
Policy Recommendations
For a General Improvement in Psychiatric Care
in Japan
April 2010



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Proposals to Save 200,000 Psychiatric Refugees in Japan

A 100 Year-Long Misfortune of Being Born in this Country

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By Way of Introduction

On Sunday, June 8, 2008, an incident of mass murder took place in Tokyo's popular electronics district. Seven people died and 10 others were injured after a man hit pedestrians with a truck and then stabbed passersby indiscriminately with a dagger knife. The incident got extensive media coverage because the assailant was a temporary employee, used a dagger knife as a weapon, and had posted messages from his mobile phone to a Web site, announcing his massacre beforehand. Exactly seven days ago to the day, on June 8, 2001, a school massacre took place at Ikeda Elementary School in Osaka Prefecture. A 37-year-old man named Mamoru Takuma, armed with a kitchen knife, entered the school, killed eight children, and seriously wounded 13 other children and two teachers.

The mass media covered the two incidents, to a varying degree, in relation to mental disorders. The suspect of Akihabara massacre, it was reported, underwent psychiatric tests. The murderer of the Osaka school massacre, Mamoru Takuma, had a history of mental illness, and some papers described him as a psychiatric outpatient. Thus mass media helped create public sentiment that mentally-disabled people are dangerous. (By the way, a month after the Osaka school massacre, I myself was asked to make comments on this incident by *The Chuokoron*, one of the leading magazines in Japan, and my comments were published with the title "Psychiatrists, Justice and Police Have Been Conned by the Suspect Takuma" in the August issue of the magazine in 2001.)

In this social context, then Prime Minister Junichiro Koizumi directed his staff to consider judicial countermeasures, and this sparked political debate on the issue which eventually led to the enactment of a new law: Act on Medical Care and Treatment for Persons Who Have Caused Serious Cases under the Condition of Insanity. At that time, I was working as a government-paid policy secretary to Mr. Eita Yashiro, Diet member with a physical disability, and could carefully observe interactions and negotiation processes between the government and the ruling party not only as a social worker but also as a family member of a mentally-disabled person.

To tell the truth, my brother got a psychiatric diagnosis fifty-five years ago. He had been intermittently hospitalized as long as 36 years since the first diagnosis, during which time he had been diagnosed seven times and had got five different disease names. Though it was for only a short time, he did have a chance to live alone independently. He started living in an apartment house, but died a sudden death from a heart attack. Twenty years have passed since then.

For long periods of time, I have watched treatment and rehabilitation for mentally disabled people including my own brother. I have also worked as a social worker for health care centers, private health care institutions, and rehabilitation centers for as long as 40 years. At the same time, as a volunteer, I have launched or helped launch sheltered workshops and group homes. I also served as Managing Director and Director-General of the Secretariat of the National Federation of Families with the Mentally Ill in Japan (now dissolved) and campaigned for improvement of legal systems for mental health care and welfare. Fortunately, I had a chance to go on an inspection tour and to look over current situations and practices of psychiatric care and rehabilitation in advanced nations, some of which I even filmed.

On the basis of my experience and observations over a period of many years, I would like to make some proposals to improve mental health care system in Japan. The proposals will be listed in the following page under the heading of Policy Recommendations. And the following five chapters will contain data and discussions supporting the recommendations.

Takehisa Takizawa

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April 2010

Policy Recommendations

For a General Improvement in Psychiatric Care in Japan

1. To shift to community-based mental health care while drastically reducing the number of beds for inpatients by amending Act on Mental Health and Welfare for the Mentally Disabled, Medical Service Act, and the system of medical treatment fees.
2. To abolish the legal guardian system in Mental Health Act and to lift the practice of "involuntary" hospitalization in the name of "medical-protective admission."
3. To reduce the extent of duty of support stipulated in the Civil Code (878), and amend the existing Penal Code's Article 39-(1) "An act of insanity is not punishable", to " Act of insanity shall lead to the punishment being reduced."
4. To augment manpower in the mental health care sector where an acute shortage of mental health professionals has long existed due to the Special Provisions to the Medical Act.
5. To set up beds for psychiatric care in general hospitals and comprehensive hospitals (general hospitals with 100 or more beds) so that citizens in general may not hesitate to get a check up.
6. To establish a nationwide emergency mental health care system.
7. To secure user-friendly residential houses in communities for the "social hospitalization" cases to live, to establish care systems, and to urgently add more small-scale self support shelters.
8. To ensure income security for the mentally disabled and to raise benefit amounts per capita.
9. To greatly strengthen vocational rehabilitation by financially supporting the mentally disabled to be covered by Act on Employment Promotion etc. of Person with Disabilities

Chapter 1

Seeking Psychiatric Evaluation from Mental Science

◆ Psychiatric Evaluations vs. Judicial Rulings

The two stabbing incidents mentioned in By Way of Introduction shocked the Japanese people who generally think that they are living in a peaceful, quiet country. Mass media frantically tried to find the motives for the crimes, and, as they always do whenever they can not find definite motives, they began to report the incidents in relation to mental disorders or the problems of the mentally-disabled people. And, like always, they rushed to seek comments from psychiatrists and forensic psychologists, who, in turn, made comments without enough scientific evidence. And their "professional" comments soon gain currency among people, which only made the problems more complicated. This kind of things has been time and again repeated in Japan. I have deep reservations about the attitudes of justice and prosecution in Japan which expect an old-fashioned mental science and psychiatric evaluation to find out motives of crimes.

Even in the case of "insanity" provision of section 39 of Criminal Code, both defense lawyers and prosecutors seem to place more importance on psychiatric diagnoses called psychiatric evaluation than judges who are authorized to judge.

