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JAPANESE MENTAL HEALTH CARE IN HISTORICAL CONTEXT: WHY DID JAPAN BECOME A COUNTRY WITH SO MANY PSYCHIATRIC CARE BEDS?

Tomoko Kanata

Mental health care has been shifting from psychiatric institutions towards community-based settings for the last 40 years in most countries. However, Japan still has a very high ratio of psychiatric care beds per capita, and the average length of stay in psychiatric institutions is nearly 300 days. By examining the history of Japanese mental health care, this paper analyses the reasons why it has been heavily dependent on hospital-based care, and why Japan still relies on it to this day. The roles of psychiatric social workers, who promote the rehabilitation of people with mental disorders, is also presented in the conclusion

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Before the war, people with mental disorders used to live in their communities. In those days, they were seen as part of life in Japan. It could be said that the people of Japan were liberal and treated people with mental disorders with dignity. However, after the war, most of these people just disappeared, because they were admitted to mental hospitals by national policy (Ishikawa, 1990).

INTRODUCTION

For the last 40 years mental health care has shifted from hospital-based settings to community-based ones in most countries. As a result the number of psychiatric care beds has fallen considerably internationally (Glasby & Tew, 2015:106). More and more people with mental disorders are living and being cared for in the community. In contrast, Japan still has a very high ratio of psychiatric care beds per capita among member countries of the Organisation for Economic Co-operation and Development (OECD), with 269 beds per 100,000 population compared to the average of 68 (OECD, 2014:11). The United Nations (UN) clearly indicates in the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care that every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives (United Nations, 1991). The Japanese government has instituted numerous mental health policies and laws for over 20 years, aiming at a more community-oriented mental health care system; however, the progress has been very slow and more than 300,000 psychiatric patients are still receiving care in hospitals (Mental Health and Welfare White Paper, 2014). Why can they not be discharged from mental hospitals in Japan? Why does Japan have so many psychiatric care beds and so many psychiatric inpatients? Of course, these questions are interrelated.

This paper will examine the history of mental health care in Japan and analyse the reasons why Japan has so many mental hospitals and still depends heavily on hospital-based care. First, this article will briefly present the current situation of hospitalisation of people with mental disorders in Japan. This will be followed by a discussion of the development of mental health care based on government policies and laws related to mental health, since it is assumed that the present problems were historically constructed. Then the cause for Japan's reliance on hospital-centred mental health care will be examined from a historical perspective. Finally, conclusions will be drawn which will include recommendations for psychiatric social workers to address the promotion of discharging people with mental disorders.

SITUATION OF PSYCHIATRIC HOSPITALISATION IN JAPAN

Japan consists of four main and many small islands with a combined area of approximately 378,000 square kilometres (Statistic Bureau Ministry of Internal Affairs and Communication Japan, 2015), which is only 31% the size of South Africa. The Japanese population in 2014 numbered 127 million people and was ranked tenth largest in the world (Statistic Bureau Ministry of Internal Affairs and Communication Japan, 2015).

TABLE 1
THE NUMBER OF PERSONS WITH DISABILITIES (ESTIMATE)
(UNITS: 10,000 PERSONS)

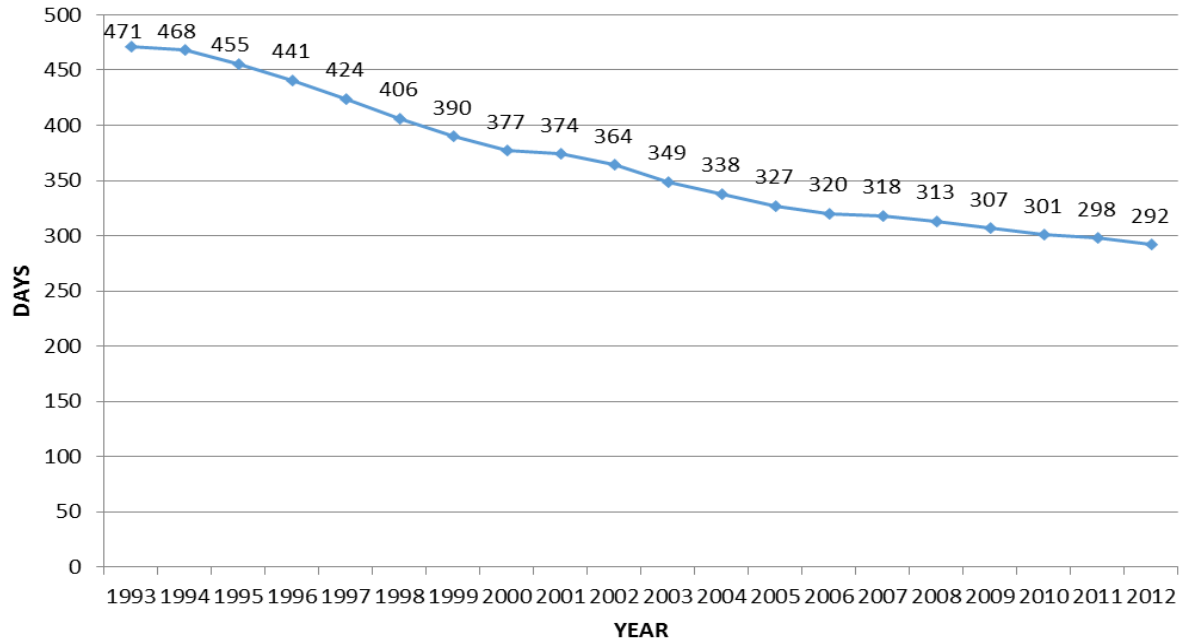
Type of Disabilities	Total	At home	Institutionalised
Persons/Children with Physical Disabilities	393.7 (50 %)	386.4 (98%)	7.3 (2%)
Children and Persons with Intellectual Disabilities	74.1 (9%)	62.2 (84%)	11.9 (16%)
Persons with Mental Disorders	320.1 (41%)	287.8 (90%)	32.3 (10%)

Source: Cabinet Office, Government of Japan. 2015.

