospitals to provide multiple roles.
- Increase in the nurses to patients ratio in psychiatric hospitals.
- Increase in the number of social rehabilitation facilities currently catering for more than 10 000 users.

B. Local government level

- Mental health centres have played a key role to organise basic mental health services, facilitate the use of the local community resources, and work with social sectors such as education, labour, welfare, and law, local residents, users and families
- Factors in reducing beds and length of hospital stay included:
 - empowerment of community activities in mental health
 - public promotion campaigns to increase patient acceptance

C. Private psychiatric hospital level

- Private hospitals and outpatient clinics can create innovations in community treatment and rehabilitation in a financially viable way
- A range of different service components can be provided by private facilities:
 - emergency services, inpatient services, psychotherapy, day and evening care, respite care, activities support centre, sheltered workshops, welfare and vocational training and supported group housing
- Outreach medical services can monitor and treat patients at home especially those with poor compliance
- Home can function as a hospital room, hence using the concept of creating "Hospital at Home" service
- Training and exposure of service providers and professionals to modern community models of care have contributed to such change

D. Psychiatric inpatient facilities level

- Inpatient facilities with wide open space, bright and clean environment, adequate personal space and appropriate patient aids
- Conditions that minimise restrictions and treats the patients in a humane way
- Community oriented hospital practice aiming for short length of stay
- Multidisciplinary team approach with clearly defined team roles
- Individual patient care plans instituted
- High staff to patient ratios
- Occupational therapy workshops and conducive ward environment have led to a low level of violence and low need for seclusion
- Use of effective medications with low side effects at low dosages and low rates of polypharmacy

E. Community level

- Community mental health programs have extended the medical model to psychosocial model to provide rehabilitation outside the hospital infrastructure
- Community based discharge programs run by NGOs or private facilities can provide vocational rehabilitation programme and community living support effectively to discharged patients
- It is possible to change perception of both staff and community that mentally ill patients can be discharged out of hospital and can live independently in the community.
- Key factors that promote the discharge process include:
 - adequate preparation to live in the community before discharge
 - engagement with patient and family
 - coordination between hospital and community
 - strong liaison with housing providers in the community
 - developing good relationship with the stakeholders in community
 - prompt crisis response from the staff who are available 24 hours
 - support patient's confidence through visits from hospital staff after discharge and peer support

Opportunities for Further Improvement

Support and attention could be considered in the following areas for the development of current and future community mental health service models in Japan.

General aspects

1. Current cost-effective and culturally appropriate models of community services are not widespread and need to be built up over time. An action plan is necessary to extend the current capacity by scaling up the working models of community care to other facilities.
2. Providing a clear strategy for policy development, funding support, and sustainable service implementation at the local governmental level, especially in the integration of medical and social welfare services
3. Developing local administrative, professional and community leadership in directing the action plan in reform

4. It is inevitable that overall bed occupancy rates will eventually fall with time so hospitals need to actively prepare for alternative community-oriented services for the future by gradually building up community models of care.
5. Comprehensive community and rehabilitation services for newly admitted patients in their early illness phase will aid in preventing the development of future chronic patients.
6. Qualified and experienced community based mental health workforce is required. Further confidence in mental health workforce needs to be adequately developed. (See textbox)
7. Evaluation plans and monitoring mechanisms for reform process should be implemented with performance indicators use to promote system improvement.
8. While recognising the provision in the current health system for users to be 'free to choose services', considerations should be given to practical forms of catchment-based mental health service responsibility. This has many advantages including:
 - a. Overlap between local government and mental health service catchment area allows practical implementation of administrative policy, funding schemes and resources
 - b. Services are locally accessible, equitably distributed and integrated with local health and related service
 - c. Linkages with local housing, social and welfare networks are strong
 - d. Ability to use local community resources and volunteers in mental health care and programs for patients

Whichever community care model that is used, appropriately trained staffs are essential to carry out such functions. There is a need to increase leadership capacity and confidence in mental health workforce ranging from administrators, psychiatrists, nurses and allied health, community workers, and NGOs. Incentives and encouragement for staff to work in the community setting are also required. A leadership in community mental health course can help meet these needs.

