Abstract

Background: Japan has continuously received influences from foreign countries to improve care for patients suffering from mental diseases throughout its history. But an article documenting on the foreign influences on Japanese mental health (MH) care is not readily available. Methods: The author reviewed the published books, papers, and government documents on the MH care in Japan. For comparisons, the publications on MH and psychiatric care, especially those in the United States of America, the United Kingdom, as well as countries of the Organization for Economic Co-operation and Development, were also reviewed. The author also recounted his personal observations on the MH care over his own life. Results: Before the Meiji Restoration, Buddhism and temples played a major role in taking care of persons with mental illness. Kampo (Chinese medicine and medicinal herbs) was prescribed during the Edo era (1603–1867). After the Meiji Restoration in 1867, the Meiji government adopted Western medicine. German medicine was introduced as an exemplified model. Before World War II (WWII), Japanese psychiatry was under the heavy German influence. After WWII, American psychiatry was introduced. At the same time, the Japan Private Hospital Association (Nisseikyo) was formed, and it contributed to build MH care system. From 1955 to 1993, Japan continuously increased the number of private hospital beds, financed through public funds. The scandals at several private hospitals helped enact the Mental Health Law in 1987, making clear to change hospital-centered services to community-based MH services and improve the human rights of inpatients in Japan. Since then, efforts have been carried out to promote community-based MH care. But Japan nowadays is still characterized by hospital-centered MH care. Conclusion: At present, Japan has more than 1,000 psychiatric hospitals with 300,000 psychiatric beds. Japan has the largest number of psychiatric beds that is on the top among all countries in the world. In this review, the author expresses his own personal viewpoints on MH care for the mentally ill in Japan with focus on its international influences.

Key words: hospital-based psychiatry, Japan, mental health system, private psychiatric hospitals


Introduction

It is an impossible task to present mental health (MH) care in Japan in a concise manner. It is like a blind man to present an elephant. I hope that he/she is not limited to touch the nose, the tail, an ear, or the trunk, but to touch the whole elephant.

In this review, the author plans to describe the history in chronological order as indicated in section titles of the review (Table 1). I will keep focusing on continuous influences from foreign countries to improve the MH care for people suffering from mental diseases in Japan.

In this review, the author structures the MH events arbitrarily into chronologic orders as sections of the review which are similar to chapters of a book which have been done by historians on Japanese history [1, 2]. As a participant observer in the history making, I also do not hesitate to give my own personal account to witness the Japanese MH care changes in each section when appropriate.

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Table 1. A chronicle of mental health changes in Japan

<table>
<thead>
<tr>
<th>Name of the era</th>
<th>Years covered</th>
<th>Key mental health events in Japan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before the Meiji Restoration</td>
<td>7th Century-1867</td>
<td>Many patients suffering from mental illnesses gathered around the temple</td>
</tr>
<tr>
<td>From the Meiji Restoration to WWII</td>
<td>1868-1941</td>
<td>“Home Custody Act of Mental Patients” was enacted in 1900</td>
</tr>
<tr>
<td>During WWII</td>
<td>1941-1945</td>
<td>Mental patients suffered from the lack of food and treatment</td>
</tr>
<tr>
<td>Immediately after WWII</td>
<td>1946-1955</td>
<td>Formation of Japan Private Psychiatric Hospitals Association (Nisseikyo) in 1949</td>
</tr>
<tr>
<td>From 1987 to now</td>
<td>1987-now</td>
<td>Mental Health Law in 1987 to protect the human rights of inpatients</td>
</tr>
</tbody>
</table>

WWII, World War II

Mental Health Care Changes in Japan before the Meiji Restoration

Influence of Buddhism from Korea and China from 7th to 15th century

Buddhism was introduced to Japan from Korea and China at the time of the unification of Japan in the 7th century. The first official description of mental illness dated back to “yourou ritsuryou” in 718 which set the exemption of taxation to peoples with mental diseases [3, 4].

Buddhist temples became the centers of medical knowledge and care throughout the history. In the 11th century, Iwakura Dainin Temple in northern part of Kyoto became famous for the care of the mentally ill after a princess got cured by drinking water from its well. Many patients suffering from mental illnesses gathered around the temple. Villagers nearby took care of them. This continues until the Meiji era, and a psychiatric hospital was built on the spot after the Meiji Restoration [5, 6].

Christianity and Western medicine in the 16th century

Christianity entered Japan in the 16th century. In addition to their religious work, missionary from Portugal provided medical care and built hospitals in Japan. Francisco Xavier (1506–1552) and his successors preached Christianity to the Japanese under the protection of Oda Nobunaga (1534–1583). He and Jesuit successors from Portugal provided medical care and imported Western medicinal plants. A few Western-style hospitals were built in the Kyushu area. But Jesuits and their activities were soon prohibited by Toyotomi Hideyoshi (1537–1598).