Table 1 shows the approximate number of persons with disabilities in Japan and is divided into three categories: physical disabilities, intellectual disabilities and mental disorders (Cabinet Office, 2015). The number of persons with mental disorders is 3.2 million, which accounts for 41% of all disabilities in Japan. About 10% of this total are inpatients who live in mental hospitals or general hospitals with psychiatric care beds.

Of all the psychiatric inpatients, 57.4% are diagnosed with schizophrenia, 22.6% have organic mental disorders, 8.6% have mood disorders, 4.5% have mental and behavioural disorders as a result of psychoactive substance use, 1.7% have neuroses, and 5.2% are categorised as "others" (Ministry of Health, Labour and Welfare, 2012a:8). With respect to the age of inpatients, the majority of them are aged 40 years and over. The breakdown is that 40.1% are between 40 and 64 years old, and 51.5% are 65 years and over (Ministry of Health, Labour and Welfare, 2012a:8). The percentage of inpatients aged 65 and over increased considerably from 19.6% in 1988 to 49.6% in 2010 (Department of Mental Health Policy and Evaluation, 2011). Over 20,000 patients die in mental hospitals every year because of the increase in the aging population in Japan (Furuya, 2015b:21).

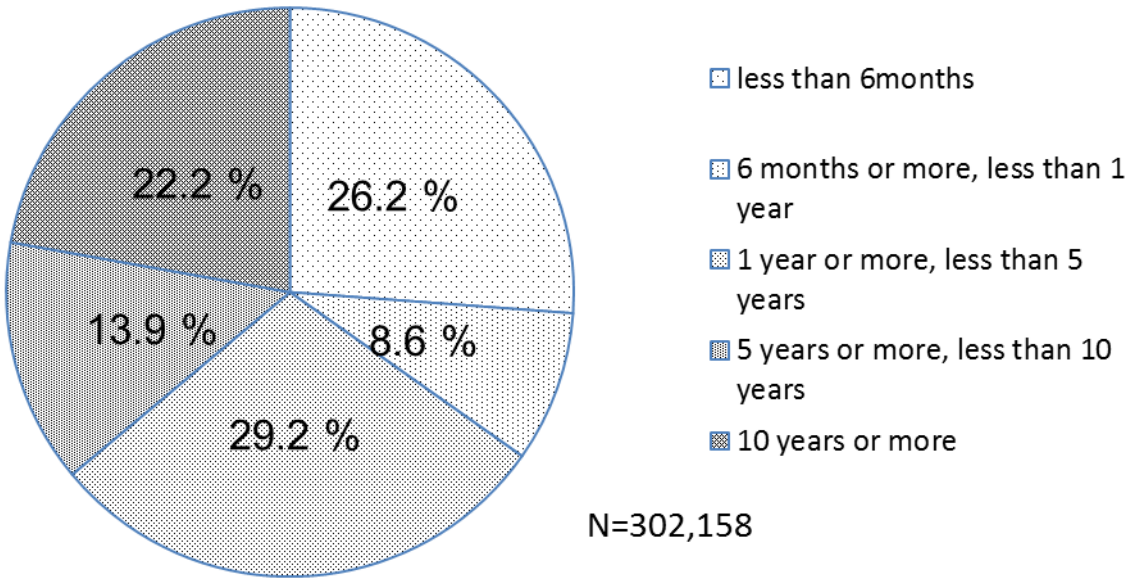
FIGURE 1
TRENDS IN AVERAGE LENGTH OF STAY IN PSYCHIATRIC CARE BEDS IN JAPAN



Source: Cabinet Office, Government of Japan (2013).

