

Mental Health Services Reform in Japan

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Economic and social pressures are driving Japan to reform its mental health services. Traditionally, psychiatric services in Japan have been custodial. Reimbursement has been principally fee-for-service, with incentives that encourage hospital-based care. Reform measures are beginning to promote the concept of "normalization," in which the mentally ill are seen to be disabled, like persons with physical disabilities. New practices including deinstitutionalization, differentiation of services, revisions in payment, and quality assessment are being introduced. This article provides an overview of the current status of Japanese mental health services, summarizes policy dilemmas, and identifies priority areas for intervention. (HARVARD REV PSYCHIATRY 1999;7:208-215.)

Mental illness in Japan evokes great stigma. In addition, care for mental disorders lags far behind that rendered for physical disorders in all respects, including patient rights, public understanding, detection and diagnosis, and quality of care. Patients with severe and persistent mental disorders typically remain in psychiatric hospitals for lengthy periods, receiving principally custodial care. The social and economic burdens of psychiatric illness and the effect of psychiatric disorders on general health-care expenditures are not well recognized.

However, in recent years the situation has begun to change. More Japanese people are being identified as suffering from mental disorders: the estimated number of inpatients and outpatients increased from 1,570,000 in 1993 to 2,170,000 in 1996.^{1,2} Mental health services are no longer

used only by a limited population of chronically ill persons. "Normalization," which involves perceiving the mentally ill as disabled, like persons with physical disabilities, is becoming a principal policy direction. At the same time, economic pressures on health-care expenditures are mounting, with an unprecedented increase in the number and proportion of the elderly, many of whom are institutionalized in psychiatric hospitals. The recent economic downturn has had a substantial impact in Japan, weakening its economy and constraining expenditures of all types, including medical care. These social and economic changes are driving Japan to reshape mental health services, through a series of governmental policy initiatives called "reform." Despite the many challenges and impediments confronting the Japanese mental health system, there are signals that change is occurring.

This article provides an overview of the current status of Japanese mental health practices; it also summarizes policy and planning dilemmas and identifies priority areas for intervention.

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MENTAL HEALTH CARE IN JAPAN

Legislation

The first legislation covering the mentally ill in Japan was the Law of Confinement and Protection of the Mentally Ill, enacted in 1900, which legalized home confinement. The Mental Hygiene Law of 1950 required medical treatment in hospitals for those with mental disorders and essentially ended the practice of private imprisonment, which is what home confinement had become.³ In 1965 the need for community mental health services prompted a revised Mental

Hygiene Law, which required each prefecture (a district much like a state in the United States) to have at least one community mental health center.

A series of scandals (including the 1964 assault by a mentally disordered man on U.S. Ambassador Edwin Reischauer and the 1984 deaths of two patients in a psychiatric hospital) were important impetuses for legal change.⁴⁻⁶ The 1995 Mental Health Act legally acknowledged for the first time that mental illness is a disability and established stricter criteria for involuntary hospitalization. This new law seeks to reduce stigma and states that people with mental disorders should be treated like those with physical disabilities.⁷

Psychiatric Services

Japanese law prohibits for-profit hospitals. Hence, all hospitals in the country are nonprofit organizations. There are 309 public and 1360 private psychiatric hospitals in Japan, meaning that 81.5% of facilities are privately held⁸ (many are owned by their psychiatrist directors). Private hospitals are privately owned but cannot generate profit. There is no distinction in clinical practice between public and private hospitals. Most psychiatric hospitals have between 100 and 399 beds.⁸

In the 1950s most patients did not receive any treatment. Some continued to be confined at home. Although hospital care was recognized as being necessary for the mentally ill, psychiatric beds were sorely lacking. The Medical Care Act of 1958 created an "exceptional case," allowing the establishment of psychiatric hospitals with staff:patient ratios less than half of those required for general hospitals. An amendment to the Mental Health Law at that time encouraged physicians to develop new psychiatric hospitals by providing them with significant financial assistance. The result was a dramatic increase in private psychiatric hospital beds during the 1960s. At this point home confinement was finally replaced by hospitalization.

The discovery of chlorpromazine did not stop the explosive increase of psychiatric beds in Japan. Nor did it enable the development of community-based services, as occurred in the United States, the United Kingdom, and elsewhere. Japan has maintained a high number of psychiatric beds per capita (2.9 beds per 1000 population,⁷ compared with 1.1 per 1000 in the United States and the United Kingdom^{9,10}), although the number has remained stable since the 1970s.

