HGPI Health and Global Policy Institute

Health and Global Policy Institute (HGPI) Mental Health Policy Project Team

Mental Health 2020 – Proposal for Tomorrow

Five Perspectives on Mental Health Policy

July 2020

Introduction

- **Introducing Health and Global Policy Institute**

Health and Global Policy Institute (HGPI) is a Tokyo-based independent and non-profit health policy think tank established in 2004. In its capacity as a neutral think-tank, HGPI involves stakeholders from wide-ranging fields of expertise to provide policy options to the public to successfully create citizen-focused healthcare policies. Looking to the future, HGPI produces novel ideas and values from a standpoint that offers a wide perspective. It aims to realize a healthy and fair society while holding fast to its independence to avoid being bound to the specific interests of political parties and other organizations. HGPI intends for its policy options to be effective not only in Japan, but also in the wider world, and in this vein the institute is very active in creating policies for resolving global health challenges.

- **Introducing the HGPI Mental Health Policy Project**

Regardless of country or region, issues related to mental health are having significant effects on modern society. In 2017, it was estimated that 4.193 million people in Japan were living with mental health issues and their number is expected to continue to increase. Already, the number of people living with mental health issues is greater than the number of people who have been diagnosed with cancer, stroke, acute myocardial infarction, and diabetes combined. The number of people receiving outpatient treatment is increasing each year and is estimated to have grown to approximately 3.891 million people in 2017. An estimated 302,000 people are hospitalized with mental health-related issues. Although their number is trending downwards, Japan has the most people hospitalized in psychiatric wards on a per capita basis in the world.[1] According to the 2018 Hospital Report from the Ministry of Health, Labour and Welfare (MHLW), the average length of stay for psychiatric care beds was significantly longer than for general care beds, at 265.8 days and 16.1 days respectively. That report also found significant regional disparities in average lengths of stay. Various factors can cause poor mental health or mental illness, chief among them social and economic stress factors. These factors include the conditions encountered after natural disasters like the Great Hanshin-Awaji Earthquake or the Great East Japan Earthquake, during pandemics like the Coronavirus Disease 2019 (COVID-19) pandemic, or in times of significant stress related to changes in the employment or household environment caused by a worsening economy. For these reasons, issues related to mental health must be approached as issues that affect society as a whole without responses being limited to the field of healthcare.

The World Health Organization (WHO) recently enacted its Comprehensive Mental Health Action Plan 2013-2020. Meanwhile, efforts are advancing to promote the spread of best practices and information through international cooperative initiatives and comparative studies. In Japan, the enactment of the Act for Mental Health and Welfare in 1995 or the issuance of the Vision for Reform of Mental Health and Medical Welfare in 2004 has led to cooperative efforts between healthcare and welfare aimed at building support systems for people with mental disorders and their families. In addition, mental health was included as a targeted field in the sixth revision of the Medical Care Plan System, which came into effect in 2013. Meanwhile, the seventh revision of the Medical Care Plan System and the fifth revision of the Disability Welfare Plan both mentioned building an Integrated Community Care System for Mental Disorders. To empower people who have developed mental disorders to live as full members of their communities with peace of mind and pride, these developments aim to create an integrated care

[1] OECD Health Data. Last retrieved June 30, 2020.

system that provides healthcare, welfare for people with disabilities, long-term care, housing, social participation (i.e. employment), networks for mutual support in communities, and education. Achieving these goals will require wide-ranging cooperation between multi-stakeholders.

Compared to the international situation, however, there are many domains of policy in Japan for which efforts must be intensified in the future. These include promoting knowledge and understanding towards each mental illness among the public, establishing care practices that are based on the needs of people with mental disorders (including during the development and provision of services), creating support systems which unite the public and various professions while advancing the establishment of the Integrated Community Care System for Mental Disorders, and building systems with the capacity to provide mental health care over the life course. Rapid reforms based on international trends are also necessary. At the same time, policies that provide effective guidance are needed to make a smooth transition from existing healthcare provision systems. For example, existing stakeholders should be provided with incentives in the event of reform. Other necessary efforts include examining the best way to structure the hospitalization system, providing diverse high-quality inpatient care, and strengthening the mental health and medical welfare systems so people who are hospitalized can transition back to community living. All of this will require the creation of an environment in which regional disparities in access to care have been eliminated to allow everyone equal access to care.

In recognition of that need, HGPI started the Mental Health Policy Project in FY2019 and has engaged in continuous activities to address issues in this field. In the last fiscal year, we organized an advisory board that included people with mental disorders, their families, and other parties most affected; existing stakeholders; and domestic and international key opinion leaders and related organizations in the field of mental health from government, industry, academia, and civil society. Over our repeated hearings with that advisory board, we crystallized current issues and discussion points in Japan's mental health policy and explored potential directions for solutions to those issues.

HGPI then held an advisory board-centered global expert meeting to provide an opportunity for experts in the field from Japan and overseas to voice their opinions on the issues and discussion points identified by the advisory board and the advisory board's desired direction for solving those issues. We published reports on that meeting to communicate the necessity of promoting mental health policy to stakeholders in Japan and abroad. The global expert meeting was held in two sessions entitled "Leading Experts' Talk on the Global Trends in Mental Health" and "Multi-stakeholder Discussion on Japan's Mental Health Policy – The Way Forward." This event was hosted jointly with the Department of Frontier & International Psychiatry of the Graduate School of Medicine of Kyoto University with participation from the Johns Hopkins University Department of Psychiatry and Behavioral Sciences in the United States. These sessions were an opportunity for active opinion exchanges and discussions between various stakeholders, especially the panel discussions. Key points raised in each panel discussion are summarized below.

1. The importance of promoting a life course approach and discussion among multi-stakeholders
The need to promote research by uniting those most affected, academia, and the rest of society based on a solid understanding of medicine and science while keeping the needs of society in view was pointed out as one requirement for the results of academic research in the field of psychiatry and mental health to be reflected more effectively in policy. In particular, to benefit people with mental disorders, long-term and large-scale research that spans the entire life course must be conducted in addition to separate studies conducted in each disease field. To make effective use of such research in

policy, discussions also touched upon the need to formulate policies in a manner that cuts across fields and specialties. It was pointed out that existing policies also require verification, and that it is important to establish a cycle in which such the results of verification studies are collected and used to formulate new policies based on evidence. Action items for achieving evidence-based policymaking that were brought up in discussions included securing sufficient funding and building an environment for R&D in a strategic manner. Other commenters said Japan should aim to create policies that improve quality of life (QOL) for those most affected or protect human rights while referring to WHO recommendations, best practices from each country, and other such sources of information on international trends to allow Japan to exercise leadership on the international stage.

2. The need to unite all related professions and local organizations to achieve mental health care for the entire life course

To take steps towards creating the Integrated Community Care System for Mental Disorders, building a society of communal co-existence, and bringing healthcare facilities, regions, each specialty, and Japan's mental health policy one step closer to those most affected, participants in the discussions pointed out the need for multi-disciplinary cooperation between healthcare, welfare, and long-term care as well as between communities and facilities like hospitals and school. In particular, from the perspective of adopting a life course approach, it was pointed that comprehensive mental health policies that include prevention and education should be created and that community mental health care should be defined through effective cooperation between healthcare institutions moving forward. Also, transferring the responsibility for mental health care to local communities is important for improving the lives of those most affected, and that is all the more reason why it is necessary to carefully design systems, improve environments, and provide funding to that end. There is also a need to implement measures that are based on evidence, so a framework is necessary for verification. When building such a framework, it is necessary to refer to real-world examples from abroad or from other fields of healthcare or public health and to incorporate systems for data collection. In addition, many participants said they expect that building a regional transition model that can respond to the real-world circumstances in each region and verifying that model from the perspectives of those most affected will assist in the effort to promote effective and efficient policies.

3. The importance of gathering the experiences of those most affected and healthcare providers and promoting cooperation between them to formulate policy proposals from the perspectives of those most affected

To create systems that reflect the opinions of those most affected in as many aspects of future mental health policy as possible, participants pointed out the importance of spreading awareness towards the current circumstances surrounding the ability of people with mental disorders to voice their opinions and the importance of deepening research on methods for helping them voice their opinions. The importance of creating an environment that makes it easier to gather the voices of those most affected was also mentioned. In addition to the experiences of people with mental disorders, it was also mentioned that it is necessary to gather the experiences of healthcare professionals involved in providing clinical care and using their stories as objective evidence in mental health care and when making policy recommendations. Also, it was pointed out that it is necessary to enhance understanding of mental health by building a cooperative platform based on medical and scientific expertise that emphasizes real-world examples and allows people with mental disorders and multi-stakeholders to engage in mutual learning. While a similar conversation was also held during Panel 1, to help mental health policy take one step closer to those most affected, there were also many comments that

emphasized the importance of gathering people with mental disorders and multi-stakeholders to hold discussions that surpass individual ranks and positions, to cooperate, and to take action.

- **The Position of Mental Health 2020 – Proposal for Tomorrow and Future Activities**

In addition to the discussion points collected over the course of our meetings in FY2019, based on our hearings with people with mental disorders and other multi-stakeholders, we examined how to shape mental health policy to be more beneficial to those most affected and the public. Then, from a neutral standpoint, we synthesized that knowledge into the directives of the Mental Health 2020 proposal. Moving forward, we will make our proposal more substantial by holding repeated opinion exchanges with a greater variety of multi-stakeholders to discuss it. We must also mention that the Mental Health 2020 proposal does not mention specific issues related to dementia within the field of mental health because HGPI is currently engaged in a separate project that focuses on dementia as a central policy issue.

In the future, we will further expand the range of stakeholders involved in the mental health policy project with an emphasis on those most affected. While referring to international best practices, our goal will be to operate as a platform for achieving better mental health policy in Japan. We anticipate profound discussions and progress over the next several years, particularly in the period leading up to the eighth revision of the Medical Care Plan System and the seventh revision of the Disability Welfare Plan in FY2024. Over this period, HGPI will aim to be a driving force for policy reform that contributes to improving QOL for everyone affected by the field of mental health care. We humbly request anyone reading this proposal to share their opinions with us and to actively participate in this endeavor.

Mental Health 2020 – Proposal for Tomorrow
Executive Summary

- **Our Vision for Mental Health Policy**

Based on meetings and hearings conducted throughout HGPI's Mental Health Policy Project in FY2019, we have drafted Mental Health 2020 – Proposal for Tomorrow to achieve better mental healthcare policy in Japan. Our proposal addresses the current circumstances and issues in mental health in Japan from five perspectives and presents multiple policy recommendations from each perspective. When drafting it, we emphasized the inclusion of as many perspectives as possible. Moving forward, we will continue issuing statements and proposals to contribute to improving QOL for those most affected by gathering opinions for Mental Health 2020 – Proposal for Tomorrow from an even wider range of stakeholders, by sharpening our focus on specific agendas, and by paying close attention to international trends and innovative practices from abroad.

The WHO defines mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." In other words, it is not defined by the presence or absence of any specific disorder. Rather, it should be perceived as a subjective concept of how we want to live our lives as social creatures interacting in society. In that sense, every one of us is a beneficiary of mental health policy, from those of us who require continuous support for mental disorders or disabilities from experts in medicine, healthcare, or welfare, to those of us who find everyday living to be a minor yet constant struggle.

