WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

Japan 0025

30 May 1968

ENGLISH ONLY

ASSIGNMENT REPORT

November 1967 - February 1968

by

Dr. D.H. Clark
Consultant in Mental Health

Title of project	:	Mental health advisory services
Geographical location	:	Japan
Participating agencies	:	Government of Japan World Health Organization
Subject	:	Mental health
Form and type of assistance	:	Advisory services
Staff	:	WHO - Mental Health Consultant
Source of funds	:	Regular
Duration	:	November 1967 - February 1968

WPR/210/68

CONTENTS

1. TERMS OF REFERENCE

1.1 To advise the Government on the development of community mental health services in the country.

1.2 In collaboration with the national counterpart, to develop a plan for the integration of community mental health into the general health services and to establish preventive and treatment facilities particularly for ambulatory, non-institutionalized patients.

1.3 To plan within community health services for facilities for the mentally retarded.

1.4 To generally assess the problems, initiate surveys to the extent possible where required as a basis for guidance in planning.

1.5 To advise upon related matters on request and to submit a report upon completion of the assignment.

The reason and purpose of the Japanese Government in requesting the consultantship is contained in the following statement dated and sent to the Western Pacific Regional Office on 13 December 1966:

> "The community mental health care programme to promote early detection and proper rehabilitation of the psychopaths and mentally disordered, including the mentally retarded, is one of the urgent social and public health problems we have been facing in Japan.
>
> "Under the circumstances, the Mental Health Law was revised to stimulate mental health activities in the community by means of establishing Mental Health Centres which are to function as the technical consultation centres for community mental health (there are 7 centres now, to be increased to 46 by March 1969), while putting additional function to 826 health centres to act as front-line administrative agencies for mental health services in the district.
>
> "However, we have not yet achieved integration of the community mental health programme into the general health services in terms of sufficient cooperative relationship between the public health facilities and the mental hospitals, general practitioners and other community resources.
>
> "It is understood that the community care for the mentally ill in the United Kingdom has been so well organized and developed and been functioning successfully through the social rehabilitation institutions such as the day centres, night hostels, etc. with close relation with community or district mental hospitals under the coordinated activities of Regional Mental Health Tribunals, Mental Health Officers, etc.

"We are therefore requesting the services of a short-term consultant who will review and evaluate the present situation and the main problems mentioned as above and advise us how to integrate community health care into the general public health services, and it is particularly hoped that we could receive such adviser from U.K."

2. OUTLINE OF PROGRAMME

After an initial period of orientation and meetings with senior Ministry officials, the writer made a number of visits to programmes and institutions for mental health. In this he was greatly helped by his counterpart, Dr. Masaaki Kato, Chief of Adult Mental Health at the National Institute of Mental Health, Konodai.

He travelled to different parts of Japan to see regional variations and had many useful discussions on the long train and car journeys across Japan. After he had a fair grasp of general patterns, he arranged talks with informed persons in order to clarify certain issues. Everyone was most helpful and tolerant of many questions covering a wide range of subjects. The informants have not been listed in detail, nor all the institutions visited lest they be considered in any way responsible for the writer's observations and recommendations which arise from what he personally saw and thought.

The writer went to 8 cities (Tokyo, Yokohama, Sendai, Matsumoto, Nagoya, Tsu, Kyoto, Osaka) and 9 prefectures and visited 15 mental hospitals (7 public and 8 private), 7 institutions for the mentally retarded, 5 mental health and child guidance centres and 5 university clinics and many other institutions and facilities, such as sheltered workshops, halfway houses, prefectural and ministerial offices. He also gave 12 lectures to audiences ranging from 3 to 200 on aspects of British psychiatry.

Everyone strove to be helpful and to answer the queries they understood but communication difficulties beset all the writer's work as he did not speak Japanese and some informants could speak no English. Some Japanese doctors could speak English slowly (though nearly all could read it). Only a few people could speak and think fluently enough in English for intensive or deep going conversation to develop. This was a constant bugbear and a limitation on the writer's understanding but was implicit in the original conditions of the consultancy.

This report falls into four sections: Background, Observations, Discussions and Recommendations. In Background a few historical facts are mentioned (well-known to the informed) for the information of non-Japanese readers. In Observations some of the more important things which the writer saw or found out are set down. In Discussions certain selected topics were considered which seemed important to the emergent issues of Japanese mental health. Recommendations lists those areas where the writer feels action can and should be taken in the near future with a fair chance of useful results.

3. BACKGROUND

3.1 Historical

Before the Meiji Restoration (1868) problems of mental illness were dealt with by traditional methods in Japan. A few temples developed a reputation for curing psychosis. Various forms of gross psychoneurotic disturbance were dealt with by shamanistic exhortation. The feeble-minded and the quiet psychotic were absorbed in and tolerated by the rural community, while the severely mentally retarded and the grossly psychotic succumbed rapidly to intercurrent infectious illness.

After 1868 Western medical methods were widely adopted, including the practice of psychiatry as developed by Kraepelin and other German teachers. The Kyoto Prefectural Mental Hospital was opened in 1875. During the twentieth century, psychiatry in Japan developed slowly. It remained an organically based German dominated specialty, concerned with the care of psychosis and epilepsy.

The mental hospitals were few and tended to receive only those psychotics who caused social difficulties. Most families kept their sick members at home, often locked in. The number of inpatients was further decreased by the war-time air raids which, in devastating the cities, often damaged the mental hospitals, and the post-war disorganization and starvation when many of the chronic schizophrenic inpatients died.

3.2 Previous WHO reports on mental health in Japan

In 1953 Dr. Paul Lemkau[1] and then Dr. Daniel Blain[2] visited Japan on behalf of WHO. They found Japan recovering from the war and the occupation, with industry expanding and standards of living rising. The population was increasing rapidly and many children were being born. Dr. Blain found 22 975 psychiatric patients in hospital in 1952, a rate of 2.6 per 10 000 population and commented "There is a tremendous latent demand for hospital beds in Japan". They noted that hospitals were small, dilapidated buildings, but well staffed. Dr. Lemkau noted that "The concept of long term psychotherapy, generally considered necessary to obtain good results in psychotherapy, is not generally known or appreciated" ..... He speaks later of ..... "The demand for psychotherapists that will almost certainly become very pressing within the next few years".....

---

1 Report of Consultant in Mental Hygiene to Japan, June 2 - July 14, 1953.

2 Report of Consultant in Mental Health, 13 November - 12 December 1953, January 1954.

Dr. Blain noted that the "psychiatric leadership and experience in the office of the Ministry of Health and Welfare is far too low". They made many other comments and a number of recommendations, especially about professional training, which have since been implemented. Dr. Blain recommended that the number of psychiatric hospital beds be raised to between 10 and 20 per 10 000.

Dr. Morton Kramer [1] also visited Japan in 1960 and reported on the methods of gathering psychiatric statistics.

3.3 Health services in Japan

In the last fifteen years Japan's industries have expanded greatly. The standard of living of her people has risen, first in the towns and more recently in the countryside. The expectation of life is rising and major infectious diseases, such as tuberculosis and dysenteric infection, are now being controlled. The young people are healthier than ever before. The birthrate which was very high just after the war was stabilized by 1955 and is now fairly steady at about 18/1000. The total population was 98 274 961 in 1966 of whom about 6% were over 65, 25% under 15, and 69% between 15 and 64. If present trends continue the proportion of young people will decline slightly and the proportion of elderly rise significantly by 2000.