Financing and Management of Mental Health Services

Japan has three major types of insurance: employers' insurance, including government-managed societies and mutual-aid associations for employees; national health insurance for the self-employed and unemployed; and insurance for the elderly (age 70 and over). Beginning in the year 2000, long-term insurance will be introduced, but only some patients

(e.g., those with dementia) will be eligible for it. Most individuals with mental disorders will not benefit from this new insurance coverage.

Despite multiple insurers, payment rates to health-care providers are set by a national fee schedule. Per diem inpatient and nursing costs as well as laboratory and X-ray examination fees are determined by a "point-fee" system. (For example, the daily cost of hospitalization is multiplied by the length of stay, test and drug fees are added, and the patient's copayment is subtracted to determine the amount to be paid to the health-care institution.) All health-care costs except doctors' salaries are paid based on established prices for each service or supply through this fee-for-service system.¹¹ The national fee schedule is reviewed and revised every 2 years.

According to the data for 1996,¹¹ psychiatric care represents 10.9% of total inpatient costs (the third highest cost after circulatory disorders and neoplasms) and 2.6% of total outpatient costs (the twelfth highest). In persons between 15 and 44 years old, psychiatric care accounts for the highest proportion of inpatient costs among medical disciplines. In a recent study of 152 psychiatric hospitals,¹² 87.6% of their revenue was from inpatient care. This means that mental health services still depend on expensive inpatient care at a time when the nation faces difficulties affording health care, especially due to an aging population.

Regulation

Following enactment of the Medical Care Act of 1948, psychiatric hospitals have been inspected annually by the local government for structural components of quality, such as number of staff, availability of medical equipment, and appropriate room size. In addition, in each prefecture a Psychiatric Review Board including three certified psychiatrists, one lawyer, and one other professional has reviewed all involuntary psychiatric admissions since 1987.

Patient Rights

Four legal statuses characterize hospital admission: (1) voluntary admission with the consent of the patient; (2) compulsory admission by order of the prefectural governor for the patient who is dangerous to him- or herself or others; (3) compulsory admission at the request of the legal guardian of a patient who is not dangerous to him- or herself or others but does not consent to admission; or (4) emergency temporary admission by order of a certified psychiatrist when a mental disorder is suspected but time is required to make a diagnosis. When a voluntarily admitted patient wishes to leave the hospital, the psychiatrist can keep him or her hospitalized for 72 hours following the person's petition for discharge.

The responsibility of families has been a principal ethos in the history and practice of Japanese mental health ser-

TABLE 1. Estimated Number of Inpatients and Outpatients by Diagnosis*

ICD-10 Diagnosis	Inpatients	Outpatients
Dementia	36,500 (10.9%)	8,800 (4.9%)
Alcohol-related mental or behavioral disorders	17,200 (5.1%)	8,300 (4.7%)
Other substance-related mental or behavioral disorders	1,200 (0.4%)	500 (0.3%)
Schizophrenia	216,600 (64.9%)	47,700 (26.7%)
Mood disorders	22,300 (6.7%)	38,000 (21.3%)
Neuroses	7,200 (2.2%)	43,300 (24.3%)
Mental retardation	12,300 (3.7%)	2,900 (1.6%)
Other mental or behavioral disorders	12,500 (3.7%)	6,100 (3.4%)
Epilepsy†	8,100 (2.4%)	22,800 (12.8%)
Total	334,000 (100%)	178,400 (100%)

*This table is based on a 1-day survey by the Japanese Ministry of Health and Welfare in 1996.²

†Epilepsy is not categorized under "mental or behavioral disorders" in ICD-10 but is usually treated by psychiatric services.

vices. If a patient's family concurs with the psychiatrist, hospitalization is considered to be "with consent," even if the patient does not provide such consent.¹³ In 1997, 29% of psychiatric admissions occurred under this form of "guardianship"—compulsory admission at the request of the legal guardian.⁷

Since the government guaranteed payment for care of the poor when they were hospitalized by order of the prefectural governor, patients typically were involuntarily admitted to psychiatric hospitals in order to assure governmental payment. Such involuntary admissions occurred quite frequently in Japan until 1987, when the Mental Health Law was amended to legally recognize voluntary admission and to assure governmental reimbursement for voluntarily admitted patients as well. The amended law enhanced patient rights further by required written confirmation from involuntarily admitted patients that they had received a physician's explanation.