For mental health policy to contribute to improving QOL for the parties most affected - in other words, every living person - the first step will be to wipe away stereotypes and prejudices towards mental disorders. Then, we must become more sensitive to subtle changes in our own mental health and learn how to be considerate towards the difficulties others may be facing in their lives, no matter how great or small those difficulties may be. In addition, we must build an environment that helps those who need professional support to access healthcare and welfare systems on their own terms while taking steps to continually evaluate and improve mental health systems based on scientific evidence. Within that effort, we have high expectations for coordination between specialists with various perspectives to establish a care system that can provide the necessary services at the necessary times. It will also be absolutely essential for service providers to listen to the voices of users while making continuous improvements to mental health systems without being overly-reliant on existing systems. At the same time, policy evidence must be gathered and research and development must be promoted so that both beneficiaries and specialists have the latest information and are able to choose the best type of support among various options. Finally, a framework that allows multi-stakeholders to unite, hold discussions, and elevate their voices is needed to sustain efforts to improve mental health and QOL for all.

- **Five Perspectives on Mental Health Policy and Policy Recommendations**

Perspective 1: Expand policies that raise mental health literacy in society and promote the activities of those most affected.

1. Promote the activities of people with mental disorders and those close to them to improve mental health literacy for all of society.

2. Improve every individual's ability to respond to mental health issues over the life course by expanding education on mental health in primary and secondary education and by reinforcing support services.
3. Promote peer support activities to encourage self-determination among people with mental disorders.

Perspective 2: Establish systems for providing care that are integrated into communities, compatible with everyday life, and meet the needs of people with mental disorders.

1. Enhance inpatient care systems to fully meet the needs of people with mental disorders while providing care in a way that upholds their dignity and respects their rights.
2. Enrich systems for providing outpatient care with community engagement and multi-disciplinary cooperation.
3. Promote cooperation between healthcare and welfare services to build an Integrated Community Care System for Mental Disorders.

Perspective 3: Build an infrastructure for community living that provides places to live, places to work, and places to belong.

1. Ensure that people with mental disorders can plot their own life courses, including those who wish to consider their medium- and long-term career development.
2. Empower people with mental disorders to objectively grasp their own psychological states and allow them the flexibility to adjust their daily lives accordingly.
3. Unite housing support organizations, people with mental disorders, and mental health specialists to take local housing conditions into account and establish environments that are agreeable to both borrowers and lenders.

Perspective 4: Create systems for gathering the data and information needed for evidence-based policy-making and policy evaluation.

1. Combine existing systems for data management and research for the more effective promotion of research that aims to discover the causes of mental disorders.
2. Build a platform for gathering comprehensive data and information that emphasizes patient empowerment and unites all fields related to mental health, including welfare services.

Perspective 5: Establish an environment that allows for multi-stakeholders to engage in continuous discussions on mental health policy.

1. Ensure that all policies and projects are implemented and evaluated from the perspectives of people with mental disorders by including them in all discussion forums.
2. Enact a Basic Act for mental health that emphasizes the perspectives of people with mental disorders and promotes the creation of comprehensive mental health policies for prevention, treatment, and welfare.

Mental Health 2020 – Proposal for Tomorrow
Full Text

Perspective 1: Expand policies that raise mental health literacy in society and promote the activities of those most affected

Current Situation and Issues

According to the 2016 World Mental Health Survey (WMHS), the lifetime prevalence of mental disorders in Japan is 22.9%. This means that more than one in five people will develop a mental disorder at least once in their life, making mental disorder an issue that is close at hand for everyone. However, stereotypes and discrimination towards those with mental disorders have been long-standing issues in international society. Japan, as well, once used home surveillance for people with mental disorders and had the former Eugenic Protection Act, and efforts to eliminate stereotypes and prejudices against people with mental disorders are still ongoing. In hearings HGPI conducted with people with mental disorders and their families in 2020, we found that prejudices against mental disorders still remain strong. Those hearings also highlighted that people with mental disorders and their families feel that accurate understanding towards the symptoms of mental disorders and their treatments is still lacking. Also, as was pointed out at the "Global Trends and Japan's Mental Health Policy" Global Expert Meeting[2] (hereinafter referred to as the "global expert meeting") held by HPGI in December 2019, that although it has been proven that early detection and appropriate early measures are effective at improving life after diagnosis for people with mental disorders just as they are for people with other diseases, providing interventions from specialists in a smooth manner during the early stages of illness remains an issue. This problem is measured by indicators such as Duration of Untreated Psychosis (DUP) [3] or Duration of Untreated Illness (DUI).[4] We believe this is caused in part by a lack of knowledge concerning the symptoms and treatments, the effects of early intervention in particular. From the perspective of increasing social acceptance while enhancing the effects of treatment, Mental Health Literacy (MHL) must be improved.

In terms of Disability-Adjusted Life-Years (DALYs, a comprehensive measure of the years of life and quality of life lost to disease), mental disorders cause the greatest disease burden for people ages 15 to 44. Almost 75% of people who develop a mental disorder first experience symptoms before age 25, and it is believed that around half of them experience initial symptoms before age 14. We believe deepening understanding towards mental disorders among children and young people will create more opportunities for early intervention. Providing specialist support during periods that were previously unsupported is likely to decrease the disease burden of mental disorders in the future, and may make it possible to contribute to improving QOL for all people with mental disorders. For early intervention to take place, understanding and coordination with related parties outside of healthcare are important, as is building awareness among those parties. Primary and secondary educational institutions and their educational curriculums have significant roles to play in the effort to improve mental health during childhood and adolescence.

[2] A global expert meeting held on December 18, 2019 co-hosted by the Department of Frontier & International Psychiatry of the Graduate School of Medicine of Kyoto University and HGPI with cooperation from Johns Hopkins University. (For the full event report, see https://hgpi.org/en/events/mh2019-report.html)

[3] Duration of Untreated Psychosis (DUP): The time between the onset of positive or primary symptoms and the initiation of any intervention by a care professional, particularly pharmacotherapy.

[4] Duration of Untreated Illness (DUI): The period consisting of prodrome and DUP.

As for the situations that arise after diagnosis, efforts are accelerating in recent years to support people in independently determining the direction of their treatment or their lifestyle after hospital discharge, particularly for people who require inpatient care. Mental health policy in Japan has also moved in this direction, such as when the Act on Mental Health and Welfare for the Mentally Disabled was revised in 2013. Its eighth article was amended to require efforts to discover the best way to support decision-making and expressions of intent among people with mental disorders concerning treatment or discharge. In addition, the Basic Act for Persons with Disabilities and the Act for Comprehensive Welfare for Persons with Disabilities specify that when people with disabilities use welfare services, they must be provided with environments in which they can independently make decisions, and that the Government, local municipalities, and service providers are obligated to support them in doing so. Processes in which people can independently determine the circumstances that are best suited to them and can independently define their own values are essential for promoting the concepts of self-determination and personal recovery (which is currently a global trend within efforts to support people with mental disorders). However, in the hearings conducted by HGPI, we heard several times that long hospital stays tend to cause people to become passive receivers of care that only follow the instructions of the people providing them support, including family members. This highlighted the fact that the dignity and rights of people with mental disorders must be ensured before the best methods of supporting their self-determination can be understood. To leave behind the outdated form of care that consists of one side providing support and the other side passively receiving it, we must construct frameworks that allow the people providing support to perceive the people receiving support as equal parties in the decision-making process and for decision-making to take place under conditions of equality.

Policy Recommendations

1. Promote the activities of people with mental disorders and those close to them to improve mental health literacy for all of society

As discussed above, society's understanding towards mental disorders and disabilities is insufficient. Efforts must be made to improve mental health literacy (MHL) in society to eliminate prejudice and to promote understanding throughout all society as well as early diagnosis and intervention.

Various programs have been implemented to promote understanding towards mental disorders. Among them, activities conducted by people with mental disorders or their families in which they share their opinions and stories of their experiences are very likely to have positive effects on society. If people with mental disorders can talk about the treatments they underwent or the experiences they lived, or if their family members could share their experiences providing support with the world, not only will it become possible for the voices of those most affected to reach the rest of society, it will also have the potential to deepen understanding towards mental disorders. To deepen understanding towards mental disorders, it is extremely important for society to possess accurate medical knowledge concerning mental disorders and to learn about the unique experiences and feelings of people that have them. Such activities are also beneficial to people with mental disorders because it allows them to learn about the experiences of others. This knowledge improves MHL and is useful in everyday life.

Promoting the activities of those most affected requires an environment that allows them to resolve the issues that isolate them from their local communities and from information and to come together to express their opinions in spaces that are psychologically safe. Additionally, participants in our expert meetings pointed out that those most affected should share their names and faces with the public and

speak with a sense of agency. Establishing an environment in which people with mental disorders can express their opinions and engage in fair and mutual exchanges with their communities and with other people with mental disorders will be a starting point for deepening understanding towards mental disorders and people with mental disorders in society. We anticipate future mental health policy will go one step further in creating environments for promoting the activities of those most affected.

2. Improve every individual's ability to respond to mental health issues over the life course by expanding education on mental health in primary and secondary education and by reinforcing support services

As described above, children and adolescents are more likely to develop mental disorders, so it is essential to have a detailed approach to overcoming mental disorders among young people. Improving MHL among children and adolescents will make it possible to provide interventions in the early stages of illness. Because young people are able to readily absorb various types of information, we expect that improving MHL among children and adolescents will greatly contribute to improving MHL for all of society. We would like to place a particular emphasis on efforts targeting compulsory education, mainly primary and secondary education. Efforts should be considered from the perspective of improving educational curriculums and consultation support systems.

Improving mental health education curriculums for children and adolescents is likely to improve their current mental health and help them acquire the knowledge and self-management skills they need to maintain good mental health over the life course. Currently, there is no mention of mental health in educational guidelines for primary and secondary school, so the number of schools that provide opportunities for students of all ages to learn specifically about mental health in Japan is not likely to increase. Other countries have implemented mental health education for children and adolescents that is much more well-developed than in Japan. One example is Australia's Be You program.[5] By teaching young people specific actions to take to respond to bullying and to prevent mental health issues as well as by building understanding towards the effects of educational intervention, Be You provides an educational curriculum for improving resilience (which includes both the mental resilience and the natural healing power for overcoming adversity). Be You also includes support for building systems that allow teachers and schools to coordinate with facilities for health, medical care, and welfare. Providing knowledge about mental health, teaching specific coping methods, and building concrete support systems in this manner is likely to contribute to improving MHL among children and adolescents. Improving MHL will increase self-awareness and mutual awareness among students of all ages, and we expect that young people sharing issues they notice as a result of improved MHL with teachers and specialists will help them obtain early and appropriate interventions. Although the textbooks currently used in middle school educational curriculums in Japan do not cover topics related to mental health, the educational guidelines for high schools have been revised and will include information about mental disorder prevention and recovery from FY2022. Unfortunately, that information goes no further than explaining mental disorders. Educational curriculums that are more detailed, more practical, and more in-depth when teaching students specific information about mental disorders must be created to further deepen understanding towards mental health. Mental health education should aim to help students of all ages gain an age-appropriate understanding of mental health as an issue that affects them. Opportunities should be created for students to hear about the experiences of people with mental disorders directly or to think about how to respond when someone close to them, such as a friend or

[5] Be You: A comprehensive program that combines "Kids Matter," which targets children, and "Mind Matters," which targets adolescents.

relative, develops a mental disorder. For example, school education could be linked with the activities conducted by people with mental disorders mentioned in the previous recommendation by inviting members of the community with mental disorders or their family members to speak at schools.