Armed with such big words as "academic," "scientific," or "professional," psychiatric evaluation imported from Western countries, has long ignored individual personalities of mentally-disabled people, and dazzled the eyes of public administration, politicians, and citizens in general. Yet, as a matter of fact, even in these Western countries, no clear causes of mental disorders have been found, and even their advanced treatment techniques have not exceeded the level of supportive measures.

Many people seem to think that it is possible to find out meanings and causes of human actions in general by means of evaluation and interpretation by mental science or psychiatric medicine. I strongly oppose this type of thinking.

After receiving a report from police, two designated psychiatrists, usually from

private hospitals, conduct a psychiatric evaluation. The evaluation is conducted under the jurisdiction of the administrative office, in place of judicial authorities, and it takes only from an hour to two depending on the gravity of the matter. The fact is that this type of "semblance" evaluation goes unchallenged and that the suspect has already suffered "social" punishment before the formal trial. See Table 1 below showing the number of psychiatric evaluations conducted under the jurisdiction of the administrative office.

Table 1.

Number of Psychiatric Evaluations under the Jurisdiction of the Administrative Office

Year		No. of Reports	Evaluated	Hospitalized	Not Hospitalized	Exempted	
						Insanity	Suspension
1960	Reports from Citizens	20,350	14,609	2,913	11,696	343	-
	Reports from Police Officers	1,795	1,456	680	776		
1965	Reports from Citizens	26,698	24,127	13,417	10,710	404	-
	Reports from Police Officers	5,407	4,883	3,362	1,521		
1970	Reports from Citizens	17,163	16,165	11,801	4,365	384	-
	Reports from Police Officers	5,981	5,415	3,491	1,924		
1975	Reports from Citizens	9,084	8,453	6,065	2,388	500	-
	Reports from Police Officers	5,107	4,000	2,124	1,876		
1980	Reports from Citizens	3,525	3,183	2,447	736	548	-
	Reports from Police Officers	4,152	2,891	1,514	1,377		
1985	Reports from Citizens	1,336	1,190	877	313	442	330
	Reports from Police Officers	3,510	2,274	1,208	1,066		
1990	Reports from Citizens	581	481	329	152	489	355
	Reports from Police Officers	3,665	2,354	1,283	1,071		
1995	Reports from Citizens	394	329	246	83	457	331
	Reports from Police Officers	4,202	2,972	2,153	819		
2000	Reports from Citizens	511	367	282	85	480	206
	Reports from Police Officers	7,557	4,889	3,579	1,310		
2005	Reports from Citizens	355	234	172	62	439	375
	Reports from Police Officers	10,386	5,899	4,161	1,738		

One thing I have learned from having talked with many psychiatrists over a period of years is that the majority of them have thought that they have done their duty by giving a diagnosis, without any ulterior motives, according to the fee-for-service reimbursement system.

Tsutomu Miyazaki, who had killed four little girls, was executed not long ago. This serial killer had undergone psychiatric examinations and given three different diagnoses by three psychiatrists. And this fact has only increased a sense of distrust

of psychiatric examination among not only learned individuals but also the general public.

◆ Living under Sentence of "Social" Death

It is ignored that any psychiatric evaluation or psychiatric diagnosis of crime suspects may cause violation of human-rights of mental patients and mentally disabled people.

It was almost forty years ago that Mr. Kazuo Ohkuma, then Asahi Shimbun reporter, published a well-documented reportage of actual conditions in a mental hospital. The book helped the general public understand the current situation of mental health care in Japan, but at the same time it helped them become more aware of accidents or incidents caused by the mentally-disabled. Since around that time, there has been more media coverage on mental health conditions or history of mental illnesses of the suspects. The media coverage like this has unfortunately given average citizens a false impression that the percentage of accidents and incidents caused by the mentally disabled accounts for a substantial fraction of the actual crime rate.

For a patient who has already received a diagnosis of mental illness with a certain medical term, the very term disseminated by the media would virtually deny his or her character as a social being. It would be almost equal to giving "death sentence" to him or her, who could otherwise have led their own social lives. Needless to say the families of the patients would also suffer from the same agony.

The patients and their families are always agonized whenever they see or hear these types of news reports. It is not psychiatrists but the patients and their families who really feel "pressured" by psychiatric evaluation. The heavy toll on human rights of the mentally-disabled and their families should never be ignored.

Chapter 2

Hospitalization Creating Mentally-Disabled Persons

◆ Ministry of Health and Welfare: 3,030,000 Mentally-Disabled Persons

It was said that the number of the mentally-disabled in Japan was about 1,000,000, according to a survey on the actual conditions conducted in 1973. However, the Ministry of Health, Labor and Welfare announced in 2005 that the number was 3,030,000. There is a significant difference between the two reports. One of the reasons is that the former was based on an actual condition survey on the mentally-disabled which was conducted by the health ministry by the Japanese Government's standard, while the latter survey, in response to the UN's resolution of International Day of Disabled Persons, was conducted according to the WHO's International Classification of Diseases. In other words, the government officials adopted international standards and just counted the number of persons who had received psychiatric services at hospitals or clinics. (Of the 3.03 million persons mentioned above, only 442,728 had received Identification Booklets for the mentally-disabled at the end of March, 2008.) The number of mentally-disabled persons in Japan in 2005 is as shown in Table 2 below.