The Psychiatric Review Boards play a role in reviewing psychiatric services, including patient rights. Their role is limited, however, as is indicated by the fact that they make few recommendations. (For example, in 1996 they reviewed 84,392 involuntary admissions, but in only 23 cases (0.03%) did they recommend to the hospitals that the involuntary admission be changed to voluntary or the patient be discharged.¹²) Patients can appeal their involuntary status to the boards by telephone, and telephones now must be made accessible on hospital wards. There were 910 patient appeals in 1996, and 44 (4.8%) of these patients were deemed to have been inappropriately admitted upon board review.¹²

Patients' rights to provide informed consent, recently a focus of debate within the medical field, are still a long way from the current status in Western psychiatric practices. Although 76% of psychiatrists report that they obtain informed consent from their patients, only 2% state that they inform their patients of the diagnosis of schizophrenia,¹⁴

suggesting a disparity between what is perceived as engagement with patients in their care and what actually occurs. In Japan patients are often not told a serious diagnosis. For example, both patients and families are commonly informed of early cancer, but only families are told of advanced cancer. Psychiatrists are even more reluctant to offer patients and families a diagnosis of schizophrenia because both are likely to resist the diagnosis as well as the treatment.

DILEMMAS FACING THE JAPANESE MENTAL HEALTH SYSTEM

Long Lengths of Stay

The average length of stay in 1997 was very long (423.7 days) because the primary method of care for persons with severe and persistent mental illness has been long-term hospitalization.⁴ Due to stigma, lack of community services, and family burden, hospitalization also has become a desirable solution for many families of the mentally ill. Schizophrenia accounts for the greatest proportion (nearly 65%) of psychiatric inpatients² (see Table 1). Persons with this disorder who were hospitalized during the expansion period of psychiatric hospitals during the 1960s are still in the hospital, which substantially raises the average length of stay in psychiatric hospitals.

According to a survey in 1989,¹⁵ 33% of persons who were hospitalized for more than 2 years were inpatients for social, not medical, reasons. After many years as inpatients these individuals have fewer social skills, and there are few places other than hospitals where they can go. Hence, they continue to stay in hospitals. These lengthy hospitalizations symbolize the isolation of the mentally ill from mainstream society.

Older persons make up a higher percentage of the inpatient population than do other age groups^{2,7} (see Figure 1) and have few, if any, alternatives in the community to allow

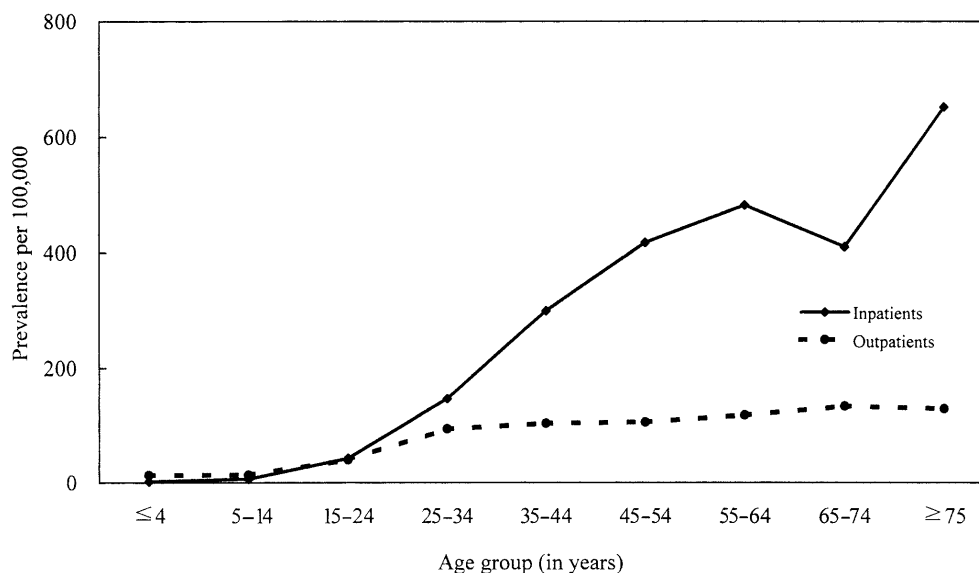


FIGURE 1. Psychiatric inpatients and outpatients by age group, based on a 1-day survey by the Japan Ministry of Health and Welfare in 1996.^{2,7}

for hospital discharge. This suggests that older patients play a substantial role in raising the average length of stay for psychiatric hospitals.