Tokugawa era and the Dutch influence

Tokugawa Ieyasu (1543–1616) conquered Toyotomi clan and opened his bakufu (government) in Edo (Tokyo) in 1603. Tokugawa government continued for 264 years until the Meiji Restoration in 1867. Tokugawa shoguns prohibited Catholic but allowed Protestants to continue foreign trades in a very limited area of Nagasaki. The Netherlands was a source for Western knowledge throughout the Edo era. Over 200 years, more than sixty Dutch doctors stationed at Dejima, Nagasaki. Through them, Rangaku (Holland medicine) was introduced to Japanese doctors who were interested in Western medicine. But their medical contribution was limited only for surgery and ophthalmology.

During the Edo era, medical practices were carried out by Kampo (traditional Chinese) medicine doctors, who used medicinal herbs, acupuncture, and hot-spring. Some traditional medicine prescriptions were used for treating mentally ill patients. The first book on mental diseases in Japanese was published in 1819 by a Kampo doctor.

Mental Health Care Changes in Japan from the Meiji Restoration to World War II

The Meiji Restoration in 1867 and adoption of German medicine

The Meiji Restoration was instrumental to the emergence of Japan as a modern nation in the early 20th century. Vaccination for small pox was introduced at the end of the Edo era, and its center in Tokyo later became Medical School of Tokyo University. Leaders of the Meiji government decided to take Western medicines and teach them at universities.

The government decided to adopt German medicine as a master. Robert Koch discovered a number of bacteria at the end of the 19th century and identified them as the cause of epidemic diseases.

The Meiji government employed foreigners as teachers at medical schools and sent brightest students to European countries to study up-to-date scientific knowledge using a considerable part of the meager government fund. Psychiatry was introduced as a branch of modern medicine by foreign doctors at the end of the 19th century.
The building of Western-style asylum in Asia in the 19th century

Building the first asylum started soon after the Meiji Restoration in Japan. The Meiji government made every effort to import Western systems from European countries. Psychiatry and asylum for the service for the mental ill were not an exception.

The idea of keeping mentally ill patients in a closed building was observed at Bethlehem Hospital in the United Kingdom in the 13th century. This practice was brought by European masters to Asian countries. Psychiatry as a medical discipline started soon after the French Revolution by Philippe Pinel who freed mentally ill patients from their chains and treated them humanely. It was noteworthy that France passed the law for the treatment of mentally ill patients in 1838. The law recommended the establishment of special facilities for mental patients.

It is useful to understand the development of psychiatry and MH care in Japan in line with other Asian countries colonized by European countries in the 19th and early 20th centuries.

Colonization and psychiatric asylum in Asia

At the latter part of the 19th century, majority of Asian countries were colonies of the UK, the Netherlands, France, and the United States of America. India, Sri Lanka, Singapore, and Malaysia were colonized by the UK, Indonesia, the Netherlands, Vietnam and Cambodia, France, as well as the Philippines, the USA. Asylums for mental patients were built to those suffering from mental diseases in the above colonies, with the priority for treating their sailors. These asylums became prison-like institutions for insane and later psychiatric hospitals in those countries.

Japan was not a colony of Germany. But German psychiatry ruled Japanese psychiatry from the Meiji era until the end of WWII.

In Japan, following the models of Europe, Kyoto Lunatic Asylum was opened in 1875, and the Tokyo Metropolitan Lunatic Asylum in 1879. The Tokyo Asylum was later renamed as Matsuzawa hospital, which served as the leading psychiatric center in Japan.

The important purpose of building asylum was to hide vagrant psychiatric patients from the eye of foreigners. A small number of public psychiatric hospitals was opened in large cities with foreign population. But the number of psychiatric hospitals throughout the country remained small. In reality, most persons experiencing MH problems were cared for by family members at home. They may resort to Buddhist temples and local healers for their treatment.

Home Custody Act of Mental Patients in 1900

In 1900, the “Home Custody Act of Mental Patients” was enacted which prohibited the vagrancy of mental patients, making family members responsible for their care. The purpose of the law was to ensure public security, but resulted in the mandatory home detainment of many mental patients in prison-like conditions (zashiki rou). Academic psychiatry in Japan was nurtured by German psychiatry, with most psychiatrists referring to Kräpelin’s (1899) textbook until WWII. The word “psychiatry” was translated into Japanese as seishin-igaku, and “schizophrenia” as seishin-bunretsu-byou. These terms were exported and adopted in Chinese, Korean, and Taiwanese, and they remain in use even now. In the early history of Japanese psychiatry, doctor Shuzo Kure played a key rôle. Kure has been called the “father of Japanese psychiatry” for his outstanding contribution to the improvement of care of mentally ill patients in Japan.

Kure, an alumnus of German psychiatry, was a professor of psychiatry at Tokyo University from 1901 to 1925, and the director of the Tokyo Metropolitan Lunatic Asylum. As the asylum director, Kure ensured that patients were unchained, a radical idea at the time [7].