Also, establishing systems for consultation or awareness-building within educational institutions will allow for earlier detection of mental health issues possessed by students of all ages and make it possible to provide interventions from the initial stages of illness. Among school staff, homeroom teachers are the people closest to students, so it is highly likely that homeroom teachers can notice changes or signs of mental health issues among students. However, homeroom teachers are not specialists in mental health, and it is widely known that they already face heavy workloads. First, proactive efforts to implement working-style reforms within educational institutions should be made to allow teachers to have more time to interact with each student directly. At the same time, systems should be constructed that allow teachers to easily access counselling with health specialists such as nursing teachers, school counsellors, and school social workers when a teacher feels there has been a change in a student. We have high expectations for efforts that improve systems for both school counsellors, who have central roles in helping students with mental health care, and for school social workers, who provide care by improving environments for students from a welfare perspective.

The Basic Plan for Promoting Education that was enacted by Cabinet Decision in 2018 called for placing school counsellors at all public elementary and middle schools and for school social workers to be placed at all middle schools. The Ministry of Education, Culture, Sports, Science and Technology (MEXT) added an item for establishing both of these positions in the FY2020 budget. In the future, it is necessary to create an environment in which school social workers can be trained and placed at all public elementary and middle schools so students can access both mental health care and safe and supportive environments from a welfare perspective.

3. Promote peer support activities to encourage self-determination among people with mental disorders

Peer support has come to play a major role in recent years. In peer support activities, people with mental disorders and their family members act as consultants to people with similar disorders and their family members. They also engage in shared social activities. There have even been cases when peer supporters have been hired at welfare or healthcare facilities, so use of peer supporters is growing more widespread. In HGPI's hearings, we heard stories of peer supporters becoming role models to people with mental disorders, particularly through contact with them during hospitalization. We believe that there are many cases when such contact gives hospitalized people the determination to live independently. Peer supporters who are family members of people with mental disorders are also important. These peer supporters provide other families opportunities to talk to someone and avoid becoming isolated. Because these peer supporters are family to people with mental disorders themselves, they can also teach other families how to support the person in their family with a mental disorder. The surrounding environment is a significant factor when encouraging self-determination among people with mental disorders. Because peer supporters see that environment from an equal position, they can play important roles in helping people with mental disorders become independent. It is necessary to make proactive and effective use of peer supporters to encourage self-determination among people with mental disorders.

In 2000, Osaka prefecture started the first project for peer support in the field of mental disorders in Japan called the Social Hospitalization Relief Project. In it, people with mental disorders were hired as self-help workers to engage in peer support activities. Then, in 2003, the central Government kicked off

a model project called the Project to Promote Hospital Discharge Support for People with Mental Disorders. That project resulted in people with mental disorders being hired as peer supporters at various facilities nationwide. Current measures that promote the use of peer supporters include the Project to Support the Creation of an Integrated Community Care System for Mental Disorders (which is part of the Project to Promote Community Living Support), the Project to Support the Community Transition and Settlement of People with Mental Disorders, and the Project for Wide-ranging Local Coordination, etc. of Community Living Support for Persons with Mental Disabilities, which is based on the Act for Comprehensive Welfare for Persons with Disabilities. However, the use of peer supporters is still insufficient. For example, more than half of all designated prefectures and cities that have been required to implement projects using peer supporters by the Project for Wide-ranging Local Coordination, etc. of Community Living Support for Persons with Mental Disabilities have yet to start any such initiatives. While establishing an environment in which the activities of peer supporters can proceed in a stable manner, efforts to prioritize the employment of people with mental disorders as peer supporters at every welfare office should be made. These measures will ensure the continuous use of peer supporters in every region based on the public initiatives mentioned above.

Although expectations towards peer supporters are rising and the range of their activities is expanding, some have expressed the opinion that it will be necessary to further deepen understanding towards peer supporters at welfare offices in the future. To spread know-how concerning the effective use of peer supporters, positive examples of peer supporter use, their effective placement, and ways for facilities to implement them must be shared. We also look forward to the future expansion of survey research as one method of gathering evidence on how peer supporters benefit people with mental disorders.

Perspective 2: Establish systems for providing care that are integrated into communities, compatible with everyday life, and meet the needs of people with mental disorders

Current Situation and Issues

Compared to 2002, when it was estimated that about 2.584 million people had mental disorders, the estimated number of people with mental disorders increased by approximately 1.6 times to 4.193 million people in 2017. While the number of people hospitalized has trended down from approximately 329,000 in 2002 to about 302,000 in 2017, the demand for outpatient therapy has expanded. The number of people receiving outpatient therapy increased from around 2.239 million in 2002 to around 3.891 million in 2017, an increase of approximately 1.7 times.

According to Mental Health and Welfare Data from FY2019, the number of psychiatric care beds available in Japan is approximately 310,000, and their number has trended downwards for the past decade. However, according to a 2016 report compiled by the Organization for Economic Co-operation and Development (OECD), Japan possessed 2.63 psychiatric care beds per 1,000 people. This rate was significantly higher than in Belgium, the country in second place, which had 1.38 psychiatric care beds per 1,000 people. From an international point of view, it is safe to say Japan has many psychiatric care beds.[6, 7] As for the categorization of psychiatric care beds, a 2012 report published by the Investigative Committee on Categorizing Psychiatric Healthcare Functions and Improving the Quality of Mental Health Care recommended promoting the categorization of psychiatric care beds according to the conditions or characteristics of patients. Based on an estimate calculated using emergency hospitalization fees, that report found that only about 29,000 beds were available for emergency and acute care. This was approximately one-tenth of psychiatric care beds. Chronic-stage care beds, which are eligible for psychiatric ward admission fees and a 15-to-1 ratio for basic hospitalization fees within the medical service fee schedule, were significantly more numerous and accounted for around two-thirds of psychiatric care beds. Measures to reduce the number of hospital beds by establishing psychiatric wards with enhanced community transition services began in FY2016. These wards proactively promote community transition for people hospitalized in chronic-stage care beds. However, these measures resulted in a reduction of just 2,000 beds. Also, according to hospital surveys, the average length of stay in psychiatric care beds has shortened by a significant amount over the past 30 years, from 496 days in 1989 to 265.8 days in 2018. However, it is still much longer than the average length of stay for general care beds, which is 16.1 days. Recently, the average number of days patients spend living in the community one year after being discharged from psychiatric wards (or, the average day count for community living) has been adopted as one indicator for evaluating the effectiveness of cooperative community living support systems. There are plans to introduce targets using this indicator in the sixth revision of the Disability Welfare Plan.

Furthermore, one of the characteristics of mental health care in Japan is that there are various hospitalization systems. They can be categorized widely into three types. In addition to voluntary hospitalization, which is done with consent from the person receiving treatment, there are two types of hospitalization that are not based on consent from the person in question: admission by legal control and medical protective hospitalization. According to Mental Health and Welfare Data from FY2019, 141,818 people are undergoing voluntary hospitalization, 1,585 people are undergoing

[6] OECD Health Data. (Last retrieved on June 30, 2020)

[7] Psychiatric care beds are defined differently according to country, so more detailed international comparisons are needed in the future.

admission by legal control, and 127,429 people are hospitalized for medical protection. In other words, involuntary hospitalizations that are not based on consent from the patient account for almost half of the total number of hospitalizations. Among people with mental disorders and their family members, there are many voices calling for reform in the systems for involuntary hospitalization, particularly for medical protection. When people are hospitalized, it can be difficult for them to receive permission to be discharged, and among people who become accustomed to living in hospitals, some lose their desire to return to independent living. It is for these reasons some have pointed out that involuntary hospitalizations can cause people to lose the lives they led before hospitalization. According to Article 33 of the Act on Mental Health and Welfare for the Mentally Disabled, hospitalization for medical protection is a system that applies to "Persons determined to have a mental disorder based on the results of an examination by a Designated Physician and requiring hospitalization for medical care and protection, but deemed not to be in a condition fit for hospitalization for the said mental disorders pursuant to the provisions of Article 20 (voluntary hospitalizations)." While consent from a family member or other such person[8] is a requirement for hospitalization, there have been cases when a family member consenting to hospitalization for medical care and protection caused the relationship of trust between them and the person with a mental disorder to collapse, so some are calling for this requirement to be removed. This provision has also been criticized for having a wide range of possible interpretations and for being vague about conditions in which it applies. In light of these issues, the Japan Society of Psychiatry & Neurology (JSPN) made specific recommendations in the Recommendations from the Committee for the Revision of the Act on Mental Health and Welfare for the Mentally Disabled presented in March 2016 that the need for consent from family members and other such parties should be eliminated as a requirement for hospitalization for medical care and protection. In addition, they recommended that the responsibilities of the national and local Governments within the system for hospitalization for medical care and protection should be clarified and that the conditions to determine who is eligible for hospitalization for medical care and protection should be revised to apply to people who "possess a medical diagnosis for a disease that is recognized internationally in the International Classification of Disease (ICD)," whose "capacity for independent decision-making concerning their need for treatment is obstructed by a mental disorder," and for whom "it has been determined that treatment other than hospitalization is unlikely to improve symptoms or prevent symptoms from worsening."

Article 12 of the Act on Mental Health and Welfare for the Mentally Disabled requires each municipality to establish Mental Health Review Boards. Mental Health Review Boards conduct independent, expert inspections to formulate and submit requests for treatment or discharge for people with mental disabilities who are hospitalized in psychiatric wards, to provide regular reports on or submit discharge requests for people undergoing admission by legal control or hospitalization for medical care and protection, and to inspect requests to improve treatment. According to Mental Health and Welfare Data from FY2019, among the 127,429 people hospitalized for medical care and protection, Mental Health Review Boards processed discharge requests for just 3,730 cases from April 2018 to March 1, 2019. This was only 2.9% of all people hospitalized for medical care and protection. Looking at the results of those inspections, there were only 52 cases when they determined that continued hospitalization was not appropriate. That figure includes cases that had been pending since FY2017 and only amounts to about 2% of the total number of discharge requests. Among the

[8] Includes spouses, people with parental authority, people legally responsible for providing support, guardians, or curators. When no such parties are available, the mayor of the municipality must submit approval on their behalf.

discharged cases, it took 33.6 days on average from the time discharge requests were submitted to when notifications of inspection results were provided. The longest case, in Kochi Prefecture, took 57.7 days. Some have expressed the opinion that Mental Health Review Boards are not fulfilling their original intended purpose of checking involuntary hospitalization systems.

Another aspect of mental health care in Japan is that isolation and physical restraint are regulated by the Act on Mental Health and Welfare for the Mentally Disabled. According to Mental Health and Welfare Data from FY2016, approximately 9,935 people were kept in isolation rooms. Meanwhile, the number of people kept under physical restraint more than doubled since 2003, from 5,109 people to 10,298 people.

Although discussions on mental health care tend to focus on inpatient care, as described above, the number of people receiving outpatient care is increasing. As such, outpatient care and home care have come to play especially important roles. From the perspective of preventing new hospitalizations and rehospitalizations, it is important to build a system that provides an effective combination of outpatient care and home care to people living in communities.

Turning our attention to the distribution of healthcare resources, national health insurance expenditure statistics from 2017 show that hospitalization expenses accounted for 71.1% of all medical expenses for mental or behavioral disorders. Examining total medical expenses outside of those for mental or behavioral disorders, however, we find that hospitalization fees only accounted for 51.4% of all medical expenses. In other words, the ratio of expenses for hospitalization to overall medical expenses was higher for mental health care than for other types of healthcare, which is a sign that the amount of resources devoted to hospital treatment for mental health care is high in terms of medical expenditures.[9] However, work on plans to improve out-of-hospital treatments has been progressing for a number of years. In FY2013, expenditures for out-of-hospital treatments for mental and behavioral disorders was 517.8 billion yen, which was 27.5% of all expenditures for treatments for mental and behavioral disorders. That amount steadily grew to 553.9 billion yen in 2017, or 29.0% of the total.