The public health system is organized on a prefectual basis. There are 46 prefectures in Japan, containing an average of 2.1 million people, each governed by a popularly elected Governor and Assembly. In some prefectures Health and Welfare are in one department, in others they are separate. A tradition of regional autonomy has developed in the past twenty years as a reaction to the pre-war overcentralization.

Prefectural governments have been active in the control of infectious disease and have developed a network of public health clinics, staffed by public health nurses, which have taken a lead in eliminating tuberculosis. Most prefectures have a prefectural mental hospital and some a prefectural institution for the mentally retarded.

Centrally, the Ministry of Health and Welfare (one of the 12 Ministries and 4 Agencies of the Government) controls all medical services. The community mental health services, as in so many countries, involve several other ministries, such as Education and Labour. In Japan, mental health problems are the concern of a number of departments within the Ministry of Health and Welfare.

There are 10 Bureaus in the Ministry. The Public Health Bureau has a Mental Health Section (one of 7 Sections) which is concerned with

---

[1] Report on a Field Visit to Japan, 9 - 22 January 1960, 13 June 1961.

control and development of the mental health organization, and social workers - all of which affect mental health services. The Bureau of Children and Families is responsible, amongst other children, for the handicapped, including the mentally retarded and juvenile delinquents.

In recent years training institutions for the mentally retarded (incapable of ordinary education) have been developed. There are however few facilities for the support of adult mentally subnormal.

Severely subnormal persons (i.e. idiots) did not tend to survive long previously. They still remain mostly in their parents' homes. Some are accommodated in mental hospitals.

The problem of delinquency and antisocial behaviour by adolescents often homeless was a major social problem in immediate post-war years and numerous institutions were set up under special laws. The general problem is less now but the institutions remain and deal with most adolescent disturbance.

In the last fifteen years there has been a determined and successful effort to build up the number of mental hospital beds in Japan. Public hospital building was extended and there was much building of private mental hospitals, mostly small, so that by 1967 most of the inpatient psychiatric population were in private mental hospitals.

Psychiatric Beds[1]

	Public Hospitals	Private Hospitals	Total	Total Population	Beds per 10 000 Population
1955	10 982	29 254	40 236	89.2 mill.	4.5
1966	30 769	150 940	181 709	98.2 mill.	18.5

In 1967 there were 725 psychiatric hospitals. Three were national hospitals, 39 were prefectural or municipal and 683 private. The average size was about 180 beds; only a few contained over 1000 beds. There were also many inpatient psychiatric departments in university and prefectural hospitals.

In the 1968 Budget the Government estimated that it would spend approximately 75 billion yen (US $210 million) on psychiatric patients under three Laws (Mental Health Law, Daily Life Protection Law, and National Health Insurance Law). Of this, about 3 billion yen

---

[1] Source: A Brief Report on Public Health Administration in Japan, 1967.

would be for outpatient services.

The National Institute of Mental Health, founded in 1952 at Ichikawa, is directly administered by the Ministry.

3.4 Professional staff

3.4.1 Doctors

The number of universities and medical schools in Japan has increased during this period (in 1967 there were 46 schools preparing students for medical graduation). The course is two years pre-medical and four years medical school. Teaching is in Japanese but English and German textbooks are widely used and many doctors can read both languages. Psychiatric instruction consists usually of a few formal lectures and demonstrations of patients, though some universities include a period of attachment to the department of Psychiatry where some patients are examined.

After qualifications there is one year's internship and national examination leading to license. Many doctors gain honorary posts at their university hospitals and work for the Doctor of Medical Science degree as an entry to specialization.

In Japan, as in the United States, there is a growing tendency to specialization. The family doctor, as known in Britain, is rare in the cities today. A special feature of Japanese medical work are hundreds of small private hospitals, developed by a doctor and his family, and caring for his personal patients. The private mental hospitals form part of this pattern.

The larger hospitals are mostly university hospitals which have a great reputation; many patients go to their outpatient clinics directly.

The insurance system of Japan is an integral part of the medical system. Many firms run insurance for their employees; there are a number of private systems and several different governmental schemes. All have different rates of contribution and different scales of benefits. Underpinning all is a National Insurance Scheme which provides minimal benefits for all not covered in other ways. In all cases however, the doctor provides the treatment and makes a claim on the insurance organization later, though some money may be collected direct from the patient.

Many psychiatrists hold several posts, for example, working in a private mental hospital, in a university clinic and consulting for a public agency. There is little specialization within psychiatry; every psychiatrist expects to handle psychosis, inpatient and outpatient psychogenic reactions (depressions and psychoneurosis), distrubed children, subnormal persons, epileptics and psychotherapy.

3.4.2 Nurses

There are various nursing college trainings, from two to four years leading to qualification as a registered nurse or a licensed nurse. As in the United States of America this is a primarily theoretical training, with periods of limited hospital experience and the nurse is expected to acquire her practical knowledge after graduation. There are still large numbers of qualified Japanese nurses. There is no specialist training in psychiatric nursing. There are a small number of male nurses (registered and licensed) but all senior nursing positions in Japanese hospitals are held by women. There are of course some unqualified persons working with the nurses in psychiatric hospitals, but not as many as in Britain and nothing like as many as in the United States of America and recruitment problems are not so severe.

3.4.3 Social workers

Social workers nowadays take a four-year college training and are then able to take up all forms of social work. These courses were developed under American guidance in the post-war years and lean heavily on American practice and social theory. Many senior positions are held by persons who qualified by experience in earlier years. There are no specialized mental health courses to train psychiatric social workers. An association of psychiatric social workers was recently formed and is attempting to promote training and establish standards.

3.4.4 Clinical psychologists

College courses in psychology and clinical psychology developed under American sponsorship in the post-war period. Clinical psychologists work as counsellors in the educational services or in private practice. There are few in most psychiatric institutions, mostly concerned with testing and research.

3.4.5 Occupational therapists

A School of Rehabilitation was established in May 1963 by the Ministry of Health and Welfare for the training of physical and occupational therapists, with twenty students in attendance. In May 1964 WHO provided a physical therapist for the purpose of assisting in the training of the first group of qualified physical therapists and occupational therapists in Japan.

4. OBSERVATIONS

4.1 Community mental health services

This includes all mental health services but particularly those outside hospitals.

In some countries this has been given a very wide meaning, covering outpatient psychiatric services, ancillary activities such as halfway houses and therapeutic social clubs, voluntary activities such as mental hygiene leagues and suicide prevention societies and in some cases has been extended to cover psychiatric intervention in the government of the district, in advising teachers how to give sex education, television producers how to improve their programmes, and police forces how to stop riots.

There is little evidence of these extended activities in Japan. The main agencies are the public facilities for the mentally handicapped, the mentally retarded and the chronic schizophrenics, and the psychiatric outpatient departments of the hospitals, particularly the University hospitals.

There are 829 public health centres. Originally developed to control tuberculosis and other infectious diseases, these centres are staffed by public health nurses under the direction of public health doctors. In recent times some clinics have arranged for the part-time attendance of a psychiatrist, whose main function is advising the staff. It seems that these public health clinics perform a useful task in supporting schizophrenic and mentally retarded people living in their homes and taking initial steps for their removal to hospital when necessary. They seldom become involved with emotionally disturbed adults.