In recent years, the number of suicides of citizens working for companies is said to be increasing. The media take up the problem, the health ministry addresses to the issue, and psychiatrists actively make comments as might have been expected. Many of those citizens might have gone in through the "wide" gate of mental health institutions to find the road that would lead to life. May it be that psychiatrists are adding the estimated number of cases on the basis of medical examinations they have conducted? It was a widely-publicized scandal that Yokozuna Asashoryu was said to suffer severe depression and nervous breakdown when he had to miss tournaments because of his misconduct. Had this tough sumo grand champion felt himself to be mentally-disabled at that time? I am not sure about it, but he will be surely counted as one of the patients in the face of statistics.

Table 2: The Number of Mentally-disabled Persons (2005)

Total Number 3,030,000 (Outpatients: 2,600,000、
Inpatients: 350,00 <320,000 for mental illness bed>)

- Schizophrenia & its subtypes 760,000
(Outpatients: 560,000、 Inpatients: 200,000)
- Mood disorder 920,000
(Outpatients: 890,000、 Inpatients: 30,000)
- Psychoneurosis & its subtypes 590,000
(Outpatients: 580,000、 Inpatients: 5,000 (5,000??))
- Others 60,000 (?????? 通院・入院の内訳なし)
(Incl. epilepsy, Alzheimer' s disease, vascular dementia)

* The figures are estimated ones based on the survey of outpatients and inpatients conducted in 2005.

* The number of people visiting medical institutions for mental health reasons has been increasing every year. Especially, outpatients seeking treatment for mood disorder and stress-related disorders are remarkably increasing. These two categories account for 33% and 22% respectively, which combine for 55% of the total outpatients.

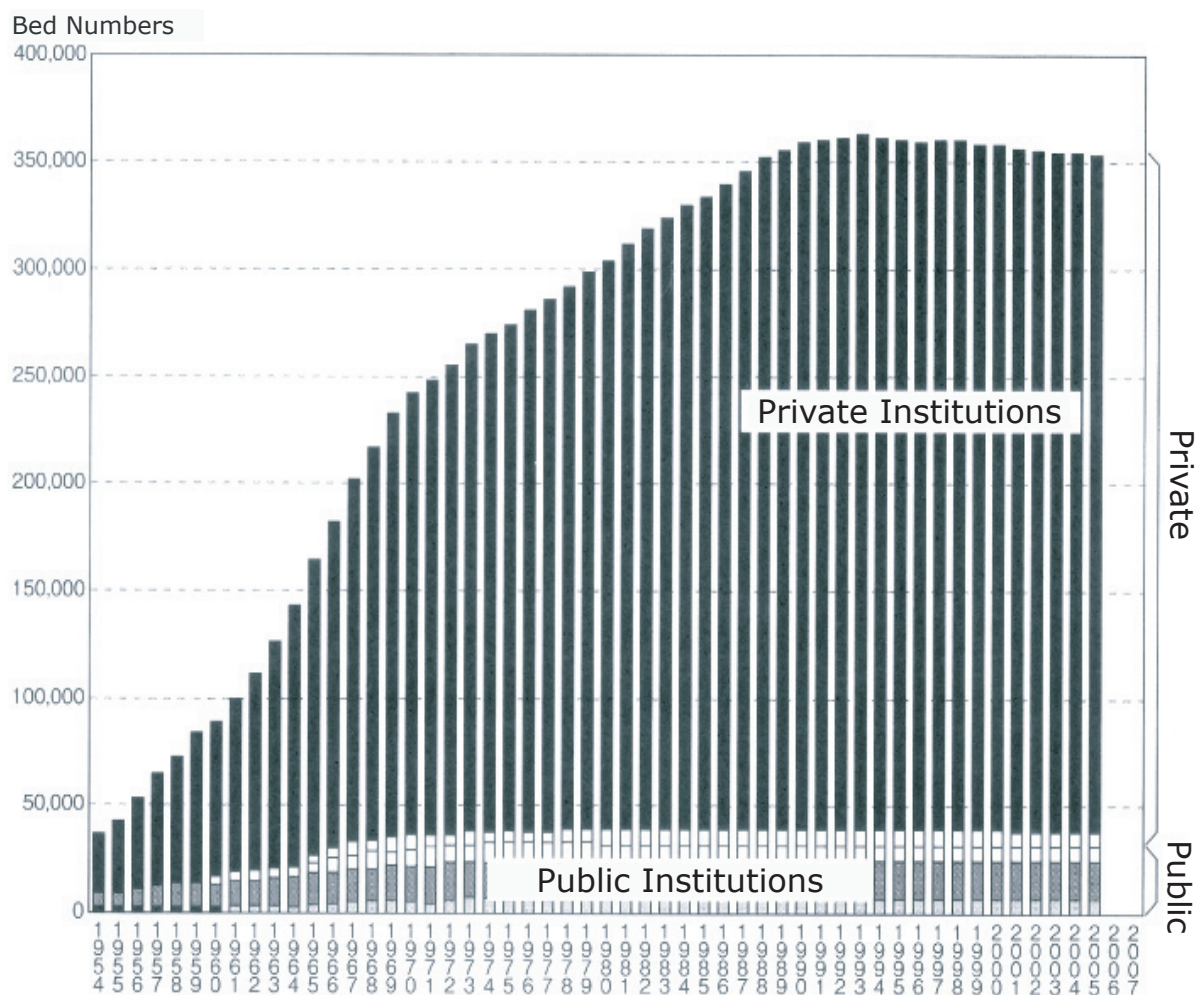
◆ Hospitalization/Institutionalization-Centered Policies

It would not be an overstatement to say that involuntary commitment for treatment advocated by hospitalization-centered policies has caused a variety of problems in Japan for these 100 years.