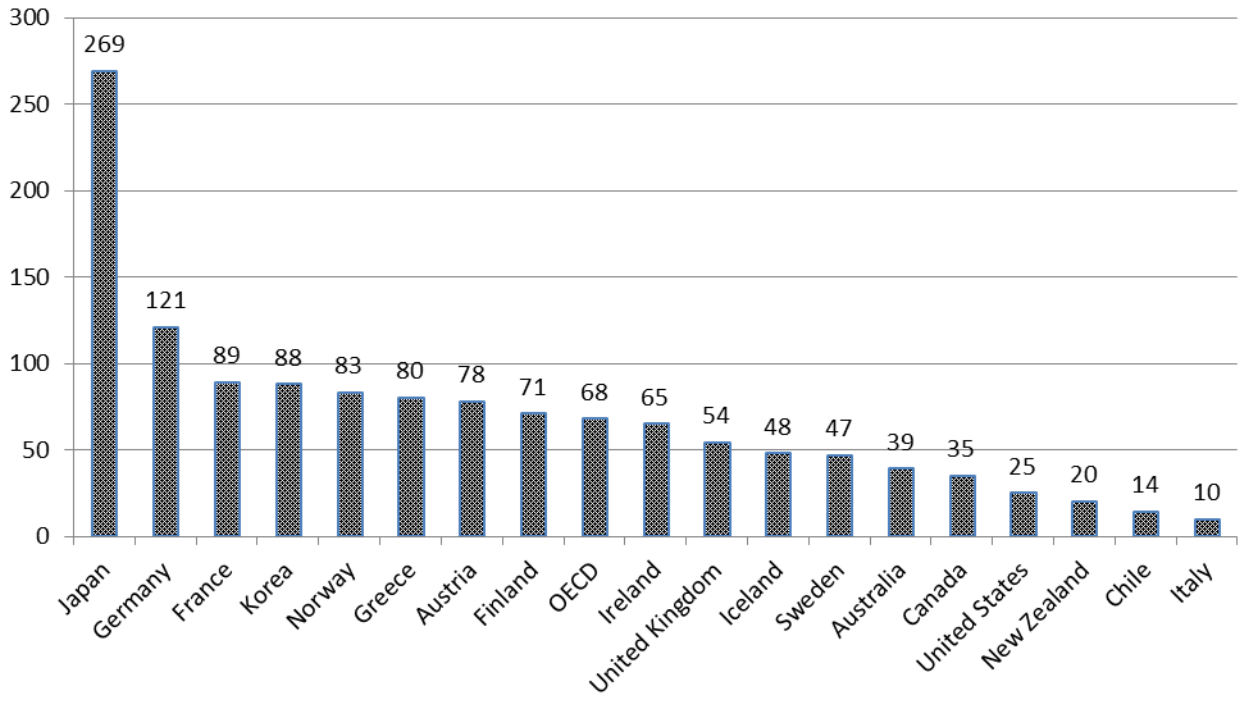
The average length of stay in psychiatric care beds declined steadily from 471 days in 1993 to 292 days in 2012 as illustrated in Figure 1. In terms of the distribution of the number of inpatients by their length of stay (Figure 2), 22.2% stay in hospitals for more than 10 years. Patients hospitalised for five years or more account for 36.1% of all inpatients. About a half of those hospitalised for more than five years are 65 years old and over (Ministry of Health, Labour and Welfare, 2012a:15). Eighty-eight per cent (88%) of newly admitted patients are discharged within one year. Roughly 200,000 people, who account for two thirds of all inpatients, are hospitalised for one year or more, and of this group 50,000 people are discharged every year. However, at the same time another 50,000 inpatients move from the less-than-one-year admission group into this one year or more group, like a game of cat and mouse (Ministry of Health, Labour and Welfare, 2013).

FIGURE 2
PERCENTAGE DISTRIBUTION OF THE NUMBER OF INPATIENTS BY LENGTH OF STAY



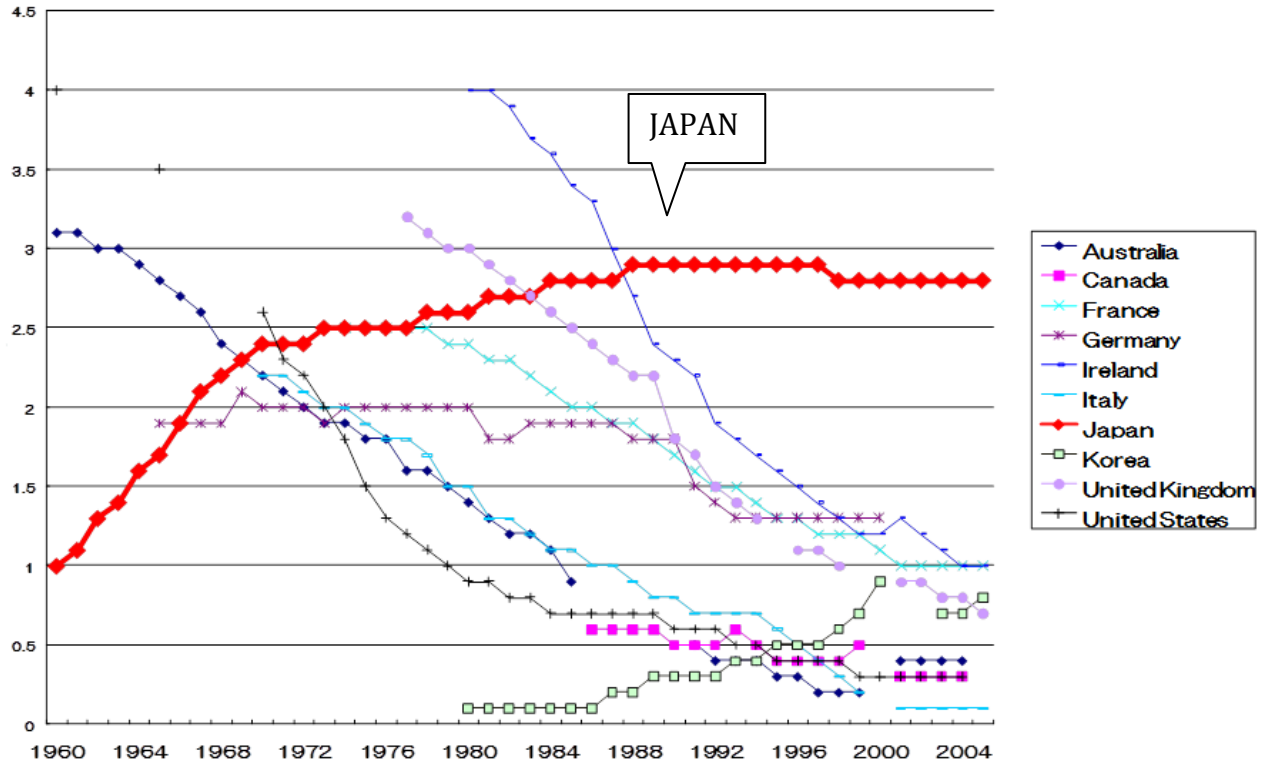
Source: Prepared by author based on Ministry of Health, Labour and Welfare (2012a:15).

FIGURE 3
PSYCHIATRIC CARE BEDS PER 100,000 POPULATION



Source: Modified from OECD (2014:112).