There appeared to be little development yet of extended aftercare services for psychologically crippled people. The Children and Families Bureau is developing plans for extended services for mentally retarded people after they leave institutions, and the Ministry of Labour is beginning to take an interest in the problems of maintaining in employment people of lowered mental capacity but this has not gone far. There are no substantial sheltered workshops for subnormal (or mentally ill) persons within the community.

Many persons with psychiatric problems go to psychiatric specialists, some to outpatient clinics operated from private mental hospitals, many to the University Hospital Clinics. These clinics deal with psychosis (schizophrenia) and epilepsy but see a number of people with psychogenic reactions (depressive and anxiety states) and psychoneurotics (obsessional compulsive and phobic anxiety, etc.). The number of patients diagnosed as psychoneurotic is increasing. The University Hospital Clinics are largely manned by honorary staff and are under great pressure. The treatment for neurotics is mostly medication and brief interviews.

Many patients attending general psysiciaus are diagnosed as "noyrosa" (German-neurose) and treated with tranquilizers.

4.2 Mental hospitals

Japanese mental hospitals differ from those in Europe and the United States of America in that they are small, recently built (few

older than twenty years) and mostly privately operated. There are however many similarities: the patients are mostly schizophrenics; many are long-stay residents; many are apathetic, withdrawn and tend to regression; the wards are overcrowded.

The writer saw 15 hospitals out of 800. Any of his assertions can therefore be dismissed as mistaken. These were however all hospitals of good, or excellent reputation. They presumably represent the best of Japanese hospital practice. He was told by several informants that other hospitals had far lower standards and that one-third of them were "very bad". He was not shown any hospitals in this category. The following observations should be seen against this qualification.

The living conditions of the patients at first appeared to be chilly and overcrowded, but after visiting a few houses of patients, it was realized that the hospitals compared favourably with what the patients were accustomed to at home. Feeding seemed good and the patients physically healthy. Most of them were young or middle aged; there were very few elderly (4% over 60). Numerically the staffing was good, with a strikingly high ratio of doctors and substantial numbers of registered nurses. The relationship between staff and patients seemed warm, friendly and good-humoured with little of the cold distance or contempt seen in poorer Western mental hospitals. In most wards the patients had ample personal belongings - a marked contrast to older European hospitals. There was generally an absence of the massive security provisions - bars, double locks, railings, armoured glass, etc. - which disfigure some hospitals in other countries.

There was not much evidence that modern methods of active treatment, and rehabilitation, had been grasped. In a few hospitals the principles of the Active Therapy of Herman Simon (1926) were still retained and there was a good level of activity, but in many others the level of patient activity was very low. Patients were sitting about idle, lying in bed at midday or making their own occupation. In one hospital in the middle of the afternoon one-third of the patients were in bed because, it was said, of an unexpected snowfall. Although some hospitals had notable programmes of work and activity and some had patients working out in the community with night hospital arrangement, many had done little about this.

Too many wards were locked unnecessarily. There was too much use of methods of restraint, seclusion rooms, cells and security blocks. Patients were locked in solitary confinement, many clearly for long periods. In two hospitals the newest buildings were security blocks with elaborate devices such as steel bars, closed circuit television, etc., all of which lead to harmful isolation and regression.

Although a few inspired medical directors were concentrating on the life, work and freedom of their patients, many mental hospital doctors appeared to confine themselves exclusively to their traditional medical role, carrying out physical treatment and writing up case notes. In some hospitals they were preoccupied with research projects in neuroanatomy and neuropathology.

The nurses, too, seemed often to see their main responsibility as providing physical care, rather than directing and promoting an active life leading to rehabilitation. It appeared that in the recent rapid expansion there had not been enough attention to the principles laid down in the Third Report of the Expert Committee on Mental Health (Technical Report Series No. 73, WHO Geneva, 1953) in the organization of the mental hospitals, and there was little awareness of recent developments in social psychiatry.

4.3 Institutions for the mentally retarded

The writer visited seven institutions for the mentally retarded and was impressed by the high standard of training being given. They were under the direction of teachers, with paediatricians and psychiatrists attending on a part-time consultative basis. The children, even those of IQs below 20 were actively occupied by devoted staff whose morale was high. The children of IQs in the 20 - 60 range were being taught sensible skills and very actively occupied with simple industrial tasks as well as trained socially. These were of course leading institutions and standards in less satisfactory ones are not known. No evidence could be seen that the children were suffering from lack of direct medical control, although some informants were concerned with this. There are not enough institutions. In many towns retarded children and adults are accommodated in mental hospitals where they were clearly an embarrassing problem. They were locked in cells because of their degraded behaviour and the irritation which they aroused in the other patients and staff.

At all institutions for the mentally retarded, however, staff expressed anxiety about aftercare and follow up. Sometimes, the institution provided this themselves by bringing the former pupils back for parties. The staff mentioned the lack of employment officers to help the retarded find jobs. These were new institutions; when asked who was going to help their former pupils ten and twenty years after they left, or when their protective parents died, no one knew. The education of the feeble-minded in special classes attached to ordinary schools or in special schools is well understood in Japan, though the number of classes is not sufficient.

There has apparently, not yet, been much development in Japan of Junior Training Centres (Occupation Centres) as seen in Britain and European countries. These are centres where severely retarded children, unable to benefit from formal education, can attend daily while continuing to live at home. These have been found most useful in helping children with moderate defect (such as Down's syndrome) from good homes. The child's attendance at the centre each day gives relief to the mother, the training prepares him for adult life, trains him in social skills and even teaches simple remunerative tasks.

The writer did not see any institutions for the very severely mentally retarded (the severe idiots). The unfortunate individuals who cannot walk and often cannot feed themselves require care and

attention all their lives. Before thirty years ago they died quickly; nowadays, with modern drugs, they survive longer periods. Mothers will often care devotedly for them for a number of years, but many of them require institutional care. It is certain that the number of these patients will increase in the coming years.

4.4 Health insurance

Many informants mentioned the difficulties arising from this system. It is peculiar to Japan and of great complexity. All hospitals have to maintain a large "Insurance Department" to find out just which insurance scheme each patient comes under and what rate of benefits he is entitled to. This complexity is hard on all patients but particularly on the clients of the mental health services, many of whom are simple-minded (the retarded), confused (the psychotic) or emotionally distressed (the neurotic) and therefore less able to manage a complex system. The writer was informed that the Insurance System will be reformed in 1968 and that there is talk of a uniform National Insurance System as in Britain. This would be greatly to the advantage of psychiatric patients.

Other aspects of the Medical Insurance System call for more direct comment. Payment rates for different forms of medical service are, as the writer understands, worked out by argument and compromise by a National Council between representatives of the insurance organizations and the organized medical associations. It is understood that there is no psychiatrist on the council. This seems unfortunate, for the medical insurance payments system is at present dictating the pattern of psychiatric treatment throughout the country.

The payments for inpatient treatment are well worked out and relatively generous. A doctor can make a good living treating inpatients and hospitals flourish economically. Outpatient psychiatric treatment is poorly paid and a flat rate is paid for each visit regardless of its length or the quality or intensity of the treatment given. This means that doctors are discouraged from spending any length of time with individual patients and have a positive incentive to see very many patients frequently for very brief interviews. The writer has been told that it is not possible for a doctor to make a living practising psychotherapy, or seeing patients for planned and lengthy interviews. There is no payment to psychiatrists for time they may spend advising courts, child guidance clinics, prefectural governments, etc. This means that there is a positive inducement for a psychiatrist to spend his time exclusively on individual treatment, especially physical treatment of inpatients and to turn his back on work for community mental health services. This must inevitably cripple development and impoverish such services.