In 1964, Edwin O. Reischauer, then U.S. ambassador to Japan, was stabbed by a mentally disturbed youth. The incident triggered a rallying cry across the country, saying "Don' t let a sickie go unchecked!" (This expression, as discriminatory, is not used today.) Responding to this public sentiment, the government implemented the measures, in an expeditious manner and with generous financial assistance, to increase the number of private-sector psychiatric treatment facilities which tended to secure the contracts at lower prices. As shown in Chart 1 below, the number of beds (especially those of private hospitals) available to mentally-disabled patients has remarkably increased since the mid-1960s. Under the guise of treatment of persons suffering from anxieties and maladjustment to schools and workplaces, the real intention they had was to isolate those persons from society. Due to these measures, hospitalization-centered system has greatly developed.

Chart 1 The Number of beds available to the mentally-disabled 1954 — 2005

Source: Ministry of health and Welfare Report (2005)

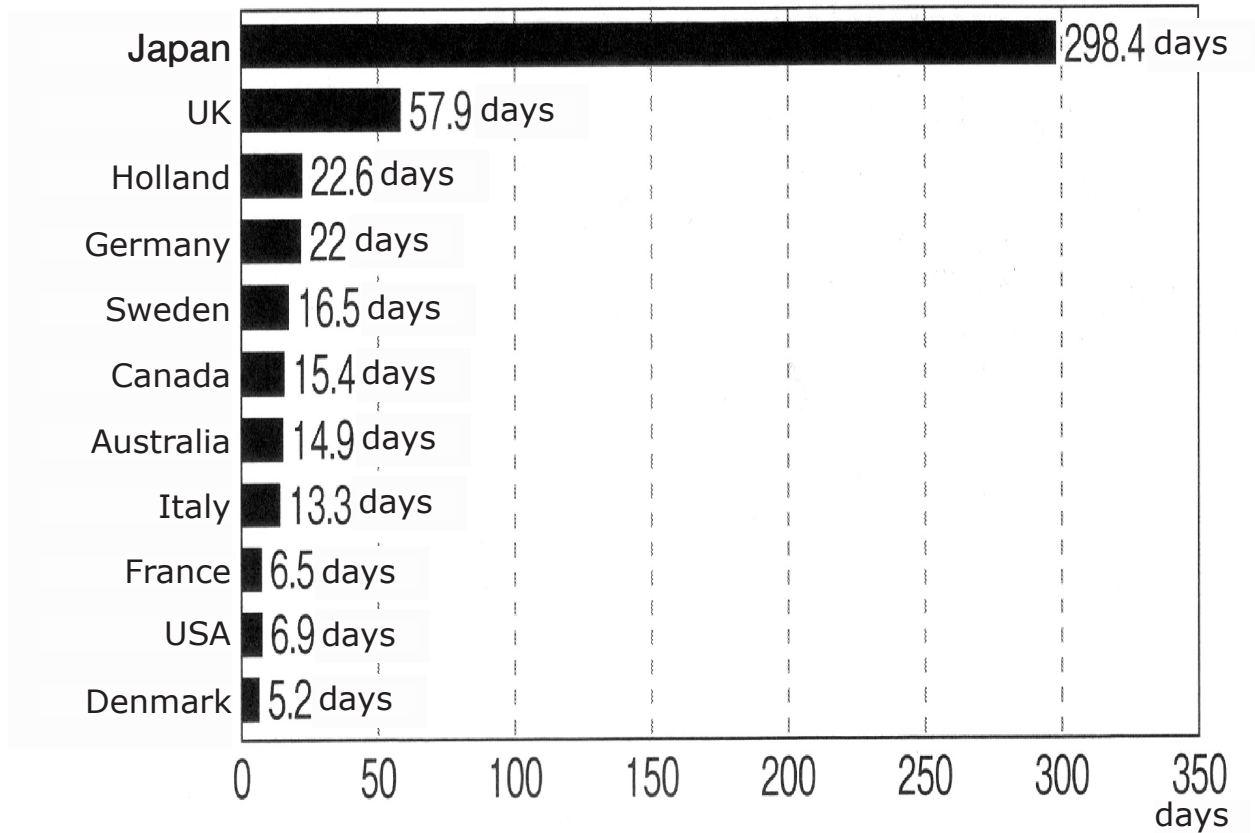


The problem is that these measures were implemented, while still preserving the "families' duty to protect and support" the mentally-disabled, which has not changed since hundred years ago. And this is one of the major reasons which have accelerated unusually "prolonged" hospitalization in Japan. Chart 2 below shows a country-by-country comparison of the average length of stay in hospitals.

Persons, who are supposedly mentally-disabled, have been asked to undergo psychiatric evaluation by psychiatrists designated by the administrative authorities before judicial ruling and have been, more often than not, involuntarily committed and isolated. In this sense, hospitalization/institutionalization has worked as a substitute for a "public safety system" in Japan. I suspect that the Japanese government carried out the policies of involuntary commitment and involuntary treatment under the veil of treatment and protection of the mentally-disabled.

Chart 2 Country-by-Country Comparison of Average Length of Stay

Source: OECD2008 & Japan's Ministry of Health and Welfare Report



Old-time psychiatric textbooks in Japan were filled with such phrases as "mental illness is incurable …," "… not complete recovery, but just a temporary lull," "… have a genetic origin," "… dangerous patients," "… no chance of rehabilitation into society," "… a confirmed invalid," "… no consciousness of disease," or "… no feeling of illness," and thus many of the mentally-disabled have been involuntarily committed and treated.