Lack of Differentiation of Patients and Clinical Services

It is often said in Japan that acute, chronic, and forensic patients should be treated separately. In reality, however, they are mixed in the same facility, even in small hospitals. Nakatani and colleagues¹⁶ studied “difficult patients” (patients in a secure ward who had stayed for a total of more than 365 days and had been admitted to the ward at least five times between April 1979 and March 1988) in the major public psychiatric hospital in Tokyo. Many of these individuals were forensic patients who had been compulsorily admitted by order of the prefectural governor because they were deemed potentially dangerous to themselves or others. The authors concluded that the hospital was unable to assess dangerousness adequately and experienced difficulties with discharge of these patients because of the court’s lack of involvement after admission. Private hospitals argue that public hospitals should be responsible for forensic patients, but public hospitals are reluctant to respond to this difficult population due to limited personnel and budgets and lack of court involvement.

Acute-care services are urgently needed. Psychiatric units in general hospitals are trying to provide acute care, but their capacity is limited. Building acute-care services remains financially and programmatically difficult for psychiatric hospitals (a shortage of trained staff limits the delivery of acute-care services), and such hospitals still benefit from keeping inpatients for lengthy periods. In psychiatric hospi-

tals, admission rates of new patients remain very low. These institutions are increasingly serving the role that nursing homes have come to provide in the United States.

Fee-for-Service Payment

The social security system in Japan has shown increasing deficits, primarily due to the costs of an aging population, higher spending on medication, and the use of advanced medical technology. Under the current fee-for-service and insurance-reimbursement system, treatment decisions are rarely questioned. Unnecessary utilization of services and procedures and overprescription of drugs are widespread. No premium is paid for quality, effectiveness, or efficiency.^{6,17} The payment system creates no incentive for hospitals to review the appropriateness of admission or to discharge patients; inpatient days generate income. Psychiatric hospitals are heavily financially dependent on inpatient occupancy rates (now at 93.7%).¹⁸ With new admissions low, any significant shift from inpatient to outpatient care would cause turmoil on many a balance sheet. Management change is needed but is difficult for most hospitals, where a practicing clinician often also serves as managing director.

Quality of Care

Since the priority for health care in Japan has been universal access for all citizens, quality has received little attention, in ironic contrast to the renowned quality control characteristic of Japanese industries. Only minimal standards of structure and process are required by the government for health-care institutions in Japan. A medical audit is the basis for accreditation. Such an audit evaluates the required