4.5 The position of psychiatry in Japan

A number of professions are involved in community mental health services, but the psychiatrists are central figures. As the writer's

discussions developed it became clear to him that psychiatry and psychiatrists occupy a different place in Japan from that in some other modern societies.

If developments in community mental health are proposed, it is suggested that society makes a different use from hitherto of psychiatrists and psychiatric services. The limits of such developments are set by how society at present sees and uses its psychiatrists - how the general public sees them, how other doctors see them, how the psychiatrists see themselves.

In Japan psychiatry is a minor medical specialty, the care of severely subnormal, psychotics, epileptics, and some psychoneurotics. It is as important as venereology or dermatology, not as important as otorhinolaryngology. Its traditions are based firmly on the diagnostic phenomenological approach of Kraepelin and later German psychiatrists. The general public knows little about psychiatry. To doctors in general psychiatry is an odd minor specialty. Every doctor expects to see and treat many "noyrosa" (German "neurose"). He treats them with tranquilizers, sedatives and good advice, if necessary firm, stern, advice on better living. He would seldom think of sending such people to a psychiatrist. Many doctors dealing with the mentally ill do not call themselves psychiatrists. Even if they do use the word about themselves, it means no more than cardiologist or dermatologist. They see themselves as doctors - physicians - part of the body of medicine. When dealing with patients they wear a white coat and carry out physical examinations on nearly every occasion. They make a diagnosis - they give treatment - usually tranquilizers, but also other drugs. If necessary they give fatherly advice on better living.

It is possible that many Japanese psychiatrists may accept and welcome this position as it limits their responsibility and allows them to restrict their attention to organic materialistic problems and thus avoid facing the much more difficult problems posed by psychoneurosis or psychotherapy or social psychiatry which demand an emotional involvement and even a personal readjustment.

Leaders in the profession, especially those with an understanding of Western psychiatry and psychodynamics (as opposed to the brief impressions gained from a short visit without involvement) are anxious to attempt a true synthesis of traditional Japanese thinking and feeling and modern Western scientific knowledge.

They regard the position of psychiatry in Western countries with surprise and some envy. The status of psychiatry is particularly high in the United States where it is a proud and affluent profession. There is a general belief in the United States of America that scientific study of man and the mind yields valuable knowledge, understanding and methods for changing men and society. As a result, psychology, psychoanalysis and psychiatry are generally esteemed. Psychoanalysis is held to have illuminated the irrational aspects of human thinking and feeling and some knowledge and understanding of psychoanalysis is part of an educated person's intellectual equipment. In America, when people are psychologically troubled, they turn for help to psychotherapists, to psychoanalysists and to counsellors. They pay large sums

for this help. Psychoanalytic treatment is given by medically qualified psychoanalysts most of whom have also had a period of psychiatric training. Only a few medical specialists - such as gynaecologists and surgeons - may be in a higher income bracket than psychoanalysts. All doctors know about psychiatry, which is well taught in medical schools, in some schools on an equal footing with surgery, so that general doctors refer many patients to psychiatrists and psychoanalysts. Psychiatrists in the United States of America are proud of their profession and do not much regret that it sets them apart from the rest of medicine.

The position in Britain is about midway between the United States of America and Japan. The position of psychiatry within medicine and within society varies considerably in different developed societies. Each country must work out its own pattern and Japan is actively doing this at present. The pattern she evolves will determine the type of community mental health services she receives.

It appeared to the writer that psychiatry in Japan was seen as a specialty dealing with the severely mentally ill. Community mental health services were therefore seen as services for the schizophrenics, the epileptics, and the mentally retarded.

On the other hand, an observation was made that an increasing number of people with psychogenic reactions (depressive states, anxiety states) and psychoneurotic illnesses were coming openly to the University clinics and the writer was informed that amongst urban intellectuals, especially those in touch with Western ideas, there was an increasing demand for intensive psychotherapy or psychoanalysis for which they could not find qualified practitioners. It seemed therefore that public opinion in Japan was moving ahead of the doctors and that there was an increasing demand for help with emotional difficulties which was not being satisfied. It was interesting to hear and to observe that there has been a great increase in new religions offering help with personal problems.

4.6 Leaderhip in psychiatry

In his 1953 report Dr. Blain wrote eloquently about the problem of leadership in Japanese psychiatry .... "Where is the leadership located ...? Who is studying the adequacy of annual reports ...?" (p.15) and also "But just now there is not a single psychiatrist in the central office" (p.15). Dr. Lemkau commented, "A program this large (5 billion yen per year) would appear to require more than nine persons including but one psychiatrist for its central stimulation, consultation and to some extent, control".

Unfortunately there is not much change in the situation today although the cost is now 75 billion yen. A number of senior psychiatrists met were concerned about the future of the mental health services, but they did not hold the positions of central governmental power.

Dr. Blain commented that there was no psychiatrist in the Ministry. The writer was informed that amongst the doctors in the

Ministry of Health and Welfare there are now two psychiatrists. They are however both junior in the Ministry and their experience of psychiatry has been brief. There is no experienced psychiatrist in a senior position in the Ministry.

The problem of the professional leadership of governmental medical services, especially psychiatric, is not a unique one for Japan. In all countries governmental medical positions are largely filled by career officers, usually public health specialists, who have worked their way up the Ministry, while the leadership of the profession is taken by men who have concentrated on their specialties. There has to be some mechanism for bringing the two groups together.

In psychiatry there are further difficulties. This specialty cares for very large numbers of long-stay patients; administrative decisions about siting, staffing and organization of hospitals will often determine their chances of rehabilitation and set the pattern of services for decades. It is particularly important that the services should be guided by an experienced psychiatrist of standing in the profession. But such experience can only be acquired by years of working in psychiatry and psychiatric clinics and hospitals, not by working at Ministry desks.

In the United States of America the Commissioner for Mental Health is a senior officer in each State, with direct access to the Governor, and often a member of his Cabinet. The Governor selects and appoints him personally; he is always a senior psychiatrist, seldom a career official and often a man of professional distinction. In Britain one of the Deputy Chief Medical Officers of the Ministry of Health must be a psychiatrist, with the right of direct access to the Minister. He is a senior man and often a distinguished member of the profession. In recent years leading psychiatrists have been brought into the Ministry for three-year tours of duty.

The writer agrees with Dr. Daniel Blain's opinion expressed in 1953 that until there is better central psychiatric staffing, Japan's mental health services will not develop satisfactorily.

In Japan, Mental Health is one of the seven sections of the Bureau of Public Health, itself one of the ten Bureaus of the Ministry of Health and Welfare. This insignificant position is a measure of the importance given to mental health within the Ministry. This may have been a just assessment when the Ministry was organized just after the war, when the major problems were those of the infectious diseases, children's welfare and social services, but it does not reflect the present position.

Within every government and every department, certain activities decrease in activity, expenditure and importance while others increase. In all modern countries, for instance, departments for tuberculosis are shrinking while those for pharmaceuticals are increasing. Presumably the Government of Japan at times surveys its departments and recognizes them in accordance with up-to-date priorities. Such reassessments are always unpopular with the established members of the Ministry because they upset priorities and may even endanger individuals' prospects of

promotion. Nevertheless, it is the duty of those in charge to carry them out occasionally.