It may be under the influence of professionals' understanding and practices that even ordinary citizens have come to hold the image of a mentally-disabled person as a dangerous one with an unusual appearance and behavior, controlled by a delusion and hallucination. As a result they too think that involuntary commitment is unavoidable. Almost 100 years ago, Dr. Shuzo Kure, one of the pioneers of psychiatry in Japan said that the mentally-disabled in Japan have to suffer not only mental illnesses but also their misfortune of being born in this country." What he said is unquestionably true even today.

◆ Excessively Prolonged Hospitalization without Rehabilitation Services

Psychiatric treatment in Japan is almost invariably medication-centered and hospitalization-centered as a result of the medical treatment reimbursement system. Although well-publicized, work therapy for vocational rehabilitation, life therapy for social rehabilitation, or psychotherapy occupies only a small portion of the nation's treatment. Rapidly-increasing mental health centers also provide medication-centered treatment.

The Japanese government had, for a period time, promoted an economic policy which was a seemingly "welfare with public funds" in order to hold private-sector mental health facilities accountable for involuntary commitment. As the result, more mental health facilities were established in this country per capita than any other nations in the world as of 1971. At that time, there were 250,000 beds available to mentally-disabled persons, and all those beds required "involuntary" admission/hospitalization procedures. Thirty-three percent of the inpatients, 650,000 persons, were hospitalized by reports from police officers or citizens (including family members) for the reason of preventing "harm to self and others." Hospitalization as administrative measures has been thus promoted. As the inpatients increased, they were "protected" in the wards with locks and lattices.

What does this vast number of involuntary hospitalization cases imply? The nation and local governments are supposed to be solely responsible for involuntary commitment to treat and protect the mentally-disabled persons, but the Japanese government has left almost all their duties to private-sector mental health care institutions by designating them as "substitute hospitals." It may be said that the government has been exploiting these substitute hospitals as loopholes.

Private hospitals are business enterprises, that is, they have to make profits. Thus they have naturally made efforts to fill their beds to capacity. It can be easily imagined that a significant number of hospitals may have drawn on "involuntary hospitalization" for this purpose. This has led to a great number of human-rights violations. At the time of law revision, "voluntary hospitalization" was renamed to "medical protection hospitalization," but there was no change in essence. It was involuntary hospitalization assigning responsibility to the patient's family. This is exactly the same to the policy of prevention of Hansen's disease, which was established and put into effect in 1953. It was a blatantly anachronistic, inhuman medical and welfare policy, and it was abolished in 1996.

Chapter 3

Two Hundred Thousand "Social" Refugees

◆ "Hospitalism" as a Result of Prolonged Hospitalization

The 1983 survey of actual conditions by the Health Ministry reported that 53 percent of all the inpatient (about 200,000) can be discharged from the hospitals, and the Education Ministry's research group also said that 50 % of the inpatients hospitalized more than a year can get out of the hospitals. Yet, there is no accepted view about the figures: some say it is 72,000, and others say 150,000. I have here used the figure "200,000" in the chapter heading. The phrase "social hospitalization" is a typically Japanese one which was dubbed in Japan in the 1970s. Patients who are hospitalized for a long time for non-medical reasons such as family circumstances and a shortage of nursing care facilities are called "social hospitalization" cases. And the great majority of the patients mentioned above are "social hospitalization" cases. See Table 3 below:

Table 3. List of Surveys on Percentage of Dischargeable Patients

—in chronological order—

- ◎ 1983 Actual Condition Survey by the Ministry of Health and Welfare
---- 53.4% (Dischargeable/dischargeable under the right condition)
- ◎ 1989 Survey by Japanese Society of Psychiatry and Neurology
---- 33.1% (Patients "socially-hospitalized" more than 2 yrs.)
- ◎ 1989 Survey by Association of Japan's Psychiatric Hospitals
---- 12.9% (Remission/Nosocomial remission)
- ◎ 1995 National Federation of Families with the Mentally Ill in Japan
---- 39.7% (Patients hospitalized more than 1 yr. under the social resources)
- ◎ 1999 Survey by Japanese Society of Psychiatry and Neurology
---- 32.5% (Dischargeable within 6 months under the right condition:
out of the patients hospitalized more than 2 yrs.)

- ◎ 1999 Survey by the Ministry of Education Research Group
 - 50.5% (Dischargeable: out of patients hospitalized more than 1 yr.)
- ◎ 2003 Survey by Japanese Association of Psychiatric Hospitals: Research & Planning Committee on Social Rehabilitation Needs
 - 15.0% (Dischargeable under the right condition)
- ◎ Notes:

(1) As of 2005, patients hospitalized 5 or more years accounted for 27% (86,000 persons) of the total number of inpatients of psychiatric institutions. Out of them, more than 45,000 patients had been hospitalized more than 20 years.

(2) Even after the announcement of Plans for the Disabled—the 7-year Strategy for Normalization (1996) and Plans for Mental Health & Medical Reform (2003), shift to community of mental health care has not proceeded much and many "socially-hospitalized" patients still stay in mental hospitals.

Persons with mental illness have been considered to have no consciousness of their illness, no matured character, no sound judgment and no responsibility capacity. And thus their families have been required to protect and support them. This paternalistic view in mental health care has forced the mentally-disabled to be involuntarily treated and committed for these 60 years in Japan.

Human beings cultivate their skills and knowledge through communication and interaction with others in daily life, in work places, and in experience learning even more than in their family lives. However, prolonged hospitalization, like an imbalanced life in some welfare, educational, or religious institutions with specific purposes, will eventually make them suffer "hospitalism."