FIGURE 4
TRENDS IN PSYCHIATRIC CARE BEDS PER 1000 POPULATION, 1960-2004



Source: Ministry of Health, Labour and Welfare (2012b).

Japanese mental health care still remains predominantly hospital-based compared to other OECD countries. As shown in Figure 3, Japan has the highest number of psychiatric care beds per 100,000 population, which means a higher reliance on hospital care than any other OECD country. According to Figure 4, most of the OECD countries started to decrease the number of psychiatric care beds from the 1960s to the 1980s because of the movement towards normalisation and the development of antipsychotic drugs. In contrast, Japan moved in the completely opposite direction and increased the number of psychiatric care beds between the 1960s and 1990s. Why did this happen? The history of mental health care was studied chronologically to find the clues.

HISTORICAL DEVELOPMENT OF MENTAL HEALTH CARE

The following discussion describes mental health care in modern Japan, identifying three periods: the period of the private confinement (1900-1944), the period of the rise of mental hospitals (1945-1986), and the period of the human rights and social rehabilitation (1987-2014).

Locking up people with mental illness at home: 1900-1944

Japan moved from the age of feudalism and entered one of full-scale modernisation in the Meiji Period (1868-1912). The government promoted a policy of encouraging new industries (*shokusan-kougyo*), which accelerated modernisation aiming at making the nation a rich and powerful country in order to compete with Western countries.

During this period the first law concerning people with mental illness in Japan, the Law for the Custody for Insane People of 1900, was enacted. There were still few mental hospitals in Japan; therefore it was necessary for the government to introduce a legal system that managed people with mental illness. The main feature of the law was to sanction the private confinement of individuals under the supervision of the police. Those who were considered to be harmful to the public were locked up in so-called *zashiki-rou* (a cell floored with tatami mats for confining people with mental illness), and their family members or relatives were responsible for monitoring them. The purpose of this law was to maintain social peace and order by excluding people with mental illness from society, and advantage was taken of the family system because of the lack of psychiatric care beds. According to a survey in 1909, the number of people with mental illness was estimated to be 25,000, but there were only 2,500 psychiatric care beds available (Taiyoubijutsu, 2011:21). Approximately 3,000 people were left in *zashiki-rou* under unhealthy conditions and without any medical care (Taiyoubijutsu, 2011:21).

In response to this situation, Shuzo Kure, professor of psychiatry at the University of Tokyo, investigated the state of *zashiki-rou* from 1910 to 1916 with his staff. He was a pioneer in modern psychiatry and had studied in Austria and Germany from 1897 to 1901. There he experienced a humanitarian method of treatment for mental patients called moral therapy, which focused on a patient's social, individual, and occupational needs without chaining or locking them up (Omata, 2000:173-174). As a psychiatrist who had learned about such humane treatment abroad, he was shocked to find Japanese mental patients locked in *zashiki-rou* and consequently published a report in 1918 called "The State of Private Confinement and Statistical Observation of Insane People". In this report he famously wrote: "Hundreds of thousands of mental patients in our country not only have to suffer the misfortune that brought this illness, but they also have to suffer the misfortune of being born in this country" (Kure & Kashida, 2002:334). He made crucial recommendations in it as well. First, facilities for the mentally ill should be prepared; secondly, laws related to mental illness should be amended; thirdly, knowledge about mental illness should be conveyed to the public; and fourthly, psychiatric knowledge should be taught to the people who treat or care the mentally ill (Kure & Kashida, 2002).

Following the publication of his report, the Mental Hospital Law was enacted in 1919, which required that public mental hospitals be built in each prefecture. However, the financial difficulties plaguing post-First World War Japan and the period leading up to Second World War made it impossible to realise this goal (Setoya, 2012).

The rise of mental hospitals: 1945-1986

After being defeated in the Second World War in 1945, Japan was placed under the control of General Headquarters (GHQ) and the Supreme Commander of the Allied Powers (SCAP), and was given the responsibility to build a social welfare system. In response the Japanese government passed three fundamental welfare acts from 1947 to 1950: the Child Welfare Act in 1947, the Act on Welfare of Physically Disabled Persons in 1949, and the Public Assistance Act in 1950. These laws were drawn up to alleviate the scars left by the war on society by providing relief for the war disabled, war orphans

and the poor. In the 1960s Japan experienced economic growth and faced new types of problems arising from rapid economic and social changes. An additional three welfare acts were passed: the Act for the Welfare of Persons with Intellectual Disabilities in 1960, the Act on Social Welfare Services for Elderly in 1963, and the Act for the Welfare of Mothers with Dependents and Widows in 1964. Thus, the Japanese social welfare system, which is comprised of six pieces of legislation referred to as "*shakai fukushi roppou"*, was established.

At the time people with mental disorders were not regarded as the subjects of social welfare services but of medical care services. The government introduced a new medical care law as well. The Mental Hygiene Law was enacted in 1950 and it prescribed medical care and the protection of people with mental disorders. At the same time, both the Law for the Custody for Insane People and the Mental Hospital Law were abolished. The main features of the Mental Hygiene Law were as follows:

- mental hospitals should be established by prefectural governments;
- private confinement should be abolished within one year;
- involuntary hospitalisation of people with mental illness is permitted by administrative order or proxy consent of a legally responsible person;
- in addition to mental illness, psychopathy and mental retardation are also included as objects of the law.

This law allowed involuntary hospitalisation under the auspices of medical care and protection, which led to the dominance of hospital care in the field of psychiatry.