The National Institute of Mental Health remains in Ichikawa and does much excellent research work, as is shown by its publications and its international reputation. A number of valuable surveys - of patients, treatment facilities, numbers and quality of professional staff, etc., - have been carried out, and national training schemes have been organized. The budget has however remained limited and plans for expansion have, the writer is told, been repeatedly deferred on grounds of economy.

Advanced countries have learned that investment in research is essential for national progress. It is false economy to stint the budget of Japan's only national psychiatric research institute.

5. DISCUSSIONS

5.1 Mental hospital population trends

Certain trends in the population of the mental hospitals were noted. During the last fifteen years many new places in Japanese mental hospitals have been made available and filled with schizophrenics. In the hospitals visited there was already a tendency for a chronic population to accumulate. The number of patients who had stayed more than five years was increasing and most of these were people in early adult life aged 25 - 35. With a normal life span they may live another thirty years in the hospitals.

It appears that Japan is in grave danger of suffering the same experience as Europe. There schizophrenics were gathered into hospitals, cared for physically and locked up in idleness. They lived long lives and the inpatient population accumulated until the hospitals filled with vast numbers of idle, hopeless, "institutionalized" people. Only recently, by the rigorous application of social psychiatry, of active therapy and rehabilitation has this trend been reversed.

There is a need for surveys here. There should be a careful check of the population of the hospitals by age and date of admission to determine the buildup of the chronic population and to forecast future trends. This should be watched by regular checks.

5.2 Siting of institutions

There is a real danger that Japan will repeat certain other mistakes made in Europe. When asylums were first built in Western Europe and the Eastern United States of America, they were placed far out in the country because rural land was cheaper. At first they were

small institutions, places of hope and active treatment. Gradually fears over accidents led to increasing security measures; the patients regressed into apathy but were kept alive by good medical care so that they survived and numbers rose steadily; because of their distance from the town, rehabilitation and community relations were difficult. Travelling difficulties discouraged relatives from visiting the hospitals and patients from going to their homes; community contacts were lost. Gradually the asylums increased in size. It is false economy to build new institutions on cheap land far from the centres of population. Rehabilitation is most difficult and patients tend to become permanent residents. The institutions become steadily larger and the ultimate bill is much heavier. If a psychiatric unit is small and in the middle of town, contact is maintained with relatives, rehabilitation is easier, discharge of chronic patients is quicker. Though the initial cost of land may be higher, the institution remains small and gives far better value.

5.3 Control of mental hospitals

Many Japanese psychiatrists spoke to the writer about the problem of control of standards in mental hospitals. Japan now has over 800 mental hospitals, 80% founded since 1945. Thus most of the mental hospitals are new institutions where people - doctors, nurses, patients, are still working out a way of life. Some are doing this very well, but the writer has been informed that others are not. It was also learned that about one-third of the mental hospitals fall well below desirable standards of comfort, hygiene, and physical medical care, not to speak of specialized psychiatric care or social therapy, and that these problems are particularly bad where the medical director or his nurses are without previous psychiatric experience or where the proprietor, anxious for a return on his investment, is putting pressure on the medical staff to increase income by overcrowding the institutions.

At present, mental hospitals, like all hospitals, are inspected by the agents of the prefectural government. Amongst these is usually a doctor but seldom a psychiatrist. This team is probably sufficient to prevent hygienic dangers or gross overcrowding but they cannot assess the quality of the psychiatric care given.

There are special problems in controlling psychiatric institutions. Ordinary hospitals and nursing homes are liable to public scrutiny and scandal. The patients on their return home speak of what they have seen; their relatives visit and complain. Psychiatric patients are regarded as deluded and their complaints are often discounted; their relatives are often unwilling to disclose their connection with the mental hospital, or, happy that their troublesome relative is locked away, are not liable to ask too many questions. It is much easier for abuses to develop and multiply in psychiatric hospitals than in ordinary ones.

There is need therefore an improved control of standards in mental hospitals in Japan and also for the encouragement of better standards, especially in social psychiatry.

A possible solution would be a National Inspectorate of high calibre. Such a measure (The Board of Control) was found effective in Britain at the time when many institutions were being founded. The inspectors (Commissioners) were highly paid and included experienced psychiatrists - some the ablest psychiatric administrators in the country. They visited hospitals and wrote reports which, by law, had to be published locally. They could revoke the licence of a hospital or order the discharge of a patient or a staff member (including the medical superintendent). Though they were much feared, they also had a valuable educative effect in carrying information of new improvements from one area to another. They were finally disbanded in recent years after the Ministry of Health had taken over all the British hospitals (including all psychiatric hospitals), as other methods of control and inspection were developed, but there is already agitation for revival of some of their activities.

5.4 Elderly patients in mental hospitals

One notable difference between Japanese and Western mental hospitals is that they contain few elderly people. Only 4% of the mental hospital population are aged over 60 while in Britain the figure is about 50%. In British hospitals these old people are a great burden on the staff, requiring much time and attention from nurses and doctors, because they are incontinent, physically helpless, often crippled, and frequently physically ill as well as being psychotic. This burden is not at present felt in Japanese mental hospitals. Japanese psychiatrists tend to assert that this is because of the traditional Japanese family situation which supports, honours and loves the elderly person; thus, they say, fewer old people have psychiatric breakdowns, fewer go to psychiatrists and there are thus fewer in hospital.

There is probably some truth in this and it may be that the medical specialty of geriatrics - of the diseases of the elderly and their treatment - will develop differently in Japan from Western countries. At present the elderly do not form so large a proportion of the Japanese population as in Britain and the United States. This is presumably due to a high mortality in earlier generations and many deaths during the period 1944-1948. A similar population structure is seen in the Soviet Union, Poland, Yugoslavia, etc. As the proportion of elderly persons in the population increases while the country becomes increasingly industrial, and extended families less common, it seems likely that more elderly people will seek psychiatric help.

Careful cross-sectional studies of British hospital populations have however shown that most of the elderly persons who are such a burden were not admitted because of psychoses of senility. They were admitted many years earlier, in early and middle adult life, suffering from schizophrenic psychosis, and had grown old in hospital. Many of the present "geriatric problems" in British mental hospitals were admitted between 1920 and 1950. Such persons are not in Japanese hospitals now. If the present accumulation of chronic patients persists however and they are

kept alive by modern medical care, there will be a great increase in the number of sick old people in Japanese mental hospitals in the 1980's and 1990's. This may appear a remote matter, but it well become a matter of major concern unless action is taken soon.

5.5 Aftercare of the psychologically crippled

Although there are spasmodic unco-ordinated efforts in this field in Japan there is a need to realize the size of the problem, and the action needed.

There are a substantial number of people in Japan, as in other countries, who are psychologically crippled, people who cannot manage to live a full personal life, but easily retire into an institutional unproductive life, but who can, if supported by well staffed services, live a free life and make a substantial contribution to the national economy instead of being a useless drain on it.

This group includes many of the high grades of mental retardation - the patients with IQs between 30 and 70, the chronic schizophrenics with persisting thought disorder, and some epileptics. These people, with diverse medical histories are similar in their social disability. They cannot support themselves; they are unlikely to marry; they can work at a simple level but cannot undertake complex tasks, bear heavy responsibility nor relate satisfactorily to other workers. They are subject to periodical breakdown, when they need medical care and often hospitalization.