◆ **“Social Hospitalization” Is Human-Rights Violation**

I am afraid that Japan’s mental health care policies may contribute to human-rights violations and that they may convert the Japanese Archipelago into The Gulug Archipelago, to use the title of a book by Aleksandr Solzhenitsyn.

The 1999 Osaka Council for Mental Health declared that "social hospitalization" is human-rights violation, but this concept has not been shared by many of other similar councils. Things that are rather invisible to inpatients are slowly and quietly going on just like a criticality accident that takes place at an atomic-energy power station. The roads leading to discharge from hospital, employment and marriage

which any citizens may naturally hope are closed to the patients and their families. And they are, in a sense, forced to live a "life with three meals, drugs and a nap." As the result, if patients' mental conditions become rather less positive, they will easily be diagnosed as "autistic" or "hypobulic." Then come increase of curative drug and even increase of kinds of drugs. These kinds of practice will eventually lead to a chronic situation of multiple drug, massive dose and prolonged administration. In this way, the socially-hospitalized will accumulate and the best medicine for them will, sadly enough, be "resignation" or "death."

My brother died 20 years ago. After a really prolonged hospitalization, he finally had a chance to live alone and independently. But he suddenly died of a heart attack in his apartment house. The cause of his death, I was told, prolonged administration of massive and multiple drug, and debilitation resulting from prolonged hospitalization. Ironically enough, the most important thing in his treatment was to take medicine dutifully.

◆ Two Hundred Thousand "Social-Hospitalization" Patients: "Refugees"

In 1953, two WHO consultants visited Japan and advised the Government to promote community mental healthcare activities, daycare services, occupational therapy services and treatment for outpatients visiting local general hospitals. However, institutionalization-centered policy was a national policy, and thus the WHO's community - centered healthcare recommendations didn't receive due recognition. In 1968, Dr. D. H. Clark, WHO consultant in mental health, visited Japan. He expressed concerns again and made more concrete recommendations. However, due to administrative failure to act, no systematic, consistent measures have taken and as a result there exists a reality that "social-hospitalization" patients account for more than half of the total inpatients of mental healthcare facilities. This is nothing else than human-rights violation and the Gulug Archipelago.

Japan is considered to be one of the leading industrialized countries and also as one of highly developed nations. However, as far as human welfare and human rights of the mentally-disabled are concerned, this country is in a disastrous situation. It is not a stretch to call the mentally-disable in this country "medical refugees" or "former citizens abandoned in exile." Will this situation continue until we have more than 200,000 "social-hospitalization" cases? This reminds me of the history of quarantine policies for patients with Hansen's disease who had suffered for a long time under the Leprosy Prevention Law.

What has produced this kind of dire situation? I am ready to accept the problems Dr. Clark pointed out in his report: the disqualification clause for the disabled and some Special Provisions for the Medical Act, inadequate community livelihood support services, and prejudice of local residents about mental illness and mental institutions. (The special provisions for the medical act allow psychiatric departments to be short-staffed: about two-thirds fewer doctors and about one-third fewer nurses.)

In addition to these problems, I would like to point out three more factors: time-honored duty of support, psychiatrists' authority to conduct compulsory treatment, and the clause of "An act of insanity is not punishable" of Penal Code's Article 39-1).

The parents' or fraternal love has been exploited by the so-called "paternalism" of hospitals which is led by economic motivation for hospital management. This has impeded the smooth development of Japan's mental health care policies.

As for Penal Code's Article 39-1), it is apparently a human-rights violation or a breach of the Constitution, under the guise of sweet-faced humanitarianism.

◆ **Psychiatrists : Not Responsible for Diagnoses and Treatment**

In current Japanese society, diagnostic terms such as "schizophrenia" which is a core disorder of mental illnesses are flying around in daily life. Mental clinics and mental hospitals are doing a brisk business, changing their names to departments of psychosomatic medicine, a more easily accessible name to the general public. On the other hand, the patients themselves are required to take drugs whole life long, and it is difficult for them to accomplish social independence, obtain employment, or get married. Their families are enduring economic difficulties resulting from prolonged treatment or hospitalization and social prejudice while they have to tackle their own problems of aging. I cannot help harboring reservation about the achievement of treatment and welfare measures in the field of psychiatry and mental health care.

Psychiatrists continue to sell diagnoses at a giveaway price although they have not yet found out exact causes and reliable treatments. The hospitals have two hundred thousand inpatients to fill their beds thanks to "social hospitalization," and their stable management is guaranteed. Psychiatrists are rarely to be held responsible for their diagnoses and treatments. Psychiatric medicine which has no concept of cure or recovery will never be able to persuade the general public to throw away prejudice against mental illnesses and to believe that they are curable illnesses.