Out-of-hospital care can generally be split into three categories: general outpatient care, emergency care, and home care. Forms of in-home care like home medical examinations and home nursing are particularly important for ensuring that people who have suspended treatment or people living at home in their community while managing their symptoms post-discharge have access to the care they need. In addition to existing types of care, efforts to establish an outreach system in which multidisciplinary teams provide in-home support are advancing. In an extension of the Community Life Support Service by Prefectures system established in FY2014, measures to support the creation of outreach programs or training programs for healthcare professionals working with people with mental disorders have started to be implemented to build the Integrated Community Care System for Mental Disorders as part of the FY2018 Community Life Support Service project. However, as of FY2018, only Tokyo and Okayama Prefecture had implemented outreach programs as part of the Community Life Support Service by Prefectures system, so we look forward to efforts to expand this program in the future. From the perspective of medical service fees, a new item called the “Management Fee for Early Intensive Support for Psychiatric Patients” was added to provide payments for home care provided by

[9]“Mental and behavioral disorders” includes intellectual disability and does not include epilepsy or Alzheimer's disease. Pharmaceuticals, hospital meals, and other such expenditures were not included when calculating their total expenditures.

multidisciplinary teams for people with unstable symptoms in the FY2014 revision of the medical service fee schedule. However, examining applications from June 2018 shows that 513 payments were made for non-intensive support visits while only 41 payments were made for intensive support visits, so providing intensive in-home care for patients with serious symptoms remains an urgent issue.

Policy Recommendations

1. Enhance inpatient care systems to fully meet the needs of people with mental disorders while providing care in a way that upholds their dignity and respects their rights

Steps to verify that inpatient care systems uphold the dignity and respect the rights of people with mental disorders while providing effective and efficient care should be taken, and inpatient care systems should be overhauled when necessary.

- **Reexamining the system for hospitalizations for medical care and protection while improving support for people with mental disorders, their families, and other people most affected**

Patient satisfaction is an important aspect of healthcare for any type of treatment. It includes their acceptance of the situation and the explanation they received from their healthcare provider. In mental health care, just as in general healthcare, a significant amount of attention must be devoted to obtaining advance consent and acceptance from the person in question towards the service being provided, and efforts to that end are necessary. However, in mental health care, approximately half of all hospitalizations are admission by legal control or hospitalizations for medical care and protection, both of which are not based on consent from the person in question. In particular, many people with mental disorders or their family members have called for reforms to the system for hospitalization for medical care and protection.

The system in the U.K. requires the inclusion of Approved Medical Health Professionals (AMHP) in the involuntary hospitalization process. Two doctors of psychiatry and one AMHP must give their approval before an involuntary hospitalization can take place. If the AMHP objects, the hospitalization process is suspended. Compared to Japan, the system in the U.K. works to minimize hospitalizations without the consent of the affected individual. Moving forward, the system for hospitalization for medical care and protection must be reexamined while referring to systems used in other countries to rebuild it in a way that ensures the dignity and respects the rights of those most affected starting with the rights granted by the Convention on the Rights of Persons with Disabilities.

While reviewing the system for hospitalizations for medical care and protection, it is also necessary to consider methods of providing care to and reducing the burdens of family members and supporters of people with mental disorders to promote the ability of people with mental disorders living in communities to maintain emotional stability while receiving treatments or during daily living. It has been pointed out that, historically, the hospitalization for medical care and protection system may have had an aspect of relieving family members from the burden of care duties, so one factors that caused hospitalizations for medical care and protection to increase was that more and more family members and supporters were unable to keep up with the demands of providing care. In the hearings conducted by HGPI, many people said, “I do not want to view our relationship as a person providing support and a person receiving it, but as family members.” Looking at other fields, discussions on the role of family members were also held when the Long-term Care Insurance System was established. During those discussions, it was mentioned that the physical and mental aspects of care provided by family members should be considered separately. Although the concept of “community living” is addressed in Perspective 3, is by no means limited to returning hospitalized people to their own

homes. Rather, there should be a system that starts by helping hospitalized people think about where they want to live and provides options for living environments that meet their preferences. Also, to prevent the burdens placed on supporting family members and caregivers from growing too large, steps are necessary to provide sufficient access to specialized welfare services to people with mental disorders living at home. When family members wish to be caregivers, it is necessary that third parties specializing in support also continue providing care to prevent the burdens placed on those family members from growing too large and to avoid unforeseen violations of the dignity and rights of the person receiving care. With this backdrop, it will be necessary for people with mental disorders, their family members, healthcare, medical, and welfare professionals, legal experts, and representatives from local governments to come together and create forums for building consensus that meet conditions in the community based on the needs of people with mental disorders and their families.

- **Establish a third-party evaluation system to conduct site inspections and assess efforts to appropriately optimize isolation and physical restraint practices**

From the perspective of upholding the dignity and respecting the rights of people with mental disorders, the use of practices like isolation and physical restraint must be kept to the bare minimum. In recent years, efforts to optimize the use of physical restraint through the reimbursement schedules for both medical services and long-term care services have been advancing. In the 2016 revision of the medical service fee schedule, a new rule was added for dementia care that clearly stated a predetermined score would be subtracted on the day physical restraint is implemented. In the long-term care fee reimbursement schedule, guidelines to optimize the use of physical restraint and similar practices were established in 2018. Those guidelines also require facilities to convene regular meetings of inspection committees on optimizing physical restraint and similar practices, and a new calculation called the “Physical Restraint Elimination Adjustment” was added to the schedule. This calculation decreases the basic reimbursement fees paid to facilities that fail to meet their obligations to optimize the use of physical restraint. These measures for optimizing physical restraint have mainly been in the field of dementia, so in the future, it will be necessary to expand their scope to cover other mental disorders and to analyze factors that lead to increased use of physical restraint in psychiatric wards. It will also be necessary to establish measures ensuring that the medical care service fee schedule accurately reflects healthcare institutions’ efforts to optimize the use of physical restraint. At the same time, methods of conducting on-site inspections and evaluations of isolation and physical restraint practices by third-party institutions, particularly Mental Health Review Boards, should also be considered.

- **Improve circumstances for Mental Health Review Boards (whose work currently focuses on document review) and expand them with two or more people representing those most affected**

On the topic of the Mental Health Review Boards, it was pointed out during the proceedings of the Investigative Committee on the Future of Mental Health Care and Welfare (which was established by the MHLW in 2016) that the review system places too much emphasis on document review, that review practices vary by region, and that Mental Health Review Boards may lose their impartiality if one of the healthcare professionals on the committee happens to be the subject of a document review.

In the future, it will be necessary to transition away from the current system that overly-emphasizes document review and replace it with one that includes site inspections at randomly-selected medical institutions that have received requests for discharge or improvement of treatment. Those inspections should be conducted by doctors who do not belong to the institutions being inspected. This will require sufficient funding to improve the review board system. In addition, the methods of how Mental Health

Review Boards are formed should be reconsidered to establish a review system based on the perspectives of those most affected. Currently, Mental Health Review Board membership is determined by the governor of each prefecture who selects two or more people with knowledge and experience in psychiatric care (limit to designated mental health physicians), one or more people with knowledge and experience providing healthcare or welfare to people with mental disorders (such as psychiatric social workers), and one or more people with knowledge and experience in law (such as attorneys or public prosecutors). To ensure that reviews are conducted from the perspectives of those most affected, one option would be to increase Mental Health Review Board membership to seven people to include people with mental disorders and their families. At the same time, a system should be established for providing people who are currently hospitalized with opportunities to express their opinions to Mental Health Review Boards and to file objections to review results.

- **Build a system that appropriately evaluates post-discharge support provided by healthcare institutions**

To help people with mental disorders be discharged from hospitals as soon as possible and live in their communities with peace of mind, not only is it important to establish an environment and the necessary systems to help communities accept them, it is also desirable that healthcare institutions provide support that takes post-discharge community living into account during hospitalization. Currently, incentives that encourage healthcare institutions to provide patients with post-discharge guidance are being added to the medical service fee reimbursement schedule. One example is the Psychiatric Care Guidance Fee, which applies to post-discharge guidance provided by multidisciplinary teams for people with mental disorders or their family members in cases when their hospitalization lasted longer than one month. Another is the Joint Guidance Fee for Psychiatric Discharge, which was added in the FY2020 revision of the fee schedule and applies to joint guidance provided at the time of discharge by multiple professionals or in a multidisciplinary manner. Because it does not apply to people who have been hospitalized for less than one month, the Psychiatric Care Guidance Fee has been criticized for ignoring early intervention. Therefore, a system should be implemented that allows discharge guidance or support to be provided during even earlier stages of hospitalization.

Furthermore, places to live, places to work, and social cohesion are absolutely necessary for daily living in communities. To provide those, healthcare institutions and local health or welfare facilitates must cooperate. Appropriate evaluations should be conducted on efforts made by healthcare facilities to cooperate with local health and welfare facilities, such as when they provide information to local health and welfare facilities providing services that people with mental disorders will require for daily life in communities after discharge.

- **Conduct fact-finding surveys and analyses on social and economic backgrounds of patients hospitalized in psychiatric wards for the construction of appropriate post-discharge support systems**

There are various reasons it is difficult for people who have been hospitalized for long periods of time to be discharged. A past study that categorized psychiatric wards into three groups by function (those groups being: treatment type, or those that treat mental disorders; public safety type, or those that provide public safety for people with tendencies for self-harm; and social welfare type, or those that prevent patients and their families from struggling financially) pointed out that regardless of the severity of psychiatric symptoms, there were cases when people were hospitalized for reasons related

to their economic backgrounds or their relationships with their families.[10, 11] To provide post-discharge support that takes the backgrounds of the people with mental disorders themselves or their family members into account regardless of disorder or severity of symptoms, surveys and analyses should be conducted on the real-world conditions facing psychiatric hospitalization based on social and economic backgrounds in addition to severity of psychiatric symptoms or their type. When doing so, steps must be taken to guarantee private personal information is protected.

2. Enrich systems for providing outpatient care with community engagement and multi-disciplinary cooperation

To improve outpatient treatment and in-home care through multidisciplinary cooperation to make community living for people with mental disorders the new standard, a system to provide the appropriate treatment and support in communities should be built while taking a multifaceted view of the circumstances facing people with mental disorders.

While some have voiced concern towards the possibility that helping people transition from hospitals or care facilities to communities may increase healthcare costs, considering the perspectives of people with mental disorders and the diversity of values in society, discussions should focus on those costs as necessary investments towards building an inclusive society and improving future public health.