The easiest solution is to push these people into institutions, where they often settle for the rest of their lives. In this way the number of patients will increase - and the burden on the nation. During the 1950's in the United States of America there were up to 40 persons per 10 000 residents, unproductively and unhappily, in mental institutions.

In the old days these people were easily absorbed into the rural economy. Japan is now an increasingly industrial society. It is difficult but possible for these cripples to fit into urban society. They often make valuable factory employees, doing undemanding jobs. They require a framework of social support that is at the moment lacking in Japan. They require a continuing contact with a community worker. At present this is provided by the public nurses, or the social welfare officer, neither with psychiatric training. They need skilled job finding; at present this provides a haphazard basis by the Ministry of Labour. They require rapid access to psychiatric treatment. Some get this from the private mental hospitals they previously attended, but there is little evidence of a medical acceptance of the need to give these people long-term support over many years, probably for the rest of their lives.

Japan has successfully tackled the problems of the aftercare and the rehabilitation of the A-bomb victims and of the crippled

soldiers and repatriates. The mentally crippled are now emerging as the major rehabilitation challenge of the future.

5.6 Psychotherapy and psychoanalysis

Under the heading "Community mental health services" in Britain and the United States of America are included the services for the emotionally disordered. Amongst these the provision of counselling, of psychotherapy and of psychoanalysis has high priority. All psychiatric outpatient clinics set aside a good deal of professional time for psychotherapy. There is an unsatisfied public demand for psychoanalytic psychotherapy.

It was therefore interesting to learn that not much time was given to psychotherapy in Japan. Many psychiatrists were ill informed about psychoanalysis and justified this by complacent statements that "psychoanalysis does not apply to Japanese people". Psychiatric training programmes at University hospitals, while including much instruction on neuroanatomy, neuropathology, brain biochemistry and phenomenology, had very little instruction on psychotherapy, on psychoanalysis or social psychiatry. The better trained psychiatrists had read some of the works of Freud and knew of the importance of psychoanalysis in American psychiatry but had also convinced themselves that this had little direct application to their work.

Further enquiry showed that there were a few psychoanalysts practising, with difficulty, in Japan and that there was a developing demand from educated persons for this type of help. Further enquiries as to where emotionally disturbed persons found help elicited different replies. Some were treated by medication and supportive psychotherapy at University psychiatric clinics, some were treated by internists and physicians, by medication, hydrotherapy, hot spring trips, etc. Many apparently feel rebuffed by the lack of medical interest and turn to religion, especially the new religions such as Risshokoseikai and Sokagakkai who offer them relief from their nervous anxieties and difficulties.

There are many emotionally disturbed people in Japan - as there are in all countries in the world. Some of this emotional disturbance is forced by the Japanese culture into particular channels (witness the suicide rate in Japan, still for women one of the highest in the world) and some may be contained by the special gratifications which offset the peculiar stresses of the Japanese way of life. It seems doubtful whether they will continue to be sufficient.

Japan is an industrial country and largely an urban one; the traditional way of life is modifying fast; the three-generation family giving way to the two-generation, the role of women is changing and the vast population of young adults see themselves as part of the moving youth of the world. Similar changes are occurring in many other advanced countries. In all of them traditional methods of dealing with emotional stress are proving inadequate; the distressed modern urban man (and woman) standing alone in an industrial society, desires personal help

and counselling. The writer considers that the demand for this in Japan will rise steadily. Even though many distressed Japanese go to the new religions, a number will demand the help regarded as the most valuable by the most advanced societies in the world, namely: professional counselling, psychotherapy and psychoanalysis and Japanese psychiatrists may be forced, however reluctantly, to provide this. They are not at the moment ready for this challenge. If adequate facilities are to be provided for the emotionally disordered then services will have to change greatly; outpatient clinics will have to expand, psychiatric training will have to include adequate psychotherapeutic training and ultimately even the undergraduate medical curriculum will have to alter.

5.7 Mental hygiene movements

The Japanese Government, in seeking advice on community mental health services, were apparently concerned why their programme of community mental health had not prospered to date. The writer, in his enquiries, has also been attempting to understand this. One immediate difference between the position in Japan and that in Britain and the United States of America was the very slight development of any lay organization devoted to mental health. He has been told that this is due to fundamental differences in the social structures of the countries.

In Britain and the United States of America nearly all social developments - services, institutions, new laws, etc., are preceded by years, often decades, of propaganda, discussion, and experiment by interested, active lay organizations. These people stimulated the tardy professionals, gathered like-minded concerned persons into associations, and as pressure groups influenced the politicians to change the laws, to provide services, and build institutions, etc.

During the last twenty years, in Britain, the National Association for Mental Health was active in the agitation for a change of the Mental Health Laws which culminated in the Mental Health Act, 1959; it ran the pioneer Junior Training Centres, Hospitals for the Mentally Retarded, training courses for the supervisors of sheltered workshops, and Halfway Houses for the mentally ill. It also holds a major National Congress every year which is attended by Royalty and leading politicians.

Lay organizations are also active in public education, by lectures and newspaper articles, by films and programmes on the national television, by local fetes, bazaars, and charity shows, to inform ordinary people about the needs of the mentally ill and retarded and to arouse their active interest. From such work have arisen the "Friends of the Hospital" groups, the volunteer workers within hospitals, and many other groups who both give active support to mental health institutions and the mentally crippled and also do much to help the professionals.

There are few such organizations in Japan, especially when contrasted with the other pressure groups, such as those for atomic bomb victims, for war veterans or for professional groups such as social workers. Their absence is both a result and a cause of the

general ignorance, fear and prejudice about mental illness and mental institutions. It perhaps accounts for the lack of public education programmes to help people understand mental illness and to dispel some of the prejudices toward it. Without such an educational programme community mental health services will develop very slowly.

5.8 Social psychiatry

One reason why community mental health services are not flourishing in Japan is that many Japanese psychiatrists do not understand social psychiatry. Some aspects of modern psychiatry are well understood and applied in Japan - diagnostic psychiatry, psychopharmacology, electroencephalography, genetic studies. Other forms are understood, but not applied, such as psychopathology and psychoanalysis. Social psychiatry is neither understood nor applied.

Comparative epidemiology or cross cultural psychiatry are quite well understood in Japan and have been applied in some interesting studies. "Social Psychiatry" is the method which has developed, especially in Britain, in the last twenty years, of seeing the patient and his illness within its social context. This applies to the diagnosis of the patient's illness, and also to its treatment. It was essentially a new dimension, a new way of looking at what happens when a patient comes to a doctor with a psychological complaint. The psychiatrist no longer looks only at what is going on inside the patient. He looks at the total situation - not only the patient's surroundings, his family, his work, his social class, but also at the psychiatrist himself - his feelings, his reactions, his preconceptions - and medical setting in which the confrontation occurs, and its place in the total framework of society.

In developing this viewpoint, psychiatrists drew on the developing writings of the social scientists, in particular the dynamically informed social scientists and sociologists. Psychiatrists learned a great deal and changed their practice so that the last twenty years have been fruitful applications of this work.