Chapter 4

Reform of Psychiatric Care in the West

◆ The Shift to Community-Based Mental Health Care

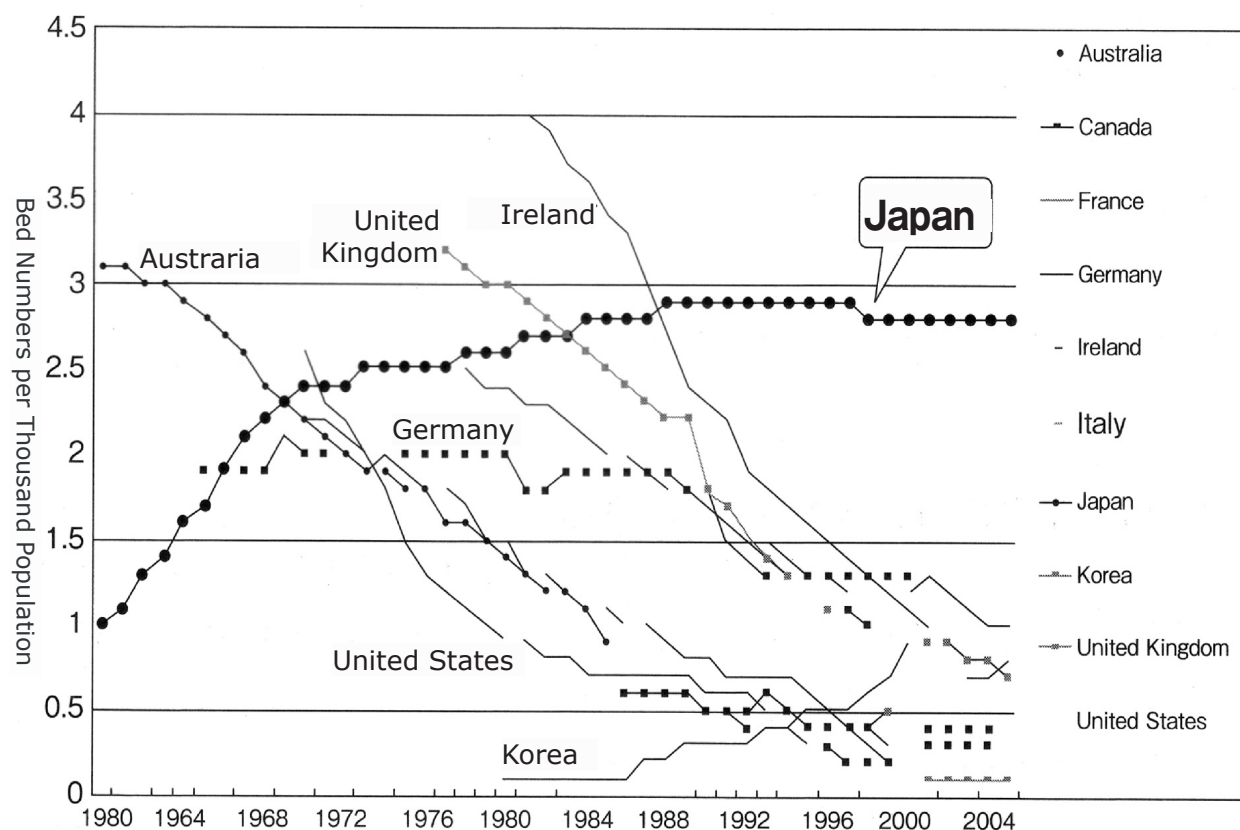
Western nations launched total reform of their mental health care system about 50 years ago and shifted to community-based health care and welfare. Following World War II, somewhat under the influence of bitter memories of Nazi concentration camps, several well-known books were published in the West, such as *Asylums* (1961) by Goffman, *The Mental Hospital* (1954) by Stanton and Schwartz, and *Institutional Neurosis* (1976) by Barton. These books, by and large, cast critical eyes toward mental institutions and argued that they had a deleterious effect on patients. They advocated that community living would be not only more effective in curing their illnesses but also more cost-efficient in providing social treatment and vocational rehabilitation.

Moves for deinstitutionalization became visibly active, and many countries in the Western world have shortened the length of stays and shifted to community mental health service that enables patients to receive treatment while living in the community since the mid-1950s. Community mental health care in Britain and the sectorization system in France are typical examples. The process of closing mental hospitals has been recently accomplished in Italy. Thus, in these countries, the number of inpatients has been steadily decreasing.

In Western nations, policies for mental health care and vocational/social rehabilitation have been developed from a basic viewpoint that every patient is an individual with his/her own personality and character. However, in Japan, a patient will be asked to receive hospital treatment by his family who has duty of support or joint responsibility. This is a typically Japanese phenomenon, "social hospitalization" mentioned previously time and again. As shown in **Chart 3** below, the number of beds of psychiatric hospitals had steadily increased until recently, in contrast to those of other countries.

Chart 3 Country-by-Country Comparison of Bed Numbers

Source: OECD Health Data 2002 & 2007



◆ Judiciary Authority and Psychiatric Care

One of the major reasons community mental health care became possible in the Western countries decades ago is because public mental hospitals have a much higher proportion of all mental hospitals there. Public hospitals range from 80 to 90 percent of all the mental hospitals. Quite the reverse is true in Japan. For private mental hospitals which account for more than 80% of the nation's mental hospitals, it would not be so easy to release their patients into care in the community, from a business point of view. In Britain and France, public institutions are responsible for community-based health care, thus they have never left their duties and responsibilities to private institutions.

Another factor that impedes the shift to community-based mental health care is "duty of support" prescribed in the Japanese civil law. Generally speaking, in a nation under the rule of law, only judicial authorities are allowed to hospitalize or confine any person compulsorily. However, in Japan, many hospitals ask the family, who has legal

duty of support, to force the patient to be hospitalized. In Western countries where individual patients' rights and duties are respected, this will never be the case. A sharp distinction should be made between psychiatric care and judicial authority. (Needless to say, the patients in the West are also endowed with responsibility and freedom that come along with their rights and duties.)

Dr. D. H. Clark, former consultant in mental health, WHO, once said that unless British psychiatric care succeeds in making patients with schizophrenia, a core illness of mental disorder, get back into community, psychiatry and psychiatric care will never be trusted by the public. The Italian people, on the other hand, enacted law that prohibits people from being admitted into the hospital. They thought that it is not individual treatment techniques but total reform of systems that will foster self-reliance and independence of the socially-rehabilitated.