- **Promote cooperation between healthcare facilities and health, welfare, and educational institutions to promote early diagnosis and improve access to treatment**

As mentioned in Perspective 1, early detection and appropriate early measures are effective at improving life after diagnosis for people with mental disorders just as they are for people with other diseases, but providing interventions from specialists in a smooth manner during the early stages of illness remains an issue. To shift public perception so that people perceive mental health care as an issue that is as close to them as general healthcare and to transform society so that people can receive appropriate mental health care services when they notice an abnormality in their mental state, various steps should be taken to improve access to mental health care. These include providing education on mental disorders or early intervention for mental disorders to family doctors in communities who treat physical health such as internists, promoting coordination between family doctors and doctors specializing in psychiatry, and promoting coordination between mental health facilities and community health or welfare institutions, such as public health centers. As we also mentioned in Perspective 1, evidence suggests that many psychiatric symptoms first appear during childhood or adolescence, so coordination with primary and secondary educational institutions is important. One positive example of coordination between health and educational institutions comes from the Vision Project of Psychiatric Care from the Perspective of Psychiatric Clinics conducted by the Japanese Association of Neuro-Psychiatric Clinics (JAPC). In that project, psychiatric social workers from psychiatric clinics were independently placed at schools as school coordinators. There, they acted as points of contact for information exchange with local schools, participated in case interviews, and conducted school visits based on requests from schools or family members. This project provided several examples of how to build face-to-face community support networks for children. However, the medical service fee

[10] Goto, M. 2019. “The History of the Structure of Psychiatric Hospitalization in Japan: Social Defense, Treatment, and Social Welfare.” University of Tokyo Press, pp. 6-7.

[11] Ando, M. and Goto, M. 2020. “Long-term Psychiatric Hospitalization within Public Assistance: Analysis the 'Fact-finding Survey on Mental Disorders in Hospitals' 1956 Registry.” Psychiatria et Neurologia Japonica, 122 (4), pp. 261 -281.

schedule does not have an entry for the activities of school coordinators, such as school visits. While referring to positive examples like this, when systems for sharing information or for coordination between healthcare and educational institutions have been built, economic incentives for health or educational institutions should be provided and systems to provide support through national or local Government projects should be considered in the future.

- **Create systems for providing a wider variety of treatments through multidisciplinary cooperation**

To provide better post-discharge community living support, services and programs like psychiatric day care services, multidisciplinary outreach programs, and services providing home visits by psychiatric nurses should be improved. To improve outreach, particularly those targeting people with severe symptoms, outreach programs should be expanded and the addition of relevant incentives for healthcare institutions in the medical service fee schedule should be considered.

It is likely that utilizing the expertise of various professionals in addition to psychiatrists can improve emergency and in-home care. These include nurses, psychiatric social workers, certified psychologists, clinical psychologists, and occupational therapists. In the U.K., Mental Health Teams (MHT) that include psychiatrists, nurses, clinical psychologists, certified social workers, and occupational therapists have been established in every region to provide each patient the psychiatric care and welfare services they require on an individual basis. MHTs include Primary Mental Health Teams (PHMTs), which provide primary care in the field of mental health by collaborating with health and educational institutions, and Community Mental Health Teams (CMHTs), which provide comprehensive support for people with severe symptoms. PHMTs include clinical psychologists and nurses who provide primary mental health care and can refer patients to institutions providing secondary healthcare or welfare services. CMHTs include social workers and occupational therapists who work as coordinators to create support plans for each patient. Said plans provide individualized support from each professional as well as comprehensive multidisciplinary support. The main role of coordinators is to manage support systems for patients and to review and alter support plans according to changes in the patients' symptoms or environments. The establishment of CMHTs in every region has created a centralized system for providing health, medical, and welfare services in the U.K. We consider this one positive example of a system for improving QOL for people with mental disorders by supplementing support from psychiatrists with multidisciplinary support from other professionals such as nurses, certified social workers, occupational therapists, and psychologists.

To improve support for developmental disorders in Japan, the FY2020 medical service fee schedule revision added coverage for services provided by specialists other than physicians. For example, eligibility for payments for counseling targeting specified chronic diseases in childhood was expanded to include certified psychiatrists that only physicians were eligible to receive in the past. To promote further cooperation between healthcare, medical care, and welfare and to build systems for implementing support based on the expertise and experience of each professional, support plans that fit the conditions, environments, and needs of people with mental disorders must be created and implemented in each region. The provision of support in those systems should be managed by specialists in support management such as psychiatric social workers. Although cognitive behavioral therapy (CBT) is a standard form of psychotherapy and is a viable alternative to pharmacotherapy, in Japan, the medical service fee schedule only provides coverage for CBT when it is provided by physicians or teams of physicians and nurses. In the U.K. and other countries, there are many cases where such care is provided by clinical psychologists. Japan should also consider using certified and

clinical psychologists to provide CBT. At the same time, the skills of certified and clinical psychologists should be improved through training programs using curriculums which clearly outline the necessary knowledge and skills needed to provide CBT.

- **Examine the effects of online medical examinations on those most affects and verify safety and effectiveness**

In June 2020, the time of writing, advances in information and communications technology (ICT) and the spread of the Coronavirus Disease 2019 (COVID-19) pandemic have resulted in high levels of interest towards online medical examinations. Online examination systems can lower costs for patients by eliminating the need to commute to healthcare institutions. They also have the potential to improve access to healthcare and prevent the suspension of treatment among people whose psychiatric symptoms or surrounding environment make it difficult for them to leave their homes. Online examinations also have the potential to help people with mental disorders balance treatment and employment. From the perspective of establishing a greater variety of treatment options, online examinations should be considered for psychiatric care in the future.

In Japan, the FY2018 revision of the medical service fee schedule defined in-person consultations as the baseline for providing care and added a new entry called the “Online Examination Fee,” which applies when information transmission devices are used to conduct examinations. Within psychiatric care, patients must qualify for the "Support Management Fee for Home Care for Psychiatric Patients" for applicable online examination fees to be reimbursed. These conditions were changed in the FY2020 revision of the medical service fee schedule and, on April 10, 2020, it became possible to conduct initial examinations online as a limited measure in response to the spread of COVID-19. Given these developments, we expect interest in online medical examinations to increase more in the future.

Online examinations for mental health care are starting to be introduced in the U.S. as well. A study conducted by the RAND Corporation comparing the benefits of online video examinations to in-person examinations found improved access to treatment and improved the ability of doctors to grasp the living conditions of patients for examinations conducted online.[12] On the other hand, online examinations made it more difficult for doctors to detect non-linguistic information such as patient gestures or expressions, and there were also many issues related to patient privacy management and scheduling. It must also be mentioned that this study had a limited target period and cohort size.

In the future, it will be necessary to gather evidence for the effects of online examinations in mental health care from the perspectives of people receiving care, such as by gathering user impressions. While doing so, it will also be necessary to refer to real-world examples of the implementation of such systems in other countries and fields of medicine.

3. Promote cooperation between healthcare and welfare services to build an Integrated Community Care System for Mental Disorders

Currently, to help people with mental disorders live true to themselves with peace of mind and as full members of their communities, efforts are underway to build an Integrated Community Care System for Mental Disorders with the capacity to respond to mental disorders in aspects such as healthcare,

[12] Lori Uscher-Pines, PhD, Jessica Sousa, MSW, Pushpa Raja, MD, Ateev Mehrotra, MD, Michael Barnett, MD, Haiden A. Huskamp, PhD. Suddenly Becoming a “Virtual Doctor”: Experiences of Psychiatrists Transitioning to Telemedicine During the COVID-19 Pandemic. Psychiatry Online. American Psychiatric Association. 2020

disability welfare and long-term care, housing, social participation (employment), community cooperation, and education.

During discussions at expert meetings hosted by HGPI or in hearings we conducted with people with mental disorders, their families and supporters, and representatives from medical, health, or welfare institutions, many stakeholders mentioned that the existing environment surrounding mental health care and welfare places hospitals on the opposing side of communities and patients. However, hospitals have many critical roles to play in the effort to create the Integrated Community Care System for Mental Disorders, particularly in providing emergency care. Discussions must be based on a shared recognition that hospitals are important local resources for creating inclusive communities.

- **Include psychiatric care beds in Regional Medical Care Visions for the optimal distribution of healthcare resources in communities**

Based on the Amendatory Law to the Related Acts for Securing Comprehensive Medical and Long-Term Care in the Community (which amended the Acts for Securing Comprehensive Medical and Long-Term Care in the Community), efforts have been underway to formulate Regional Medical Care Visions within Medical Care Plans (MCPs) at each prefectural and municipal government since FY2015. The goal of Regional Medical Care Visions is to outline healthcare provision systems that best meet the needs of communities by 2025, when the baby boomer generation will be age 75 or older. To do so, these visions categorize care beds by function to estimate future healthcare demand and the necessary number of beds in each region. They also aim to promote cooperation in healthcare, to improve in-home care, and to train and secure healthcare professionals.

Mental disorders were included as one of the five illnesses targeted by the sixth revision of the Medical Care Plan System that came into effect in FY2013, which requires every prefectural government to formulate plans to guarantee the necessary mental health services can be provided. To ensure the creation of the Integrated Community Care System for Mental Disorders in the future, Regional Medical Care Visions created within each regional MCP should include psychiatric care beds. The current bed categorization system used by the MHLW assigns different types of beds to different organizations. While general care beds and long-term care beds are managed by the Health Policy Bureau, psychiatric care beds are under the jurisdiction of the Mental Health and Disability Health Division together with mental health and welfare services. To more accurately grasp the need for psychiatric care beds as a healthcare resource in each community, systems for managing psychiatric care beds in the same manner as other care beds should be considered. For example, they could be placed under the jurisdiction of the Health Policy Bureau when necessary.

Perspective 3: Build an infrastructure for community living that provides places to live, places to work, and places to belong

The Current Situation and Issues

In situations when someone has been hospitalized due to the state of their mental disorder, it is absolutely essential for communities to have places to live and work as well as social cohesion in order for the hospitalized person to be discharged and return to community living as soon as possible. Therefore, a foundation for community living must be established to provide both places to belong as well as social participation. However, according to people who have been hospitalized with mental disorders or their family members, there are many cases in which it is difficult for them to return to workplaces or schools after being hospitalized. Many people have told us about cases in which lengths of stay among hospitalized people grew longer because they did not possess a vision of their life after discharge. In addition, a survey conducted by the MHLW found that among people who did not want to be discharged, some of them did not want to be discharged due to financial reasons. Others felt uncertainty towards finding places to live or lacked confidence in their ability to live alone or manage a household.[13]

Among people with disabilities, the number of people who want to work is increasing while measures to employ them are advancing year by year. Meanwhile, employers are gaining a deeper understanding towards employing people with disabilities and efforts to promote the employment of people with disabilities at facilities related to employment support are accelerating. These facilities include Employment and Livelihood Support Centers for Persons with Disabilities, Vocational Centers for People with Disabilities (including Wide-area and Local Vocational Centers for Persons with Disabilities), and Hello Work. Their efforts have resulted in increasing employment numbers and employment rates among all types of people with disabilities.

Furthermore, based on the Act on Comprehensive Support for Persons with Disabilities, programs to help people with disabilities find employment and continue receiving support while working have been established within welfare services for people with disabilities. These programs include the Employment Transition Support System for Persons with Disabilities, which aims to help people find standard employment; Support for Continuous Employment programs, which are categorized into Type-A and Type-B programs according to the content of support being provided or if standard employment is difficult; and the Employment Retention Support Program, which was established in FY2018 and aims to help people with disabilities maintain employment after transitioning to standard employment.

The Employment Transition Support System for Persons with Disabilities aims to help people with disabilities gain standard employment by providing the necessary knowledge, technology, and support for job-seeking activities, as well as retention support after successful placement. According to data from the MHLW from March 2019, 9.1% of people with mental disabilities were users of this system. The time limit for using this system is two years, during which it provides employment preparation programs, support for job-seekers, and job simulations. Unlike the Support for Continuous Employment

[13] FY2014 Ministry of Health, Labour and Welfare Comprehensive Welfare for Persons with Disabilities Promotion Project. “Needs Survey for Community Transition and Daily Living Support for People with Mental Disorders.” https://www.mhlw.go.jp/file/06-Seisakujouhou-12200000-Shakaiengokyokushougaihokenfukushibu/0000099369.pdf.

program, users of this system cannot receive wages. While some of its users would like to pursue short-term contracts or part-time work while receiving training for future employment through this system, as a general rule, they are not allowed to do so because municipalities consider part-time positions to be employment. Considering the steps users must take to obtain standard employment, expectations are high for this system to become more accessible, flexible, and effective at increasing user motivation towards employment in the future.