Social psychiatry has changed the practice of British psychiatry markedly and it is from this background that the community mental health services have developed. Many of these principles were set out in the Third Report of the Expert Committee on Mental Health of the World Health Organization in 1953. The application of their recommendations has brought great benefits to British mental health services.

Within the mental hospitals there has been a revolution, as the role of the patients has been reassessed and the social organization of the hospital restructured with a focus on patient rehabilitation rather than the preservation of the hierarchy of professional privilege. From this has come the Open Door Policy, Industrial Therapy and Halfway Houses.

The rehabilitation of so many patients and the realization of the part played by adverse social factors in precipitating further breakdowns lead to a great development of psychiatric services outside of hospital - the Community Mental Health Programme with sheltered workshops, Hostels, Day Care Centres, and Therapeutic Social Clubs, also a great extension of the work of the social workers.

Allied with this was a much greater deliberate involvement of psychiatrists in the lay organized mental hygiene movement in Britain which has come to wield a powerful political pressure on Government. These lay groups have also formed the volunteers who are now making an active contribution to the Mental Health Service in organizations like the Samaritans (Suicide Prevention Society).

The Therapeutic Community method of treatment also emerged from the social psychiatric approach. In this method all persons in a small institution - patients, nurses, doctors and all staff - engaged in mutual egalitarian social exploration in face to face meetings. It was developed for psychopathic personalities but has now been applied successfully to all classes of psychiatric patients. The main techniques are regular community meetings followed by staff reviews, intensive social analysis of all significant happenings, free communication, role analysis and blurring, and the provision of opportunities for role playing and reality testing. The underlying principles are permissiveness, egalitarianism, democratization, decision by consensus and peer group social control. This method is intensive and makes great demands on all, especially staff. They have to acquire effective skill in communication in groups, psychotherapeutic insight and personal flexibility and have to be prepared to relinquish many of their professional defensive reaction formations.

Finally the effect of this approach and all these studies on the life of the ordinary working psychiatrist was marked. English psychiatrists now work in hospitals, in outpatient clinics and in the community. Within the hospital they work as team members with nurses and other staff in arranging the patients' environment. In outpatient clinics they work very closely with social workers on whose reports and activities they rely greatly. In the community they frequently visit patients' homes and consult often with the family doctors, the community social workers and the public health nurses. The psychiatrist is still the expert in diagnosis and in some forms of treatment - drug treatment, physical treatment and psychotherapy, but in much of the investigation and in a great deal of the treatment he is a member of a team in which one of the other members - the nurse, the social worker, the general practitioner, the family member or another patient - may be the most active member.

Although only a limited number of British psychiatrists call themselves "Social Psychiatrists" this viewpoint has permeated British practice widely. As a result most psychiatrists accept some involvement in community activities as a proper part of their professional work.

In his visits and talks in Japan the writer found these ideas little known and less understood. A few pioneers had been propounding

them for years, often against opposition and even to their own professional disadvantage. A number of Japanese psychiatrists had read the works of Maxwell Jones, but very few indeed had made any attempt to apply them. There is no doubt that one of the many reasons for the slow development of the community mental health services (as well as the lack of activity and freedom in the mental hospitals) is due to lack of understanding of the modern principles of social psychiatry amongst Japanese psychiatrists.

6. RECOMMENDATIONS

6.1 Government

It is recommended that the Government of Japan consider very seriously the present organization of their mental health services. The writer was asked to advise because it was felt that community mental health services were not developing satisfactorily. His studies indicate an alarming situation, in which the number of persons remaining as long term residents in psychiatric hospitals is rising steadily, and is likely to continue to rise, placing an increasing burden on the Japanese economy.

A number of areas requiring attention have been indicated but it is considered that the question of central management of psychiatry is very important. In this area there has been little change since Dr. Blain's report of 1953.

It is therefore recommended that:

6.1.1 Mental health should be a Bureau on its own equal with public health, child welfare and the other departments.

6.1.2 The Ministry should apply itself to staffing. It should recruit able, well trained young psychiatrists, as a long term plan. In the short term it should explore the possibility of some form of secondment or special hiring by which outstanding professional men (such as retired professors) might be induced to come in to guide the new Bureau.

6.1.3 The work of the National Institute of Mental Health be strengthened and extended, that its budget be increased, and that more clinical facilities within Konodai Hospital be allocated to the Institute for research and teaching purposes.

6.2 Improvement of mental hospitals

Japan is accumulating large numbers of schizophrenic persons as inpatients in her many mental hospitals; they are slipping into

institutionalized apathy, and are becoming an increasing burden on the national economy. There is considerable experience available in Britain, Europe and the Union of Soviet Socialist Republics about the treatment of such people by Social Therapy, Work Therapy and the Therapeutic Community Method. The Ministry of Health and Welfare should take active steps to make this knowledge available to mental hospital staff and to encourage active treatment and rehabilitation to prevent a steady rise in hospital inpatient population. The following methods are suggested.

6.2.1 Lectures in Japan. During visits the writer gave a number of illustrated lectures on Social Psychiatry and the changes at one British hospital, which appeared to stimulate interest. Further lectures by Japanese or foreign speakers could be arranged for all grades of staff.

6.2.2 Refresher courses held centrally at selected hospital staff with lectures from persons at present in Japan and films and information about European practice could be organized by the National Institute of Mental Health.

6.2.3 Fellowships for promising hospital administrators to study overseas. Long-term fellowships for attachment to the practice of institutions carrying on active therapeutic community work are recommended. These attachments should last a year and would entail active work with patients and direct involvement in social psychiatry. These could only be open to persons speaking fluently the language of the country visited. The World Health Organization, the British Council and other official bodies might be prepared to help with finances and arrangements. Short fellowships or brief tours should be discouraged as they are of very limited value.

6.2.4 Better exchange of information about good programmes in Japan.

It was surprising how little hospitals knew of good work elsewhere. The Ministry should encourage inspection visits, professional open days and conferences at outstanding programmes. The following programmes should be more widely known:

(1) Musashi Hospital - Patient's work and occupation programme. Very wide range of activities.

(2) Hatseiso Hospital - Drama therapy and self-government programme.

(3) Shironishi Hospital - Very good public relations; night hostel.

(4) Moriyama Hospital - Industrial therapy (animal breeding for laboratories).

(5) Takachaya Hospital - Rehabilitation programme. Patients handle money and go out to sheltered workshops in town.

(6) Chichibu Institution - Teaching of mentally retarded of very low IQ.

(7) Sunagawa Rehabilitation Centre - Very good rehabilitation and placement in sheltered occupation.

6.3 Control of mental hospitals

The Ministry of Health and Welfare should consider the establishment of a National Inspectorate of Mental Hospitals to improve standards of care for the mentally ill. A new law would be required. Such an Inspectorate should consist of full-time highly paid psychiatrists and other specialists (teachers, social workers, nurses). They should be charged with visiting every mental hospital in Japan at least once a year and writing a full report on each hospital, for publication with recommendations for action. The new law should give the government power to revoke the licence of any mental hospital on the recommendations of the inspectors.

For Inspectors to visit a hospital, examine it, travel back to Tokyo and write a report would take three - four days. To cover 1000 hospitals in one year would require at least twenty inspectors.

Although the Inspectors would of course be concerned with physical standards, overcrowding, hygiene, and feeding, their main concern should be the raising of standards of psychiatric care, the provision of workshops, night hospitals, outpatient clinics, follow-up services, etc. They should also enquire into the numbers, training and quality of staff and encourage arrangements for their education.