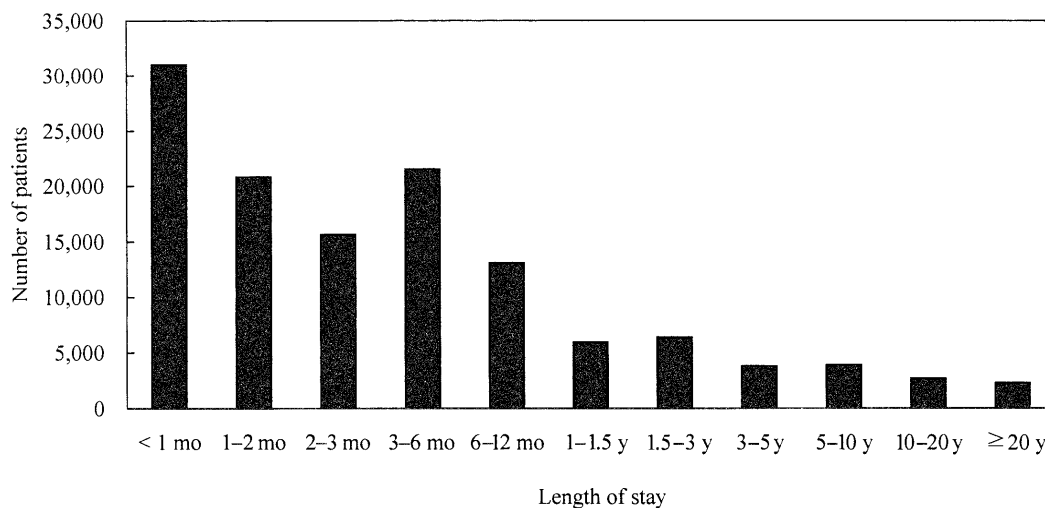


FIGURE 2. Average length of stay for patients discharged from psychiatric hospitals between April 1995 and March 1996 based on a survey by the Japanese Association of Psychiatric Hospitals in 1996.¹⁹

number of staff, the maximum number of inpatients, and the appropriateness of facilities and equipment. In addition to the medical audit, psychiatric services (including patient rights, as mentioned above) are monitored by Psychiatric Review Boards.

Psychiatric hospitalization remains more physician- or family-driven than patient-driven in Japan. The relative absence of independent quality monitoring in the country can be explained by a belief that a minimum standard of quality care is assured by each physician. However, in reality great variation occurs in quality of care. For example, the nurse:patient ratio differs greatly: of the 649 psychiatric hospitals surveyed in 1997,¹⁹ 72 (11.1%) reported 1:3 ratios while 233 (35.9%) reported 1:6. As a consequence of the survey and public interest, demand is increasing for explicit criteria to help ensure the quality of psychiatric services.

Cultural Values

The Japanese government and society value public order over individual rights.⁵ People with mental disorders have been kept out of the public eye first by home confinement and subsequently by long-term hospitalization. Mental illness in a relative reflects poorly on the reputation of the entire family and adversely affects the marriage prospects of other family members, and hospitalization has served as a “solution” to these problems.²⁰ According to the results of a survey of families of hospitalized patients,²¹ 33.9% of families responded that they did not want their family members discharged, and 29.5% said that discharge would be difficult even though the families reportedly wanted their relatives to return home. Families rated stability of symptoms as the most important condition of discharge, a point worth noting for service planning. Deinstitutionalization in Japan will

truly challenge the ethos of public order and will expose many families to shame and community censure.

MENTAL HEALTH REFORM: PROGRESS AND PROBLEMS

Deinstitutionalization: Shortening Hospital Stays and Providing Community Services

Although the Japanese government and health-care professionals generally agree about the need for hospital downsizing and the development of community-based services, implementation has been slow in coming. Many challenges exist, especially in provision of community services and alleviation of stigma and family burden. Although lengthy hospital stays continue to draw criticism, change is beginning to occur (see Figure 2): an examination of discharged patients in 1998²² revealed that 51% were discharged within 3 months (compared with 11.5 days in the United States¹⁰).

Of the 330,000 psychiatric inpatients sampled by the Ministry of Health and Welfare in 1996,²³ at least 10% were considered to be hospitalized for social reasons and able to be discharged if community-care facilities were established. The government has a plan to discharge 20,000–30,000 patients between 1996 and 2002. To reach this goal, the 900 group homes and rehabilitation facilities that existed in 1996 and served 10,000 patients would need to be increased to at least 2000 facilities by the year 2002.

These new community-based patients will need services, but to provide such services the mental health centers in the various prefectures will need to be functioning better than they are now. Discharging patients to the community without adequate numbers of trained professionals in the mental health centers will overload existing community resources,

choke access, and probably result in adverse clinical events and unnecessary hospital readmissions. Also, if inpatients are simply moved from a hospital to another sheltered institution in the community, they will only be reinstitutionalized, and little will be accomplished with respect to normalization of life or individual liberty.²⁴

Community services are further impeded (indirectly) by financial disincentives. The Japanese government financially assists low-income outpatients by paying 95% of their medical costs. Access to and continuity of care for the poor mentally ill is possible through this system (and is much less expensive for the government than inpatient treatment). Inpatient services, however, have little incentive to discharge patients because of a fee-for-service system that continues to pay for extended hospital stays. Community services are likely to remain dormant until hospitals need to turn to them to accept discharged patients.