The abolition of the practice of *zashiki-rou* created an urgent need for accommodation of people with mental illness. Because of the financial deficits of prefectural governments, it was necessary to depend on private hospitals in order to realise the establishment of mental hospitals which would institutionalise people with mental disorders (Sakuragi, 2015:160). Under the Mental Hygiene Law, the prefectural governments could substitute private hospitals for public hospitals as appointed hospitals and give a subsidy. The Japanese Association of Psychiatric Hospitals (JAPH) was established in 1949, one year before the law was enacted. The enactment of the law and the establishment of JAPH were pushed forward at the same time. Actually, the draft of the Mental Hygiene Law was compiled by a few members of JAPH (Sakuragi, 2015:160), which highlights the good relationship between the government and the mental hospital industry.

The Japanese government implemented measures to ensure that private mental hospitals were profitable. For instance, it introduced a special measure in 1958 called *seishinka-tokurei*, which allowed mental hospitals to have a lower ratio of medical staff to patients than general hospitals, and they made low-interest loans available for the creation of mental hospitals in 1960. In 1961 the subsidy from the national government for involuntary hospitalisation by administrative order (*sochi nyuin*) was raised from 50% to 80%, with the prefectural governments making up the remainder, and so an economic incentive was introduced for the acceptance of *sochi nyuin*. At the time most families of psychiatric patients were not wealthy, therefore *sochi nyuin* was also intended to provide

financial relief (Fujino, 2005), because the hospitalisation fee was covered by public expense. Thus, it was treated as an "economic measure." In this way the policy created a snowball effect that allowed *sochi nyuin* to become widespread. (Sakuragi, 2015:160). The number of psychiatric patients under *sochi nyuin* increased from 8,455 in 1957 to 62,719 in 1964 (Ministry of Health, 1966:23), which accounted for 37.5% of all psychiatric inpatients (Sakuragi, 2015:160). As a result the private hospitals that accommodated patients under this policy received large subsidies from both the national and prefectural governments and expanded their number of psychiatric care beds. The number of psychiatric care beds more than doubled in only seven years from 64,725 in 1957 to 153,639 in 1964 (Ministry of Health, 1966:19).

In Western countries deinstitutionalisation became more prevalent as a result of the development of an antipsychotic drug called chlorpromazine, which enabled people with mental disorders to be cared for in their communities and not in hospitals. The movement for normalisation, which started to spread to Europe and America in the 1960s and 1970s, became a driving force behind the trend towards deinstitutionalisation. In Japan some mental hospitals were criticised for giving priority to economic gain over the wellbeing of their patients who were in hospital care (Sakuragi, 2015:162). Therefore, there were discussions about whether the Mental Hygiene Law of 1950, which emphasised hospitalisation, should be revised and whether mental health care should become more community-based (Fujino, 2005).

A crucial incident occurred on 24 March 1964 in which the then US Ambassador to Japan, Edwin O. Reischauer, was stabbed by a 19-year-old man who had experienced a psychiatric episode in the past. This incident created a big sensation. The mass media reported it on a large scale under headlines such as "A mad boy was arrested" and "Don't allow them to run wild" (Setoyama, Motoyama, Imamura, Miyazaki & Kasa, 2013). The Japanese government responded to this commotion immediately by insisting that the Mental Hygiene Law be revised in order to increase the control that the police had over people with mental disorders so they could re-institutionalise those living in communities who had ceased treatment. Various organisations and groups, such as JAPH, the Japanese Society of Psychiatry and Neurology, and family members opposed this measure (Takizawa, 1993:26) and started a counter-movement.

Following the Reischauer incident, the Mental Hygiene Law was revised in June 1965. The law included community care services through the medical care for outpatients at public expense and the establishment of public health centres in each community as frontline agencies for mental health. Moreover, it prescribed increased management and control of people with mental disorders and reinforced mental hospitals' commitment to them. It seemed that this revision had adopted the opinions of two contradictory viewpoints: the promotion of community-based care and the strengthening of hospital-based care. However, it was quite obvious that its main concern was to safeguard the public from people with "dangerous mental disorders". In order to do so, people considered to be a danger to the public because of their mental condition needed to be cared for and monitored in communities as well as in hospitals so that they would not be able to harm others. Though the revised Mental Hygiene Law was originally a law about mental health care, it also

played an important role in maintaining peace and order in society in cooperation with the police.

Japan was about to take a step towards deinstitutionalisation like Europe and America, but, in response to the Reischauer incident, it moved in the completely opposite direction towards re-institutionalisation. In 1968 a British psychiatrist, D.H. Clark, visited Japan as an advisor from the World Health Organisation and warned that "the Ministry of Health and Welfare should take active steps to make knowledge of social therapy, work therapy and the therapeutic community method available to mental hospital staff and to encourage active treatment and rehabilitation to prevent a steady rise in hospital inpatient population" (Clark, 1968). Also, he predicted precisely the present problem facing Japanese mental hospitals, stating that there will be a great increase in the number of sick old people in Japanese mental hospitals in the 1980s and 1990s if the accumulation of chronic patients persists, and "it will become a matter of major concern unless action is taken soon" (Clark, 1968). However, the Japanese government paid little attention to his warning and the hospital inpatient population has grown ever since, as the number of beds increased. The number of psychiatric care beds rose further from 164,027 in 1965 to 333,570 in 1985 (Ministry of Health, Labour and Welfare, 2015). The Japanese government continued to encourage the building of private mental hospitals that cost less to operate, and in 2012 84% of all mental hospitals were private, and private mental hospitals accounted for 92 % of all psychiatric care beds (Ministry of Health, Labour and Welfare, 2012a:3).