Support for Continuous Employment programs teach people how to find employment opportunities and help them improve their skills. As of March 2019, approximately 14.0% of people with mental disabilities were using Type-A Support for Continuous Employment programs.[14] Type-A programs require companies to form employment contracts and usage contracts with the people using the program and with welfare services. People who use Type-A programs are considered employees and are eligible to receive wages that satisfy minimum wage standards. Providing welfare support while securing employment opportunities that satisfy minimum wages is a significant issue for those operating Type-A programs. Meanwhile, 39.3% of people with mental disabilities were using Type B Support for Continuous Employment programs as of March 2019.[15] Among all welfare programs for people with disabilities, Type B support programs have the most users. Type-B programs provide welfare support and work activities that are appropriate to users' abilities. It is difficult for Type-B program operators to find employment opportunities that satisfy minimum wage requirements, so there are many cases when the earning potential of program activities is not enough to cover service usage fees. As a result, it has been reported that many program operators face difficulties helping users maintain their motivation. However, in addition to providing a stepping stone to employment, multiple people during our hearings expressed the opinion that Type-B programs effectively provide places to belong, so it is safe to say that Type-B programs have great social significance among people who are not yet ready to aim for standard employment.

The newly-established Employment Retention Support Program aims to help people with disabilities who have transitioned to standard employment overcome lifestyle issues that accompany employment while helping them maintain employment. Program representatives visit workplaces and homes or have users visit the program office so that program representatives can provide guidance or advice. Program representatives also serve as liaisons between the user and employer because there are cases when people with mental disorders are unable to recognize issues as readily as other people might recognize issues. Therefore, supporters must be highly-skilled communicators who can help program users communicate with people at their workplaces or healthcare institutions in a precise manner.

In vocational support programs within welfare services for persons with disabilities, support must be provided in a precise manner according to the characteristics of the mental disorder of the program

[14] Type-A Support for Continuous Employment programs: For people facing difficulties finding or maintaining standard employment and who are able to accept contract-based employment, these programs provide opportunities to work or engage in other productive activities by forming employment contracts and other agreements. They also provide other forms of support such as training to acquire the knowledge or skills required for employment.

[15] Type-B Support for Continuous Employment programs: For people facing difficulties securing standard employment through contract-based employment or through other such agreements, these programs provide opportunities to work or engage in other productive activities. They also provide other forms of support such as training to acquire the knowledge or skills required for employment.

user in addition to the user's personality and abilities. However, there are significant differences in the quality of support according to each program operator. Also, from the perspective of enhancing program sustainability and securing highly-specialized staff, the framework for providing payments to program operators has been an issue that has received continuous discussion. Various aspects of this issue were mentioned in our hearings. For example, when many users simultaneously transition from programs to standard employment, it can cause program operator income to plunge until more users join the program. This is a significant source of uncertainty. Another item that was raised is that the fixed monthly payment for program operators provides one fixed monthly payment per user without reflecting the practical value of each individual user while ignoring variations in the levels of support required by each user. Also, payments for psychiatric day care services or outpatient healthcare institutions that serve program users after they are discharged from hospitals have yet to be established in clear terms. As a result, current programs are limited to activities at businesses or healthcare institutions that participate voluntarily. Incentives that promote rapid cooperation between healthcare and welfare must also be established.

On the topic of housing, low-cost housing is limited and there are cases in which rental applications for private rental properties from people with disabilities are rejected. As the population declines, providing more public housing is not a realistic option. There are also many cases when people with disabilities have nobody who can serve as their guarantor, have no family members who can respond in emergencies, or require support services for daily living.

With that backdrop, the New Housing Safety Net System was put into place after the 2017 revision of the Act on Housing Safety Net. This system provides a registration system for rental properties that do not reject people requiring special assistance in securing housing (such people belonging to low-income households, victims of natural disasters, elderly people, people with disabilities, and people with young children), economic support for remodeling or moving into registered properties, home matching services for people requiring housing support and moving support for easier move-ins, and an insurance system for landlords. The Ministry of Land, Infrastructure, Transport and Tourism (MLIT) has also created guidelines to help landlords rent to people who require special assistance in securing housing.[16] Additionally, to promote the creation of an environment in which people who require special assistance securing housing can move into private rental properties more easily, Residential Support Councils have been established by building networks between parties such as municipal governments, real estate-related organizations, and housing support organizations (such as NPOs and social welfare corporations). In addition to promoting mutual cooperation and information exchange between these parties, Residential Support Councils make efforts to increase the number of local properties that can be rented to people requiring special assistance in securing housing. By the end of May 2020, a total of 98 Residential Support Councils had been established (47 at the prefectural or regional level and 51 at the municipal level).[17]

[16] Ministry of Land, Infrastructure, Transport and Tourism. *Landlords' Handbook for Renting to People Requiring Special Assistance in Securing Housing.* https://www.mlit.go.jp/jutakukentiku/house/jutakukentiku_house_tk3_000056.html. Last retrieved August 7, 2020.

[17] Confirmed over telephone with staff at the MLIT Housing Bureau Safe Housing Department on June 4, 2020.

In addition to support for the tangible aspects of housing, types of support that address abstract aspects of maintaining stable, independent daily living and help people handle the demands of daily life, such as general household management or financial management, are also necessary. The 2018 revision of the Act for Comprehensive Welfare for Persons with Disabilities established services to support independent daily living for people who wish to live alone. Specifically, users of these services receive regular home visits during which supporters check on their situations to confirm they are able to perform everyday tasks associated with independent living, such as cooking, laundry, or cleaning; paying bills and rent; maintaining physical health; making scheduled visits to healthcare facilities; and forming relationships with other people in the community. They also provide users with whatever information, advice, and consultation they require, and contact and coordinate with related institutions (such as the Project Consultation Support Office, disability welfare service centers, and healthcare institutions) when necessary. In addition to providing the support needed to establish an environment in which the people receiving support can independently handle the tasks associated with daily living, supporters also handle consultation requests from non-regular or occasional users.

Looking at the general situation in Japan, however, the housing safety net is insufficient. Rents are generally higher than welfare benefits, particularly in urban areas, and even when people manage to raise the funds to cover rent, it tends to cause pressure on other aspects of their daily lives. Also, due to worsening economic conditions accompanying the global spread of COVID-19 that began in early 2020, the difficulties of securing housing faced by people who lost their jobs has already become a major topic that has been reported in various news outlets. Although the focus of this document is to propose policies for the field of mental health, determining how to help people maintain the bare minimum cultural standards for daily living in good health and the best way to ensure housing security, such as by providing a housing allowance in addition to income support, is an issue for all of society.

Policy Recommendations

1. Ensure that people with mental disorders can plot their own life courses, including those who wish to consider their medium- and long-term career development

As average lifespans grow longer, the importance of recurrent education has been strongly emphasized in recent years. Recurrent education aims provide people opportunities to attend educational institutions even after they have completed compulsory education so they can pursue new career paths. People with mental disorders also require such opportunities. That education should not only involve people deciding what type of work they wish to do in the medium- to long-term, planning their ideal future lifestyle, and working towards the goal of obtaining stable employment; opportunities must be created for people with mental disorders to receive the right education at the right times according to their psychological health or level of skill. That education should start as soon as they can receive employment support services and involve cooperation from third parties like educational institutions. Furthermore, to support people undergoing inpatient treatment, it is necessary to build incentive models that allow psychiatric day care services and outpatient healthcare institutions to be able to provide support with the goal of achieving independent living that starts as soon as people are discharged. This can be achieved by providing financial incentives that supporters can readily access, such as by providing allowances for cooperative efforts between healthcare and welfare institutions.

Government assistance is needed to support all varieties of facilities providing employment support so they can work with specialists in human resource (HR) utilization and training. These specialists might include people with experience at HR departments in companies or organizations. That assistance should help facility personnel develop skills that will be useful both during normal program operations

and after the people receiving support secure stable employment. It is also necessary for the Government to establish a framework for supporting facilities as necessary and evaluating support facilities that actively work to help people with mental disorders establish career paths.

2. Empower people with mental disorders to objectively grasp their own psychological states and allow them the flexibility to adjust their daily lives accordingly

People with mental disorders sometimes experience changes in their psychological states that even they did not anticipate. While current employment standards for people with mental disorders require them to work 20 hours or more per week, people with mental disorders that can cause sudden changes in their psychological states can face greater obstacles due to this requirement, particularly among people affected by the season. While various businesses and municipalities have already begun trials with "super short employment" contracts,[18] an environment that allows people to continuously maintain employment must be created. Doing so might require fundamental reform of existing employment regulations for people with mental disorders so systems allowing for flexible employment can be created. In such systems, people would not be forced to suspend their employment because they experienced a change in their psychological condition.

To help people with mental disorders grasp their own psychological states and be able to choose health, medical, and welfare services independently, it is important for them to perceive themselves as playing the leading roles in their own lives. And, when working or engaging in other forms of social participation, it is absolutely essential for people with mental disorders to be able to grasp their current psychological states in an objective manner. Systems using ICT that help them to do so must be developed and popularized. One such system is the Supporting People to Improve Stability (SPIS)[19] system that was developed as an employment retention support system in 2012 by people with mental disorders. The SPIS system allows people to enter data on their psychological and physical states every day so they can obtain an objective view of their condition. It also allows them to share that data with employers or support specialists. We anticipate the SPIS system will help people with mental disorders and those around them to communicate in a smoother manner. Financial support should be provided to businesses and employment support offices that implement such systems.

Additionally, because it is possible for anyone to develop a mental disorder, opportunities for early detection and intervention must be created. This can be done by incorporating mental health checks into all types of medical check-ups and by improving mental health checks conducted regularly by employers. At the same time, systems must be established that allow people to maintain daily lives as close to normal as possible.

3. Unite housing support organizations, people with mental disorders, and mental health specialists to take local housing conditions into account and establish environments that are agreeable to both borrowers and lenders

[18] An employment model proposed by Associate Professor Takeo Kondo of the University of Tokyo's Research Center for Advanced Science and Technology in which workers are eligible to receive pay for even if they can only 15 minutes per day. https://www.u-tokyo.ac.jp/focus/ja/features/z0508_00009.html.

[19] SPIS Laboratory is currently working to popularize SPIS as well as provide user support and is responsible for system development. https://www.spis.jp/.

Housing support provided to people who require special assistance in securing housing[20] should be provided together with livelihood support. This is a policy issue that cuts across Ministries, so close cooperation between the MHLW and MLIT is essential. Regularly convening the Liaison Council for Strengthening Cooperation in Welfare and Housing Administration (which was established through a joint effort by the MHLW and the MLIT and last convened on September 25, 2018) will make it possible to stay updated on the situations in each municipality and to develop the necessary measures for the issues in each area. First, it is necessary to promote the rapid establishment of Residential Support Councils in each municipality, to clearly define the duties of Independence Support Councils and Regional Housing Councils within Residential Support Councils, and to promote the development and verification of best practices for coordination between those councils.