Deinstitutionalization is necessary for normalization of the mentally ill and to reduce governmental inpatient costs. The potential positive impact of deinstitutionalization includes the end of hospitalization for social reasons; improvement in patients' rights, freedom, and quality of life through life in the community; an increase in patient satisfaction; and reduction of hospital costs. The potential negative effects include the closing of hospitals because management does not change to meet changing practices; a great burden on families; and, for patients, the lack of social acceptance because of the public's fear of violence by the mentally ill, as well as poor self-care, noncompliance with treatment, and an increase in homelessness, substance abuse, suicide, and crime.

Specialty Care

Although consensus on segregating types of patients and developing specialty services has not yet been reached in Japan, financial pressures and knowledge from other countries have drawn many proponents of specialty care. Psychiatric services in Japan today are beginning to differentiate into three categories: acute care, chronic care, and dementia care. Some psychiatric hospitals with many long-term patients have become de facto nursing homes. Demand for long-term care is increasing due to the aging of the population.

Community-based individual clinicians and mental health centers will have to be organized to provide "primary care" for the mentally ill. The roles of psychiatric hospitals or psychiatric units of general hospitals will also have to shift: rather than continuing to be the primary locus of care, these institutions increasingly will need to provide brief treatment and to support community practitioners. Long-term-care hospitals, over time, could serve the most severely behaviorally disordered patients (principally those with psychotic illness) and persons with advanced dementia.

Payment System

Since 1995 an attempt has been made to control costs by tying payments for inpatient care to shorter lengths of stay. Some acute psychiatric units have been held to a standard whereby 50% of patients must be discharged to their home or to housing for the mentally ill within 3 months. In other words, if more than 50% of inpatients remain hospitalized longer than 3 months, the unit no longer meets criteria for acute care and is paid as a general-care unit. The day rate for general-care units is set at one-third less than that for acute-care units. Revising the rules for payment has been and will continue to be a ground-breaking challenge for the Japanese psychiatric care system. The effectiveness of this and other plans and their unintended effects remain to be seen.

The Japanese recognize that fee-for-service fosters overutilization and that capitation invites the risk of underutilization. Linking payment to diagnosis offers little direction, as has been shown by the American experience in psychiatry.^{25,26} Yet budgeting realities will require some form of payment restructuring. The Japanese, like everyone else, are searching for a conscionable solution.

Quality of Care

Quality of care is also beginning to gain attention. The government has tried to improve the quality of psychiatric care by introducing stricter criteria for involuntary admission. The Japan Association of Psychiatric Hospitals (a voluntary organization representing 88.4% of private psychiatric hospitals) has conducted "peer review" inspections in hospitals, based on the association's criteria, since 1989. The Council for Quality Health Care (CQHC), a counterpart of the Joint Commission on Accreditation of Healthcare Organizations in the United States, was established in 1995. The CQHC uses the site-survey as an evaluation tool and has developed specific quality criteria for psychiatry that are different from the criteria applied to other medical specialties. Third-party accreditation, through the CQHC, has begun but is only in its infancy.²⁷

The importance of clinical outcome has been discussed in Japan, but measuring outcome has not become standard practice, with some "pilot" exceptions. The development of performance measures for Japanese psychiatric services is under way, although publications in this area have not yet appeared. Quality concerns intensify in Japan (as they should) whenever cost-containment is sought. Until better accreditation procedures and measures of quality are instituted in mental health, reform will be clinically risky and will engender appropriate resistance.

Consumer Empowerment

Unlike the United States, Japan is a racially homogeneous nation. In addition, most people have similar values and per-

ceive themselves as middle class. Deviance is poorly accepted in the society; being different from others creates a social barrier. Individuality is not valued. Furthermore, harmony and social order are considered more important than individual rights in Japanese culture. In such an environment, achieving some degree of consumer empowerment will be extremely challenging. Many psychiatric patients and their families hesitate to speak out about their problems because of the powerful and negative public attitude concerning mental illness. Although health-care information is common in the media, little coverage is provided for mental health (except for crimes perpetrated by the mentally ill). A campaign of public education on mental illness and its treatments is absolutely necessary if any acceptance is to be achieved.

REFORM: CONCLUSIONS AND RECOMMENDATIONS

The Japanese mental health system has begun the process of reform. Efforts to reduce average length of stay and to build community care are under way, and financial incentives are being considered to facilitate these ends. Quality control, especially through accreditation, is also emerging, albeit more slowly than in the West. Acute-care services, with specialty services directed at particular patient populations, are still more the exception than the rule. But true reform of mental health services in Japan has not yet occurred, despite a series of governmental legal and financial initiatives, some dating to 1900 and others as recent as 1995. An understanding of the values and traditions of Japanese society helps to explain why change has been so limited and should inform all future initiatives, including efforts currently under way.