The Utsunomiya hospital scandal was disclosed in March 1984 by the *Asahi Shimbun*, one of the leading newspapers in Japan. It reported that two patients had been beaten to death with steel pipes by some of the male nursing staff (Anon, 1984). As the investigation proceeded, it was also revealed that 222 patients had died under suspicious circumstances in the hospital over a three-year period (Kobayashi, 1993:70), that unlicensed staff had been used for clinical procedures, and that many patients at the hospital had been illegally detained under the Mental Hygiene Law (Nakamura, 2013:59). Utsunomiya hospital was opened as a private mental hospital in 1961 during a boom in mental hospital development. The owner and director of the hospital was originally a physician, but later became a psychiatrist because he had discovered that it would be more profitable to operate a mental hospital than a general medical clinic (Kobayashi, 1993:70). The hospital accepted patients who had been refused by other hospitals, and over the years it quickly expanded from 57 beds to 920 beds by 1983 (Nakamura, 2013:59).

The article on the Utsunomiya hospital scandal revealed the circumstances surrounding mental hospitals and the treatments they administered, which had previously been invisible. Utsunomiya hospital was not the only hospital to conceal such incidents. The uproar caused by the Utsunomiya hospital incident drew a lot of attention from the international community as well as the citizens of Japan. Members from the International Commission of Jurists (ICJ) and the International Commission of Health Professionals (ICHP) visited Japan to investigate the state of mental hospital care. Under external and internal pressure, the Japanese government was urged to make drastic amendments to the Mental Hygiene Law in order to protect the human rights of mental hospital inpatients.

Human rights and social rehabilitation: 1987-2014

The revised Mental Health Law was promulgated in 1987. The law for the first time stipulated the protection of the human rights of patients in mental hospitals and the promotion of social rehabilitation for people with mental disorders. It is a little ironic that the introduction of the notion of social rehabilitation in the law was partly a result of concerns about the maltreatment of patients in mental hospitals. It included:

- the establishment of a Psychiatric Review Board in each prefecture to review the necessity of involuntary hospitalisation and appropriateness of treatment;
- an obligation of informed consent for admission;
- the introduction of voluntary hospitalisation;
- the establishment of rehabilitation facilities.

Establishing rehabilitation facilities, such as daily living training facilities and vocational facilities, as stipulated by the law, can be seen as the first step in the transition from hospitals to communities. The introduction of this law effected a dramatic change in the way patients were admitted. Voluntary hospitalisation enabled psychiatric patients to be in hospitals of their own volition, which meant that they could discharge themselves if they wanted to. In 2012 54% of psychiatric patients stayed in hospitals voluntarily (Mental Health and Welfare White Paper Editorial Committee, 2014:212). However, because of a lack of community-based services and programmes, long-term hospitalised psychiatric patients tended to be reluctant to leave.

In December 1993 the Basic Law for Persons with Disabilities was enacted and people with mental disorders were recognised by the law as people with disabilities. Before that the only legislative measures defined for this group were stipulated in the Mental Health Law. Following the enactment of the Basic Law for Persons with Disabilities, the government was obliged to formulate a welfare programme for people with mental disorders as well. The Mental Health Law was further revised and renamed as the Law Related to Mental Health and Welfare of the Person with a Mental Disorder (Mental Health and Welfare Law) in 1995 to reinforce welfare measures by:

- introducing a health and welfare handbook which was designed to facilitate access to social welfare programmes;
- adding welfare homes and welfare workshops for those with mental disorders as new types of social rehabilitation facilities.

In 1995 the Action Plan for Persons with Disabilities: A Seven Year Strategy to Achieve Normalisation was formulated and it expanded welfare programmes for people with mental disorders by setting up the target figures to be achieved within the period of the action plan (Cabinet Office, 1995). The plan's aim was to realise the principle of normalisation and was extended for another ten-year period, from 2003 to 2012, with new target figures so that people with disabilities could have community lives as members of society. In June 2012 14,774 people with mental disabilities stayed at accommodation-type rehabilitation facilities, such as group homes, and care homes; and 78,697 used services during the day, such as local activities support centres, continued employment support, transition support

for employment, and training for improving physical functions and social abilities (Mental Health and Welfare White Paper, 2014:231).

The National Certification for Psychiatric Social Workers was established by the Psychiatric Social Workers Act of 1997 to promote the rehabilitation and social participation of people with mental disabilities. Before the certification was introduced, most psychiatric social workers (PSWs) worked at medical institutions such as mental hospitals or clinics. However, as community care services were gradually increasing after the introduction of the welfare programme of 1995, PSWs began to work in communities as well. The number of registered PSWs was 71,371 at the end of March 2016 (Social Welfare Promotion and National Examination Center, 2016). According to a survey in 2012, 35% of PSWs worked at medical institutions, 30.2% worked in communities, and 13.4% worked for government organisations (Social Welfare Promotion and National Examination Center, 2012).

In 2004 the Ministry of Health, Labour and Welfare announced the Vision for Reform of Mental Health and Medical Welfare, which clearly stated the Ministry's aim to facilitate the transition "from hospital-based care to community-based care". In order to achieve its goal the Ministry declared its intention to dissolve the practice of social hospitalisation. The practice of social hospitalisation refers to the continued care of long-term inpatients who cannot be discharged for social reasons. It was estimated that there were approximately 70,000 cases of social hospitalisation. The government planned to discharge these patients and reduce the number of psychiatric care beds by 70,000 within 10 years by informing the public of mental disorders, reforming psychiatric treatment systems and strengthening community care systems.