Furthermore, in the future, systems for providing tax benefits or financial assistance for renovations and other such costs must be improved to promote the proactive and effective use of vacant houses and apartments, particularly through efforts at Residential Support Councils. At the same time, to promote the use of services to support independent daily living among residents, systems that create relationships of trust and cooperation between tenants, landlords, and surrounding members of the community must be built. Residential Support Councils should include people with mental disorders living in the community and local specialists in the field of mental health, such as public health nurses or psychiatric social workers. Incorporating the perspectives of those people or expert knowledge from specialists will make it possible for Residential Support Councils to identify comfortable living environments for people with mental disorders and to find the best methods for providing them daily living support. This will support efforts to provide residential and daily living support that fit the conditions in each region.

Furthermore, in recent years, organizations providing comprehensive support including housing and employment support have started to appear.[21] While taking the psychological conditions of the people receiving support into account, they arrange housing among various options such as group homes or single occupancy apartments, organize opportunities for employment and other activities, and provide counseling. We anticipate popularizing and expanding such organizations and strengthening cooperation between organizations providing support for housing and daily living will help relieve uncertainty felt by people with mental disorders towards daily living.

[20] The Act on Housing Safety Net defines “people require special assistance in securing housing” as members of low-income households, victims of natural disasters, elderly people, people with disabilities, and people with young children. According to the Public Housing Law, “low income households” are those whose total monthly income is 158,000 yen or less.

[21] An example of one such organization is a public interested incorporated organization called Yadokarino Sato, which is based in Saitama City, Saitama Prefecture.
(https://www.dinf.ne.jp/doc/japanese/prdl/jsrd/norma/n199/n199_019.html)

Perspective 4: Create systems for gathering the data and information needed for evidence-based policy-making and policy evaluation

The Current Situation and Issues

The causes of many mental disorders such as schizophrenia, dementia, depression, developmental disorders (such as autism spectrum disorders (ASD) and attention deficit hyperactivity disorder (ADHD)) are unclear. Approximately one in five children faces issues related to mental health while about half of mental disorders begin by the age of 14.[22] Responding to children's mental health issues appropriately can prevent mental illness and improve their ability to adapt socially, and is likely to improve prognoses during adulthood. In reality, however, there are many cases in which counselling and medical examinations are not provided over the long term. Late responses to developmental disorders can lead to problems both at school and in the workplace. These include bullying, poor learning, and absenteeism for children and power harassment, employee turnover, and acute social withdrawal among working adults. Furthermore, developmental disorders carry an increased risk of comorbid psychiatric disorders including depression, anxiety disorders, adjustment disorder, eating disorders, and personality disorders, so early intervention is vital. In recent years, a shift is occurring in how we perceive mental disorders. Rather than considering someone affected or not affected by a mental disorder, it is becoming more common to perceive mental disorders in terms of severity of symptoms experienced over time and it is considered likely that providing rapid responses to mental health issues can help prevent mental disorders.

To guide mental health policy in Japan, the Headquarters for Mental Health and Welfare of the Ministry of Health, Labour and Welfare published "Visions in Reform of Mental Health and Medical Welfare" in September 2004 which included a vision for transitioning from hospitalization-based care to community-based care. In line with that vision, the Study Group on the Future of Mental Health Care and Welfare compiled a report entitled "Toward Further Reform of Mental Health Care Welfare" in September 2009. That report addressed the need to further promote and emphasize research and development aiming to improve the quality of mental health care. It specifically recommended securing funding for research and development for mental disorders, encouraging research aiming to discover the causes of mental disorders, and encouraging research aiming to develop methods for diagnosis and treatment through the effective use of competitive funding. After those developments, as mentioned in Perspective 2, mental disorders were included as one of the five illnesses targeted by the sixth revision of the Healthcare Plan that came into effect in FY2013, kicking off efforts to overcome mental disorders. In June 2013, the Partial Revision Act on Mental Health and Welfare for the Mentally Disabled (or the "Mental Health and Welfare Act") was enacted, and the Guidelines for Ensuring High-quality and Appropriate Care for People with Mental Disorders were presented in March 2014. Those guidelines identify the promotion of research for mental disorders as an important item for ensuring the provision of high-quality and appropriate care for people with mental disorders. To do so, it says, "1. While aiming to promote the development of pharmaceuticals that effectively treat mental disorders, promote research on non-pharmaceutical treatment methods" and "2. Promote research on the development of methods for early diagnosis and prevention and innovative therapies based on advances in neuroscience, genome science, information science, etc. to elucidate the symptoms of mental disorders and identify biomarkers (which are used to quantitatively measure

[22] Child and adolescent mental health (https://www.who.int/mental_health/maternal-child/child_adolescent/en/)

biological changes in living organisms),” thus providing a legal framework for promoting research for mental disorders. However, while the seventh revision of the Medical Care Plan System clearly mentions the need for a scientific basis for cancer and stroke, saying, “implement efforts to develop methods to diagnose cancer with a scientific basis” and “establish a scientific basis for endovascular treatment for acute ischemic stroke,” there is currently no mention of a need for mental disorder treatments to have a scientific basis.

Around that time, in international developments, the 66th World Health Assembly adopted the WHO’s Comprehensive Mental Health Action Plan 2013-2020 in May 2013. The overall goal of the WHO’s mental health action plan is to “promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.” It relies on six cross-cutting principles and approaches, namely (1) universal health coverage, (2) human rights, (3) evidence-based practice, (4) life course approach, (5) multisectoral approach, and (6) empowerment of persons with mental disorders and psychosocial disabilities.

With that backdrop, HGPI held a global expert meeting in December 2019 which included those most affected and opinion leaders from industry, government, academia and civil society from Japan and abroad. At that meeting, there was consensus on the need for evidence-based policymaking and policy evaluation as well as systems for collecting the necessary data for evidence-based policymaking and policy evaluation. One specific issue that was pointed out was that the number of birth cohort studies[23] and genome cohort studies[24] being conducted is insufficient. The need for long-term studies that target every period over the life course was mentioned as a necessary factor in creating evidence for promoting mental health support over the life course, but currently, the number of relevant cohort studies being conducted in Japan is limited. They include the Japan Environment and Children’s Study (JECS) being conducted by the Ministry of the Environment; the Study to Develop Methods of Identification and Support for Intervention Groups Using Prospective Maternal Cohort Study Results (which is part of the Comprehensive Research and Development Project for Measures for Persons with Disabilities) being conducted by the MHLW; and the Study to Contribute to Seamless Early Community Transition and Settlement for Hospitalized People with Mental Disorders (which is part of the Comprehensive Research Project for Policy for Persons with Disabilities) which is also being conducted by the MHLW. Issues identified in the field of mental health were the need to improve foundational translational research[25] and reverse translational research[26] starting in clinics and mutual cooperation among those conducting both types of research. The need for biomarkers and other indicators that can serve as objective indicators for prevention and early intervention was identified as a condition for implementing evidence-based policy. In recent years, studies on various issues have been conducted as part of the MHLW Comprehensive Research and Development Project for Measures for Persons with Disabilities. These studies include, “Developing Clinical Research Systems to Enhance Translational

[23] Birth Cohort Study: Long-term follow-up studies that examine a cohort in a certain area over a period of time from pregnancy and birth.
[24] Genome Cohort Study: Studies that follow populations in a certain area over a period of time to examine the relationships between genomes and the onset of diseases, the effects of treatments, the living environment, and lifestyle habits.
[25] Translational research: Research aiming to make practical use of the results of basic research.
[26] Reverse translational research: Studies that conduct basic research based on issues facing patients discovered in clinical settings to find results that can be used in clinical practice.

Research in Psychiatry," "Elucidating Predictors of Active Drug and Placebo Responsiveness Based on Social Function and QOL of People With Mental Disorders Including Developmental Disorders by Consolidating Individual Data From Clinical Trials and Research," "Establishing an Objective Assessment Method for Mental Disorders Stratified by Blood Metabolome Analysis and Applying it to Treatment Optimization," and "Verifying the Efficacy of Pharmacotherapy for Patients with Addiction and Developing Biomarkers Based on fMRI."

At HGPI's global expert meeting, the importance of improving QOL for people with mental disorders was also pointed out, and participants agreed that psychosocial intervention studies should be promoted alongside biological studies. They also agreed that helping participants acquire sufficient understanding of study content and ensuring long-term studies are conducted in a stable manner are important when conducting clinical studies involving people in the community or people with mental disorders.

It could be said that mental health policy in Japan satisfies the goals set for each country for 2020 by the WHO's mental health action plan to a certain degree. However, one of the directives provided by the "Recommendations for the Healthy Development of the Next Generation" presented by the Subcommittee on Birth and Development of the Science Council of Japan's Clinical Medicine Committee on August 21, 2014, was to "create comprehensive research frameworks to develop methods of treatment and education for people with mental disorders." Specifically, it says there is a need "to establish a multidisciplinary, comprehensive research foundation involving fields such as medicine, education, and welfare to conduct large-scale, long-term clinical studies involving multiple facilities." This issue has yet to be addressed. Concerning the perspective of establishing a life course approach, we believe there are various issues related to the efficiency of information-sharing systems used by Ministries and their divisions. For example, policies for early childhood are handled by the MHLW's Maternal and Child Health Division, policies applying to people during or after adolescence are handled by the Mental and Disability Health Division of the MHLW, and policies during the school years between early childhood and employment age are under the jurisdiction of MEXT. We can conclude that even though a legal framework is in place, evidence-based policymaking and the creation of data- and information-gathering systems needed for policy evaluation have not progressed to the point that they can contribute to improving QOL for people with mental disorders.

Policy Recommendations

1. Combine existing systems for data management and research for the more effective promotion of research that aims to discover the causes of mental disorders

Moving forward, it will be necessary to gather the evidence needed to implement an approach to mental health care that considers every stage of the life course (including early childhood, childhood, adolescence, adulthood, and late adulthood, as well as the perinatal period and menopause for women) and to promote policies based on that evidence. The Ministry of the Environment is currently conducting the Japan Environment and Children's Study (JECS) which examines the effects of various environmental factors, particularly chemical exposure during the prenatal period and childhood, on pregnancy and reproduction, congenital malformations, neuropsychiatric development, immunity, allergies, and metabolism and endocrine systems. It also examines the effects of genetic, social, and lifestyle factors. JECS is a large-scale and long-term birth cohort study; it includes 10,000 mothers and their children from fifteen regions nationwide who undergo regular health checks from pregnancy to when the children turn 13. Items related to neuropsychiatric development examined within JECS include general development, overall mental health and developmental disorders like ASD and ADHD.

Based on the fact that approximately half of all people with mental disorders experience the initial symptoms by age 14 and that there are many cases in which the initial symptoms of mental disorders in adults first appeared during puberty or adolescence, we believe extending the target period for JECS to adolescence or even longer (particularly from the perspective of elucidating the pathophysiology of schizophrenia, to around age 40) would have the potential to be a significant, practical, and effective measure both for implementing a life course approach and for using existing resources efficiently.

It is also important that surveys on mental health are conducted as part of annual health checkups conducted at schools, and for the results of those surveys to be used effectively for providing mental health care at schools. To that end, "mental health" should be included in annual health checkups in addition to components related to internal medicine, ophthalmology, dentistry, and otorhinolaryngology. Systems that allow for the data gathered during school health checkups to be used effectively in research must also be established. Using the results of school health checkups in research will contribute to maintaining and promoting public health and reducing public health problems. This goal must be clearly and carefully explained to the public. To achieve that, proactive steps to advance the creation of frameworks for obtaining consent towards the effective use of the data gathered during school health checkups must be taken. In addition, tools for evaluating mental health and measuring the effects of treatments (such as questionnaires) must be developed in advance. Finally, to ensure that data is used effectively in research, when designing data-gathering systems, designers must be conscious of the fact that failing to implement efficient data-gathering methods (electronic methods in particular) will create obstacles for the effective use of data.