◆ **John F. Kennedy' s New Frontier : Special Message to the Congress**

In February, 1963, John F. Kennedy, the 35th President of the United States, sent a special message to the Congress. He stated in this message:

But two health problems--because they are of such critical size and tragic impact, and because their susceptibility to public action is so much greater than the attention they have received--are deserving of a wholly new national approach and a separate message to the Congress. These twin problems are mental illness and mental retardation.

From the earliest days of the Public Health Service to the latest research of the National Institutes of Health, the Federal Government has recognized its responsibilities to assist, stimulate and channel public energies in attacking health problems. Infectious epidemics are now largely under control. Most of the major diseases of the body are beginning to give ground in man's increasing struggle to find their cause and cure. ... Yet mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the public treasury and the personal finances of the individual families than any other single condition. (Special Message to the Congress on Mental Illness and Mental Retardation, February 5, 1963)

President Kennedy must have taken a special interest in the problem of mental health because he had a mentally-retarded sister. Shortly after his inauguration, he appointed a special "President' s panel of Mental Retardation."

America' s state mental hospitals of that time were mostly awful confinement

facilities with a capacity of thousands of patients. And Kennedy's special message evolved into the Community Mental Health Act of 1963, which has greatly contributed to deinstitutionalization by providing federal funding for community mental health centers. These centers helped the mentally-disabled to be reintegrated into society through their community care and welfare services. In those days, many of professionals involved in mental health care in Japan reacted tepidly to this policy, and said, "It will just increase homeless people." The enactment of the law was part of John F. Kennedy's New Frontier. I only wish that we had had such a great statesman with vision and humanity.

Chapter 5

200,000 Persons' Worth Loss of Social Resources

◆ "Social Recovery" for the Mentally Disabled

The Japanese word for schizophrenia had long been "Seishin-Bunretsu-Byo", which literally means "a disease that breaks up or splits the mind." The connotation or implication of the word was a really negative one. That is why the National Federation of Families with the Mentally Ill in Japan asked Japanese Society of Psychiatry and Neurology to change the designation of the disease from "Seisin-Bunretsu-Byo" to "Togo-Shiccho-Sho", which could be translated in English as "integration disorder syndrome" or "integration dysfunction syndrome." The Society decided to change the age-old term of diagnosis in June, 2002. As this specific case implies, any person diagnosed with any name of mental illness has been stigmatized in society.

Persons with physical disabilities seem to be less stigmatized in Japan when compared to those with mental disabilities and more successful in social rehabilitation. They had demanded full participation and equality, and campaigned for their rights to live meaningful lives in community. Their demand had also greatly contributed toward clarifying distinction between disease and disability which led to the expansion of the concept of "recovery." In many cases, disabilities still remain after diseases are treated. And in the field of physical disability, an expanded sense of "recovery" was introduced: "social recovery." This expanded concept of recovery, it seems to me, has also promoted social rehabilitation of the physically disabled. Although they have disabilities, they are able to function in various social situations to lead meaningful and productive lives in society.

Some of us have often sought a possibility of applying this expanded sense of recovery to the cases of mental disorders. One of the standards for "social recovery" is that there is no need or possibility for further medical treatment. And I think that this standard applies to the majority of "socially hospitalization" cases. As I defined previously, the Japanese English "social hospitalization" denotes those cases who are

hospitalized for a long time for non-medical reasons, such as family circumstances and a shortage of nursing care facilities. If there are no medical reasons, the logical conclusion is that there are no medical treatments. Then why do they have to stay in hospital? Isn't it better for us, as many countries in the West have already done, to discharge them from hospital and let them live in community where they can develop social functioning ability to prepare for full integration into society? It is not the sole purpose for psychiatrists to make pathological diagnoses. Both psychiatrists and mental health care/welfare professionals should work together to rehabilitate the mentally ill so that they can lead satisfying, meaningful, and productive lives.

If we strive to translate into reality the philosophy on which the WHO has based its International Classification of Functioning, Disability and Health (ICF), the general public will begin to think, in due course of time, that people with mental disabilities can recover, that is, socially recover, and lead satisfying, productive lives in their communities.

◆ **Housing, Work and Income for Living Expenses**

First of all, a house to live, work and income for living expenses are essential for a person with mental illness to achieve social rehabilitation. The Japanese government has a 10-year program to promote hospital discharge, but it has not made much progress so far. In the meantime, inpatients will become new "social hospitalization" cases. Shouldn't the government enact such a law as "Act on Special Measures for Promoting Discharge of Socially Hospitalized Patients," drawing upon their past experiences such as building apartment houses by enacting "Employment Promotion Law," or establishing special measures to provide livelihood support to former patients after the abolition of the Leprosy Prevention Law.

◆ **Financial Loss Incurred by "Social Hospitalization"**

Historically speaking, Japan has had a negative perception of mental disorder and, by and large, has segregated and isolated people with mental illnesses from society. As a result, we have today about 200,000 "social hospitalization" cases out of the 330,000 inpatients in total. They can be rightly called "refugees." The fact that we are incurring a great financial loss of the national treasury owing to hospitalizing so many people for so long a time has never become a popular topic for discussion, but we should not ignore the gravity of the matter. At the same time, we should think about possible suppression of untapped capability of the mentally disabled confined

in hospitals. To make matters worse, Japan will be viewed in the international community as a backward nation in terms of the protection of human rights, and the image of Japan will be seriously undermined. If mental health care/welfare professionals were concerned about not only technical matters of treatment but also institutional, systemic aspects of the problems, they would be able to find the right solution. To conclude my paper, I would like to quote what President John F. Kennedy said almost half a century ago: We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity.

ABOUT THE AUTHOR

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