The government implemented numerous projects to support psychiatric inpatients being discharged and sustain their community life. The Discharge Support Project for people with mental disorders was implemented nationwide in 2006. Inpatients whose symptoms were stable had discharge training, with supporters visiting hospitals for six months before discharge and one month thereafter. However, this project did not achieve satisfactory results, because some of the local governments had financial problems and some of the mental hospitals were not cooperative (Furuya, 2015a:80). The Discharge Support Project was revised and became the Community Transition Support Project for people with mental disorders in 2008, with new roles for community coordinators, who managed support and services needed for community life. In 2010 the project was again revised and became the Community Transition and Sustainable Community Life Support Project, which added the support systems for untreated patients living in communities, the roles of peer supporters, and the enlightenment of the community. However, in spite of all these efforts, the number of psychiatric care beds decreased by only 12,214 beds from 354,923 in 2004 to 342,709 in 2012, which was far from the target of 70,000 (Table 2). Many projects to discharge psychiatric inpatients and support their community life were introduced; however, the government did not try to replicate the results on a broad scale (Kadoya, 2015).

DISCUSSION

What follows is a discussion of the causes of the Japanese government's continued promotion of psychiatric hospitalisation in the 1960s and 1970s against the global trend of deinstitutionalisation and the unsatisfactory progress made towards deinstitutionalisation in spite of the government's policy change after the 1980s.

To protect social peace and order: social defence thought

"Social defence thought" is a way of thinking that reasons that the safety of society takes priority, even if it is secured at the cost of a small minority. It is one of the reasons why psychiatric hospitalisation was promoted in Japan. In Japanese society, where people respect harmony (*wa*) and make much of groupism, minority groups are painfully aware of exclusion. Moreover, social defence thought is sometimes justified by appealing to the concept of "the public welfare," and is therefore likely to spread as something necessary.

Social defence thought is based on eugenics. In Japan the Eugenics Protection Law was in operation between 1948 and 1996; it was used "to prevent the birth of inferior descendants from the eugenic point of view" and "to protect the life and health of mothers". Under the law mental disorders were considered to be the result of inferior heredity and therefore had to be prevented. The quickest way of preventing occurrences of mental disorder was to seal off people with mental disorders in mental hospitals, which the Mental Hygiene Law made possible. The law was enacted "in order to enhance mental health of the people in general", "provide person(s) with mental disorder(s) with medical care and protection" and "endeavour to prevent onset". In other words, mental disorders should be isolated and prevented in order to enhance the mental health of the general public. In fact, the law allowed for prefectural governors, on the basis of medical advice, to hospitalise involuntarily psychiatric patients who are likely to hurt themselves or others. As mentioned before, the Japanese government made large subsidies available for such hospitalisation, and involuntary hospitalisation of patients increased in the 1960s and 1970s. It could be considered the method that best reflected the social defence thought of the nation.

Leprosy was another example of an illness being stigmatised and institutionalised for a long time in terms of social defence thought. Leprosy can be disfiguring, with the result that people who are afflicted with the disease became stigmatised by society (Sato, 2002). The Leprosy Prevention Law, passed in 1907, justified the complete isolation of patients suffering from the disease. Even after drug therapy for leprosy was introduced and the disease became curable in the 1950s, the Japanese government was very slow to change its stance on the illness and did not admit that the law violated the human rights of those with leprosy until its abolition in 1996 (Hosoda, 2010). The notion of social defence, embodied in laws such as the Leprosy Prevention Law and the practice of hospitalisation of people with mental illness, commonly called for the stigmatisation of minorities, who were then unfairly constrained for extended periods of time.

Because of the prevalence of social defence thought, which stigmatised people with mental disorders, the Reischauer incident pushed Japan into the exact opposite direction

of deinstitutionalisation. A series of consequences brought on by the incident strongly reflected social defence thought in Japan. The Mental Health Law of 1965, which was revised the year after the incident, was to stipulate the way in which to hospitalise psychiatric patients preventively and legitimately (Ishikawa, 1990:28). Seven months after the Reischauer incident, Japan hosted the Olympic Games in Tokyo and was the first Asian country to do so. It was a very important opportunity to showcase Japan as a peaceful and economically developed country on the global stage. It is not surprising that it was generally thought that people with mental disorders who might be harmful to others or who may prove dangerous to society needed to be taken from communities into mental hospitals. Clark's 1968 Report was a chance to reconsider the state of hospitalisation and to reduce the growing number of psychiatric care beds. However, one government official at the then Ministry of Health and Welfare commented on the report that there would be nothing to learn from England, since it was experiencing national economic decline (Iseda, 2000). As a consequence, Japan paid the penalty for assuming such an arrogant attitude.

To improve the economy: high economic growth

The promotion of hospitalisation for psychiatric patients was not only related to social defence thought but also economic development at the time. Furuya (2015a:65) claims that the promotion of hospitalisation was part of the rapid economic growth policy in Japan. After the end of the Second World War Japan experienced an era of high economic growth from 1955 to 1973, when other developed countries were struggling with the downsizing or closure of mental hospitals.

The Ministry of Health and Welfare published a report entitled "The Present Conditions and Problems of the Mental Health of Our Country" in 1951 and stated that people with mental disorders were not engaged in productive activities, were committing arson and murder, and keeping their caretakers out of productive activities, which amounted to an estimated annual loss of more than 100 billion yen (Kuraki, n.d.). According to this report, people with mental disorders were regarded as an economic risk factor that limited the production capacity of the family unit, and were likely to commit arson or murder. Japan faced a critical labour shortage in this period of high economic growth. This shortage was supplemented by collective employment from local farming areas and the employment of housewives; housewives who had formerly reared children started to go to work during this period (Economic Planning Agency, 1992). The number of welfare institutions for children with disabilities also increased remarkably in the 1960s, and welfare facilities were newly established for children with both mental retardation and severe physical disability in 1964 (Yamamoto, 2010). By hospitalising or institutionalising people with mental disorders or mental retardation, family members were released from caretaking and became able to go to work.