2. Build a platform for gathering comprehensive data and information that emphasizes patient empowerment and unites all fields related to mental health, including welfare services

In July 2017, the Brain and Heart Subcommittee of the Clinical Medicine Committee at the Science Council of Japan presented the "Proposal on Ideal Methods to Develop Therapies for Mental and Neurological Diseases through Cooperation Between Industry, Academia, and Government" (hereinafter, the "Public-Private Cooperation Proposal"). It recommended creating Public-Private Partnership (PPP) systems to develop treatments through cooperative efforts involving industry, academia, and government. Every issue shared by those parties that can be addressed by PPPs is important, including cohort studies and reverse translational research.[27] At the same time, it is also important to gather evidence that communicates the perspectives of people with mental disorders or contributes to improving their QOL, so psychosocial intervention studies must also be advanced alongside biological studies. A positive example of one such effort can be found in development research conducted on a Shared-Decision Making (SDM) system by a research group at the National Center of Neurology and Psychiatry. Similar intervention studies should be advanced.

While effectively expanding upon the above-mentioned development efforts, people with mental disorders, academia, pharmaceutical companies, healthcare institutions, welfare offices, private care providers, NPOs, NGOs, and national and local Governments must come together to form PPPs in the field of mental health (hereinafter, "mental health PPPs"). With a focus on people with mental

[27]Shared challenges in the pre-competitive phase for PPPs include: Developing imaging biomarkers, building case databases for clinical trials and research, developing Brain Machine Interfaces (BMIs), developing methods to stratify mental disorders, building a foundation for efforts to develop methods for treating neurological disorders, and undertaking initiatives for cross-disease genetics-based pharmaceutical discovery.

disorders, mental health PPPs should create opportunities to evaluate and verify objective data for issues in mental health and have discussions based on that objective data. Six essential action items for mental health PPPs are: (1) identify themes for research and activities by examining the needs of those most affected, such as people with mental disorders; (2) prioritize issues facing mental health based on the overall situation; (3) based on the priorities identified, make investments in research and welfare services and continuously evaluate and verify the effects of those efforts; (4) gather knowledge in research and development and allow all stakeholders to access and share data related to mental health research, welfare services, and other such topics; (5) encourage proactive public investment and be a driving force for financial investment and involvement in measures for mental health from the private sector; and (6) make proactive use of technological innovations in ICT or AI. The "Survey on the Need for Industry-Academia-Government Collaboration in Brain Science" conducted by the Union of Brain Science Associations in Japan in May and June of 2019 proposed 42 research issues, indicating the high expectations being placed on PPPs.[28] While each proposal identified by that survey could be considered an expectation towards a database of clinical and biological information and biological samples, patient cooperation is essential to create a database containing those types of information. From that perspective, as well, we believe PPPs centered on people with mental disorders – in other words, mental health PPPs – are necessary.

While the concept of mental health PPPs are an expansion on concepts discussed in the Public-Private Cooperation Proposal, they are also similar to the concepts described in the section on "Comprehensive Cross-Disciplinary Research on Education, Welfare, Medicine, Healthcare, and Correcting Public Perception" in the Perspective on Promoting Measures to Support Developmental Disorders in the Next Generation Recommendations. Mental health PPPs require a system for smooth information-sharing and collaboration between national and local Governments and related Ministries and their divisions.

[28] Union of Brain Science Associations in Japan, April 2020. "Proposal on Collaboration Between Industry, Academia, and the Government to Construct a Mental and Neurological Disorder Database for Clinical Trials, Diagnosis Assistance Using AI, and Big Data Analysis."

Perspective 5: Establish an environment that allows for multi-stakeholders to engage in continuous discussions on mental health policy

The Current Situation and Issues

Both the seventh revision of the Medical Care Plan System and the fifth revision of the Disability Welfare Plan outline the creation of the Integrated Community Care System for Mental Disorders. This is a comprehensive vision that aims to address various aspects of life such as healthcare, disability welfare, long-term care, housing, social participation (employment), mutual community support, and education so people with mental disorders can rest assured in their positions as full members of their communities and live true to themselves. In particular, it requires those working in health, medical, and welfare to establish discussion forums. The targets set by the fifth revision of the Disability Welfare Plan aim to establish such forums at the prefectural level, in disability welfare areas based on secondary medical care areas, and at the municipal level. Within disability welfare areas, local governments must grasp the needs of those most affected and provide opportunities for discussion with unified policies addressing the three types of disability (namely physical disabilities, mental disabilities, and psychological disabilities). Based on the 36th article of the Basic Act for Persons with Disabilities, the Local Councils on Promotion of Measures for Persons with Disabilities Act requires that Councils on Promotion of Measures for Persons with Disabilities must be established within every municipality. Those councils must be composed of parties such as academic experts, people with disabilities, people providing services related to the welfare of people with disabilities, and staff of relevant administrative bodies. In addition, Community Independence Support Councils established by the third item of the 89th article of the Basic Act for Persons with Disabilities must include representatives from related administrative bodies and from related organizations, people with disabilities or their family members, and people employed in roles providing welfare, healthcare, or education to people with disabilities.

However, according to a survey conducted by the MHLW, most of the discussion forums that have been established are mainly composed of people involved in healthcare, medicine, and welfare and municipal workers, with less than half of participants being people with mental disorders or their family members.[29] The membership ratio among other stakeholders is also low, so it cannot be said that multi-stakeholder discussions are taking place.

Furthermore, for successful collaboration between different stakeholders to take place, some party must function as the central coordinator. However, in the current circumstances, facilities related to medicine are placed mainly at the prefectural level, while those related to healthcare and welfare are placed at the municipal level. Also, the roles of prefectural governments, municipal governments, public health centers, and mental welfare centers are unclear. As a result, there is nobody at the municipal level to fill the roles that will form the nucleus of the Integrated Community Care System for Mental Disorders. Additionally, the lack of a concrete legal foundation for this concept has resulted in insufficient HR investments and budgetary allowances.

Policy Recommendations

[29] Ministry of Health, Labour and Welfare. Survey results from "On Establishing an Integrated Community Care System for People with Mental Disorders," a document shared at the first MHLW review meeting on establishing the Integrated Community Care System for Mental Disorders.

1. Ensure that all policies and projects are implemented and evaluated from the perspectives of people with mental disorders by including them in all discussion forums

The slogan "Nothing about us without us" was used frequently during the formulation of the Convention on the Rights of Persons with Disabilities, reflecting the shared experiences of people with disabilities who, in the past, have not been allowed to decide their own affairs or to make decisions independently. In response, they issued a strong call to be allowed to exercise their basic rights as citizens. Because the Japanese Government signed the Convention on the Rights of Persons with Disabilities in 2013, it is obligated to answer that call with action.

Holding discussion forums on building the Integrated Community Care System for Mental Disorders will create opportunities for every topic in mental health to be discussed at the community level. These topics range from those related to building awareness in communities to the details of each service provided in health, medicine, and long-term care. Each of these items aims to contribute to increasing QOL for people with mental disorders, so it is essential for people with mental disorders to be included in those discussion forums.

Because the topics covered at those discussion forums relate to the mental health for everyone in the community, it is necessary to keep companies, schools, and people involved in providing other types of services in the community informed about what is covered at those discussions. They should also be allowed to regularly participate in the discussion forums as observers so that multi-stakeholder discussions can take place.

It is also necessary to learn about the needs of people or their family members affected by other fields of disability and to benefit from their knowledge through close cooperation with existing Councils on Promotion of Measures for Persons with Disabilities or Community Independence Support Councils. Such measures should not begin and end with opinion exchanges. Rather, to advance community development, they should include discussions with those most affected and their family members on prioritizing the needs that are identified and to examine the feasibility of various measures. To make sure people with mental disorders or their family members can express their opinions in a constructive manner during these discussion opportunities, efforts should be made on a regular basis to deepen understanding towards measures for people with mental disorders conducted by organizations supporting them or their family members and to engage people with mental disorders as full members in the effort to change society.

2. Enact a Basic Act for mental health that emphasizes the perspectives of people with mental disorders and promotes the creation of comprehensive mental health policies for prevention, treatment, and welfare

In the past, mentions of the Integrated Community Care System mainly appeared within the field of providing long-term care to elderly people. After being discussed in "Long-term Care for the Elderly in 2015," published by the MHLW's Study Group for Geriatric Care in 2003, its first appearance in a law was in 2013's Act on Promoting the Reform to Establish a Sustainable Social Security System (or, the Social Security Reform Program Act). Currently, no law in the field of mental health requires the creation of the Integrated Community Care System for Mental Disorders, so the lack of a legal basis can be expected to create obstacles moving forward, particularly when securing budgets or assigning personnel in community-development efforts advanced by multi-stakeholders. Efforts that cut across Ministries are essential to develop mental health policy for the entire life course, so to promote such efforts, instead of formulating a policy measure for each disease, it is necessary to formulate laws that

target every relevant aspect by involving the entire Ministry with jurisdiction in the target field, from prevention and treatment to disability welfare as a whole. We expect enacting a law that establishes the concept of the Integrated Community Care System for Mental Disorders while emphasizing the perspectives of people with mental disorders will be a driving force for mental health policy and lead to the creation of an environment which allows for continuous contributions from multi-stakeholders such as people with mental disorders, their families, healthcare facilities, welfare offices, industry, and members of the local community.

Mental health policy is a theme in which everyone should be considered a stakeholder, from people with mental health disorders regardless of disease and severity of symptoms, to local citizens who are currently unaffected by problems related to mental health. Whether someone experiences feelings that life is a minor yet constant struggle or has a mental disorder that requires them to be hospitalized, people require opportunities to receive the right support at the right times and from the right specialists, and an environment in which everyone can seek support without hesitation is essential. Furthermore, people may be affected by mental health issues triggered by unforeseen events that occur over the course of everyday life in society. For example, significant mental health issues can occur due to long stays in evacuation facilities after being evacuated from one's home due to a natural disaster, or in the time spent waiting for recovery activities for natural disasters to be completed. For example, recovery efforts are still ongoing for the Great East Japan Earthquake and disaster at the Fukushima Daiichi Nuclear Power Plant, both of which occurred on March 11, 2011. In addition, various sources of uncertainty and worry exist for many of the people living with diseases other than mental diseases, such as children affected by intractable diseases or their family members. Living with those sources of uncertainty for long periods of time can have effects on mental health. However, expert support from healthcare or welfare is not currently reaching them. Mental health policy targets a wide variety of topics including natural disasters, cancer, intractable diseases, and the feelings of loss for the people left behind, so we must pay attention to each and every factor that causes people to experience a lower QOL and make comprehensive efforts for them through mental health policy.

Enacting a comprehensive law such as a Basic Act for Mental Health will establish a suitable environment for a life course approach in which mental health issues can be addressed at the appropriate times over the entire life course using the best methods. We anticipate that when everyone is able to recognize that they are a stakeholder in mental health policy, they will be able to come to the conclusion that mental health policy is necessary on their own. Therefore, it is necessary for everyone to share the dignity of making one's own life decisions on one's own terms and to reexamine the issues facing people who currently have mental disorders or their families as well as the various existing social systems that surround them.

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