Specific aspects

1. Expansion of 24-hour psychiatric emergency service and acute psychiatric services to support community mental health model in a sustainable way
2. Cooperation between public and private psychiatric hospitals to provide comprehensive emergency response and acute care services within a designated area to achieve seamless service coverage
3. Extension of medical outreach service with doctors and allied health staff visiting patients in the community can be encouraged through adequate reimbursement and financial incentives
4. Optimal utilisation of allied health workforce, especially in nursing, psychology, occupational therapy and social work to promote the development of multidisciplinary community mental health teams.
5. Providing medical case management to all discharged patients would help prevent hospital readmission rates. Providing welfare case management can ensure support and recovery of function in the community. Both medical and welfare case management need to be integrated to prevent service gaps

6. There is most scope to increase the number of community rehabilitation facilities provided by local government, NGOs and community resources to support the mentally ill in the community.
7. Current hospital inpatients who could be managed in the community could be stratified into low, medium and high care categories.
 - a. High care should have medical case-management with multidisciplinary input and ACT
 - b. Medium and low care should receive community and welfare rehabilitation support at a lower intensity

Suggestions for Future Directions in Community Mental Health Reform

The following are suggestions for future broad strategic areas to be considered for community mental health development in Japan. This is not an exclusive list and is not meant to be a prescriptive rigid formula for reform. However, it aims to highlight significant areas to be thoroughly considered, explored and resolved through wide consultation with different stakeholders before strategic implementation (see textbox).

1. A policy and strategy framework is needed to assist the planning and implementation of the reform process, which can provide clear directions for the re-development of mental health system, expansion of community mental health services, re-structuring of mental health funding and stronger integration between government departments.
2. The mental health system should aim for gradual reduction in inpatient beds (especially in long stay beds) as the community services and alternative residential options are developed. Any funds that are saved from the bed closures are to be re-invested within the mental health area and any funds re-allocation clearly verified.
3. Strengthening the function of the hospitals, the human technology and skills of the mental health staff (ie the software) is a greater priority than changing the building structures of the private and public hospitals (ie hardware) for community mental health development.
4. The specification of the hospital functions should be clearly defined and developed (e.g. emergency care, acute treatment, inpatient rehabilitation, community rehabilitation, placement for chronic patients, etc). Having targeted functions will create opportunities for existing hospitals to change into renewed, decentralised, multi-functional institutional facilities
5. New financing arrangements should reflect ongoing investment and expansion of community mental health services. Funding should be allocated to services provided for patients in the community and mechanisms for funding medical outreach, NGOs and non-clinical services outside hospitals should be found.
6. Sustainability of community mental health programs is a key necessity. Hospital and community services need to implement adequate exit strategies ensure dynamic through flow of users to various community resources, and prevent unacceptable overloading at various points in the care pathway.

7. Ageing inpatient population, growing rates of dementia and carers becoming older all require integrated national strategic approach and solutions, not only for psychiatry. While rapid closure of hospital beds is inappropriate, development of clear care pathways for the aged in mental health services, with discharge and placement options are urgently needed.
8. Capacity building of the community-oriented mental health service workforce is a priority. A workforce plan and training scheme need to be developed to meet the needs for acquisition of new professional skills, changes in working conditions and new functional roles in the community. Leadership capacity and confidence in the mental health workforce need building up.
9. Individualised patient care and rehabilitation planning is required to maximise independence. Funding and legal requirement can help ensure that every patient has an individualised service plan linked to targeted clinical outcomes.
10. Establishment of a partnership between the Health and Welfare Departments is necessary to achieve integrated clinical and social community services for all patients managed in the community.
11. Creation of community treatment orders could be considered to facilitate treatment of involuntary or non-compliant patients in the community. However, the development of policy and service framework would take higher precedence than instituting legislative changes.
12. Hospitals as well as mental health centres can play a role in the promotion of mental health rather than just focussing on treatment of mental disorders to reduce the stigma, and to increase community acceptance and understanding of mental illness.

Incremental reform that builds on the current strengths and achievements would lead to progressive development of a more rehabilitation oriented and community based service system. At a national level, several broad options strategic options could be considered:

1. Support current good practice models and set up pilot projects
2. Scale up the current models to larger regions
3. Systematic policy and practice change
4. Combination of the above strategies

Practical next steps

These are some useful practical steps that the NCNP can collaboratively take forward. the findings and recommendations from this report.

- Develop a practical action plan at each level of mental health system
- Establish a network of community mental health reformers to facilitate action plan

- Develop a training program for ‘Leadership in community mental health’
- Conference presentation of best practice activities
- Publication and dissemination of final report

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