Under the concept of normalization, the mentally ill are considered disabled and mental health care is integrated into social services. This important policy change and the cost of the current system, with its dependence on hospitals, are compelling forces for change. Some hospitals are already shifting their core service from essentially custodial inpatient care to acute or rehabilitative care. If hospitals can effectively respond to the policy and economic imperatives, deinstitutionalization will be able to proceed successfully.

Public acceptance, however, is a tougher challenge because many people still see the mentally ill as dangerous to others. As we have noted, preservation of social order and control has been the primary objective shaping how the mentally ill are treated in Japan; a medical orientation to diagnosis and treatment has been subordinate. Social order and the importance of the group over the individual are fundamental Japanese values, not just attitudes concerning the mentally ill. Scientific proof will be helpful in demonstrating that mental illness is caused by brain disorders. Today's global information network makes it abundantly clear that neuro-

biological changes underlie the major psychiatric illnesses, many of which can be reliably diagnosed and effectively treated.

In addition, tradition in Japan holds families responsible for the care of the mentally ill. Custodial hospitals replaced home confinement and helped to relieve families of this burden. However, governmental legal reforms have not made the state the primary responsible agent for the mentally ill (as in Western industrialized countries). If deinstitutionalization were enacted today, the burden would fall principally on families. Community services and respite care will be necessary.

Forensic patients currently burden and diminish the clinical capabilities of hospitals. A legal infrastructure for forensic care in Japan is needed. Especially important will be a means for the courts to continue to exercise authority after admission and perhaps after discharge into the community.

An emergency psychiatry system also needs to be established. Since the general public expects psychiatric units of general hospitals to fill this role, it could be important and timely to redefine the psychiatric responsibilities of general hospitals to include the provision of comprehensive emergency services.²⁸

The shadow of Westernization is also growing in Japan, including its medical community. Deinstitutionalization has affected almost every Western country. Homelessness (as it exists in other countries) is commonly viewed by the Japanese as a harmful effect of deinstitutionalization, adding to concerns about violence in a country where the crime rate is one of the lowest in the world. Japanese people are also afraid that discharging current inpatients and reducing new admissions will result in higher readmission rates. The Japanese have reason to be cautious but not to eschew action. A balance between discharge and readmission needs to be achieved; carefully designed, empirically testable pilot projects may lead the way in this critical dimension of reform.

Perhaps the most important (and certainly the first and rate-limiting) step in reform must be public education. Vast ignorance, bias, and stigma characterize public knowledge of mental disorders and their diagnosis and treatment. Shame abounds, as does a sense of isolation and hopelessness among families with mentally ill members. A systematic public-health educational campaign is essential for reform to take root.

A second and concurrent step in reform should be a public advocacy campaign, led by families and family organizations. Adequacy of health benefits (called "parity" in the United States), access to effective services, and patient rights have been the cornerstones of such efforts in the Western world.

Because of the deep roots and traditions of current psychiatric practices in Japan, a wholesale or vast set of reforms would not be advisable or feasible. Instead, model or pilot

projects, of high profile and with good support, could be tried. These pilots could be structured to respect the cultural differences between Japan and the West—for example, they could emphasize the group over the individual, stress social control and community safety, and insofar as possible, involve families. Efforts to place and maintain small numbers of psychiatric patients in highly structured group homes, in conjunction with effective pharmacotherapy and social-rehabilitation programs, might help to reduce fears that deinstitutionalization would cause widespread homelessness.

Finally, measurable clinical performance objectives should be built into individual program initiatives and system-wide changes.²⁹ Japanese and Western quality-assessment technologies can and should be employed. Objective measures and quantifiable successes will help to demystify the reform process, defuse anxiety about the dangers of the mentally ill, and demonstrate the results of good care.

National and international criticism continues to pressure Japan to improve the quality of its psychiatric services. True advancement in this realm cannot be achieved overnight, and good community care is not without cost. Incremental changes should be sought. Success may be possible in this current round of reform, if carefully considered, well communicated, and effectively implemented.

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