With changes in the industrial structure in the 1960s, the population flow to urban areas led to the depopulation of rural areas. The government pushed for the construction of private mental hospitals in these depopulated areas using low-interest loans. Not only did this utilise depopulated areas effectively, but it also created new low-wage

employment in these areas. In fact, remote areas such as Kyusyu, Shikoku, and Toukoku still have a very have high ratio of psychiatric care beds per capita (Mental Health and Welfare White Paper, 2014:215).

In order to promote high economic growth after the war, it was necessary for the government to hospitalise people with mental disorders and secure families for the work force. Mental hospitals contributed to economic growth by accepting a wide range of patients. In this honeymoon phase the nation and mental hospitals enjoyed a profitable relationship.

Excessive dependence on private mental hospitals

After the number of mental hospitals surged in the period of high economic growth, they continued to increase steadily in number. Needless to say, private mental hospitals, which account for more than 80% of all mental hospitals, have been playing a central role in post-war psychiatric care in Japan. However, in the transition from hospital-based care to community-based care, the problem of what to do with mental hospitals naturally emerges.

Yoshikawa (2003:32) remarks that it is difficult to guide mental hospitals through downsizing or closure in Japan as more than 80% of mental hospitals are private. In other words, he points out that one of the reasons why deinstitutionalisation reforms were possible in Western countries was because most of the mental hospitals were in the public sector.

The Japanese government announced a plan to convert an empty psychiatric ward into residential facilities experimentally in order to promote the discharge of patients and reduce the number of psychiatric beds in 2014. Several groups and organisations, such as disability organisations, bar associations and the Association of Psychiatric Social Workers strongly objected the change. They pointed out that what the government was trying to do was not real rehabilitation, but a numerical operation to increase the number of people discharged (Nakamura, 2014). On the other hand, there was some who supported the government's plan. They argued that it was a realistic policy to promote rehabilitation for people with mental disorders, because the closure of mental hospitals was not possible since most of them were private (Furuya, 2015b:21). Despite the strong counter-movement, the government introduced the measure and accepted the conversion of psychiatric care institutions to residence-type facilities temporarily until the end of March 2025. The government is preoccupied with short-term solutions to increase the number of discharged patients and reduce the number of psychiatric care beds without trying to understand the nature of the problem and facilitate effective rehabilitation. With temporary solutions the problem can only be settled temporarily.

On the other hand, of course, the reason that deinstitutionalisation is being delayed is not only because a lot of mental hospitals are privately owned. For instance, most leprosaria are public institutions (Ministry of Health, Labour and Welfare, 2007). However, the government could not close any of the leprosaria, even after the abolition of the Leprosy Prevention Law, because most of the patients wanted to continue to stay (Sato, 2002). It is natural for them to wish to live in a place where they feel that they are members of the

community. In general, the longer people stay in a place, the more strongly attached to it they feel. Downsizing or closing mental hospitals is only part of the solution. Places where people with mental disorders wish to live should also be created.

CONCLUSION

People with mental disorders were isolated and hospitalised unfairly under the influence of social defence thought and principles, which prioritised economic growth in Japan over mental health care. Recently the change of direction from hospital-based care to community-based care has been attempted. Japan has been carrying out the expansion and improvement of services and systems in communities little by little, a process which has been evaluated by the international community as achieving "some success" (OECD, 2015:173). However, Furuya (2015:159) criticises what the government has been doing, calling it superficial rehabilitation that ends in half measures. Moreover, Nagano (2004) states that the government has merely changed the reform from isolation of all the mentally disordered to a more sophisticated or selective isolation of them for the purpose of reducing medical expenses.

In this context, what can the PSW profession do to promote the rehabilitation of people with mental disorders? The codes of ethics of the Japanese Association of Psychiatric Social Workers (JAPSW) declares that the PSW profession performs social rehabilitation or advocacy, and promoted the welfare of a client, and it also states that, as its ethical responsibility to society, PSWs shall contribute to social action and the improvement of mental health welfare by participating in activities in the community and society. From this point of view, it is clear that PSWs bear an important responsibility to improve mental health welfare for a client in the community and society.

According to a report on a question, "What should PSWs do to discharge long-term inpatients?", the JAPSW concludes that the PSWs should eliminate the mental barrier of inhabitants that prohibits people with mental disorders from social participation, and encourage more inhabitants to engage with people with mental disorders in communities (JAPSW, 2005:50). Matsumoto (2003) suggests the following areas that PSWs can focus on in order to reduce and ultimately abolish social hospitalisation: improvement of practice skills, provision of services and support systems, care management, and the promotion of understanding among inhabitants. These suggestions are concrete and useful, because they give clear directions for the everyday practical activities of PSWs. However, as the problem of long-term psychiatric inpatients has been constructed socially and politically, PSWs have to understand the mechanisms that trap psychiatric patients in hospitals within the wider context and expand their social and political activities accordingly.

The government does appear to create incentives to reform mental health care systems when they serve greater policy or social needs (Mandiberg, 1993:10). Social defence thought, the priority of economic growth, and many private mental hospitals which have been preventing those with mental disorders from being discharged, still operates strongly in Japanese society. Without taking these issues into serious consideration, the

transition from hospital-based care to community-based care cannot be successful. In order to promote the discharge of patients, it is clear that psychiatric hospitals require a drastic restructuring, and that making a place in communities for people with mental disorders to stay is necessary. Of course, such an action requires, as a prerequisite, the understanding of local citizens and the building of a public consensus. The Japanese government should learn from past experience and take up the responsibility of leading a fundamental mental health reform rather than entrusting private welfare service business operators and private mental hospitals with the discharging of patients. Every year 20,000 patients with mental disorders die in psychiatric care beds. There is no time to waste.

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Prof Tomoko Kanata, Department of Intercultural Studies, Kobe College, Japan.