6.4 Health insurance system

The Ministry of Health and Welfare should concern itself with the effects of the pattern of insurance payments on medical practice. The present pattern - as indicated - is positively encouraging the accumulation of patients in hospital and discouraging the development of outpatient services. This will have the effect of burdening Japan with large numbers of long-term inpatients. The Ministry should therefore press for changes in the pattern of payment. Such changes can of course only be hammered out by compromise with the interested parties, but the Ministry should press for the following principles.

The reward for outpatient work should be higher than at present so that doctors have a positive incentive to arrange outpatient rather than inpatient treatment when the condition of the patient permits it.

The payments for psychiatric patients unable to work and living at home should be higher than at present so that the families will be encouraged to take the patients home. It is cheaper for society (as well as better for the convalescent patient) to persuade his relatives to look after him at home than to maintain him in a hospital.

Psychotherapy should be recognized as a specialized form of treatment requiring time - half to one hour per session - and highly trained psychiatric skill. The payment should be at least as high as that given to a surgeon for outpatient surgery, and preferably higher.

6.5 After care

6.5.1 There is a great need for outpatient clinics staffed by psychiatrists and community workers providing treatment (i.e. medication and psychotherapy), long-term follow up, and social support for schizophrenics living in the community. This could be provided at public health centres and, in big cities, community mental health centres provided that they have adequate staff who are encouraged to undertake treatment. University clinics should be encouraged (by money and support) to set aside staff time for special follow up clinics. Private mental hospitals should be encouraged (by altered insurance payments) to provide far more extensive outpatient facilities for their discharged patients.

6.5.2 Community workers - social workers and public health nurses - require training in psychiatry. Some of them have never had any instruction. The Ministry should encourage bodies such as University departments to arrange refresher courses and should pay workers for attending these.

6.5.3 There is a great need for specialized community facilities which have been shown to be of value.

(1) Night hospitals. These have been developed at a few hospitals in Japan. Patients go out to work by day in the town and return to lodge in the hospital at night. This should be encouraged.

(2) Halfway houses and hostels are the logical extension of this principle - buildings away from the institutions, within the towns and cities - where retarded boys or chronic schizophrenics can live while working. Such hostels require trained social work staff.

(3) Day hospitals are facilities for the treatment of patients who spend the night with their families. They can provide active treatment for adult psychotics, and occupation and training for chronic or elderly patients. They require able and adequate staff - doctors, nurses, social workers and occupational therapists - but they save on bed costs.

(4) Sheltered workshops have proved most valuable in supporting psychologically crippled individuals. They require the co-operation of local industry, supervisors with craft skills and experience of managing disturbed persons and administrators with the energy to find satisfactory contracts and social workers. Such sheltered workshops have been developed in England by hospitals, by local authorities, by voluntary

societies and by a government sponsored limited Company. The Ministry of Health and Welfare, Mental Health and Child Welfare Sections, should explore which method of development is best suited to Japan.

(5) Therapeutic social clubs have proved of considerable value for various groups of psychologically crippled persons in marginal balance in the community. Operated by social workers with support from psychiatrists, they provide a regular social centre where the clients can come regularly, for social recreation or for professional support according to their need.

It is proposed that the time is appropriate to consider revision of the Article of the Mental Health Law of 1950 prohibiting the treatment of mental patients in private homes. In 1950 it was a necessary reform, but now, eighteen years later, patients with acute mental illness go to hospital. The law however prevents quiet convalescent patients being boarded out.

6.6 Rehabilitation

The Ministry of Health and Welfare should consult with the Ministry of Labour to draft new laws for the care, support and rehabilitation of the psychologically crippled. The present obvious needs are:

6.6.1 Designation and training of specialized Labour Department officers as specialists in rehabilitation, charged with maintaining registers of psychologically disabled persons, employers who will be willing to give them work, and current vacancies.

6.6.2 The establishment of sheltered workshops in the community for schizophrenics, epileptics and mentally retarded persons.

6.6.3 The development of a government-sponsored organization, comparable with Remploy (England) to set up sheltered workshops, to arrange supplies and to market their products. Such an organization requires industrialists on its board and a charter which accepts that it will not make profits and may incur losses.

6.6.4 The present Labour Laws relating to mental illness should be reviewed and where necessary revised.

6.7 Professional training

There is need to improve professional training. Though this must ultimately depend on the professions themselves, the Ministry of Health and Welfare should assist in pressing for such developments.

6.7.1 Psychiatrist

There is no nationally recognized qualification as a psychiatrist. The degree of Doctor of Medical Science in Psychiatry is held by only a limited number of physicians; it is primarily a research qualification and is not necessarily a measure of a doctor's ability to treat psychiatric patients, or to practise social psychiatry. Any licenced doctor can open up a mental hospital. The Ministry of Health and Welfare and Japan Society of Neurology and Psychiatry should examine this problem. Some nationally recognized qualification, like the Diploma in Psychological Medicine (Britain) or the Board Examination in Neurology and Psychiatry (United States of America) would do much to establish and raise standards.

6.7.2 Psychotherapy

There is great need for better training of doctors and psychiatrists in psychotherapy. Only a few University Hospitals provide this at present. It is to be hoped that an Institute for Psychotherapy will soon develop in Tokyo. This should receive active encouragement.

6.7.3 Nursing

There is a need for a qualification in psychiatric nursing in Japan. This could be a diploma course. It should be open to nurses (especially men) of long experience. Promotion to ward charge nurse - or certainly to Nursing Director - of a mental hospital would depend on holding the diploma. The diploma could be based on experience (say, two years psychiatric nursing), in-service training (lectures in psychiatry, psychology, applied social science, work therapy, etc.) and an examination. The Universities should explore the possibility of setting up such a training with the Japan Society of Mental Hospitals and appropriate University Departments.

6.7.4 Occupational therapy

The School of Occupational Therapy has recently been opened and is turning out graduates, but not enough. The Ministry should encourage the opening of more schools and arrange refresher courses for the many experienced but unqualified occupational therapists.

6.7.5 Social work

Present developments are sound, but should be accelerated. Funds should be provided to extend the courses at present organized at the National Institute of Mental Health.

7. ACKNOWLEDGEMENT

The writer should like to record his gratitude to Dr. Kato and his colleagues at the Institute and at the Ministry of Health and Welfare for the care and concern they showed to organize his visits and to smooth the necessarily complex arrangements required.

DISTRIBUTION

Government:

The Minister of Health and Welfare
Ministry of Health and Welfare
Japanese Government
Tokyo, Japan

The Minister for Foreign Affairs
Attention: The Chief
Specialized Agencies Section
United Nations Bureau
Ministry of Foreign Affairs
Tokyo, Japan

The Chief Liaison Officer
International Affairs
Ministry of Health and Welfare
Tokyo, Japan

The Second Secretary
The Embassy of Japan
Manila

WHO Representative:

The WHO Representative
Taipei, Taiwan

WHO/HQ:

Registry (6)
MH/HQ
TP/HQ
LR/HQ

WHO/WPRO:

RD
DHS
ADHSs
STAT
PIO
LRO (9)
A copy for circulation to RAs
Registry

Others:

Officer-in-Charge
United Nations Development
Programme in Japan
Tokyo, Japan

Dr. D.H. Clark
Physician Superintendent
Fulbourn Hospital
Cambridge, England