Influences of Japanese psychiatry to Taiwan and Korea

In 1895, Japan surprised the world by winning the war against China, the then Qing dynasty. At Shimonoseki treaty, Qing permanently ceded to Japan the Liaodong Peninsula, Taiwan, and the Penghu Islands. Japan started to colonize Taiwan. During its occupation, Japan built universities and hospitals in Taiwan. Japanese psychiatrists, mostly from Kyushu University, were sent to Taiwan to teach psychiatry.

Also, in 1910, annexing Korean empire by signing the Japan–Korea annexing treaty, Korea became, de facto, a Japanese colony. In Korea, Japanese doctors were also sent to teach medicine and psychiatry at universities in Korea.

Establishment of the Japan Society of Neurology in 1902

In psychiatry, Shuzo Kure started his pioneering work to improve psychiatric education and research in Japan. With colleagues from the university in 1902, he established the Japan Society of Neurology which later became the Japanese Society of Psychiatry and Neurology (JSPN), and started its official journal “Neurology.” Throughout his entire career, Kure was a vocal proponent of a humanistic treatment for mental patients. Kure started the Federation for the Welfare of Mental Patients (nihon-seishin-eisei-kai) in 1902. The Federation was intended to increase the interest in MH for the general population, promote the knowledge of MH, and improve the services for persons suffering from mental illness.

Later, Kure highlighted a double burden faced by Japanese people suffering from MH problems, stating that “mental patients in Japan have double miseries, one is to have a disease and the other is to be born in this country.”

Mental Hospital Law in 1919

In view of the paucity of psychiatric beds, Kure set about promoting the building of public psychiatric hospitals. In 1919, “Mental Hospital Law” was enacted, recommending that all local governments should build at least one psychiatric hospital in each prefecture. Despite this, the law was implemented only in several prefectures due to the
lack of financial resources in most of the prefectures and the strong stigma associated with mental diseases in local communities. From 1919 to 1941, Kure and his students made continuous efforts to increase the number of psychiatric beds and psychiatrists. The department of psychiatry was established at 20 universities and medical schools mostly by Kure’s students.

**Development of psychiatry before World War II**

During this period, the treatments of mental diseases were primitive:

- High fever therapy induced by malaria was given to patients with generalized paralysis
- Continuous sleep therapy was done to patients with depression
- Insulin shock therapy was for patients with schizophrenia
- Psychoanalysis was introduced but not accepted
- Morita therapy was developed by Morita Shoma of Jikei University for the treatment of neurosis
- *taijin-kyofu sho*.

Public mental hospitals were opened in eight prefectures, namely, Tokyo (1919), Kagoshima (1924), Osaka (1926), Kanagawa (1929), Fukuoka (1931), Aichi (1932), Hyogo (1932), and Kyoto (June 1945). The number of private mental hospitals was also increased. In 1941, the number of psychiatric hospitals was estimated to be 167, and the total number of psychiatric beds was 24,000 (3.3/10,000 in population). The importance of psychiatric treatment and research was laid on the biological and genetic aspects of mental diseases. This unfortunately deepened the stigma attached to mental disease. In this period, under the Hitler regime, Germany passed the law to terminate the life of persons not worth living. More than 70,000 mental patients were killed in Germany under the Hitler regime. German psychiatry which was the model for Japanese psychiatry involved deeply in the above undertakings.

**Mental Health Care Changes in Japan during World War II**

**World War II**

During Showa era, Japan became the country under imperialism to join the rank of powerful countries. The military power was increased. Japan started the military invasion to China since the 1930s and established *Manchku ko* (1932–1945) in Northeastern China. Japan bombed Pearl Harbor and started the WWII in December 1941.

WWII brought devastating effects to all Japanese population. The burden was heavy to those suffering from mental diseases. They suffered from the lack of food and treatment. Many doctors and nurses were recruited for military service. Many private psychiatric hospitals were forced to close down due to the lack of food and staff [8].

**My personal experience during World War II**

My personal history as a psychiatrist was deeply influenced by WWII. I was born in Kaohsiung in the southern part of Taiwan in January 1942. My father (Naotake Shinfuku, a psychiatrist) graduated from Kyushu University in 1937, employed as a psychiatrist at Imperial Taipei Medical University and its affiliated mental hospital (*yoshin-in*) in 1938, and then was recruited as a military doctor at Tainan Military Hospital in 1940. He was then sent to a Takao (Kaohsiung) military hospital to take care of mental patients and sent back from war areas such as Indonesia, the Philippines, and other island countries in South Pacific region. The rôle of psychiatrists during the war time increased as many patients showed various psychiatric symptoms under stressful conditions. He once mentioned that almost all patients were diagnosed as “malaria psychosis” because it was the only honorable psychiatric diagnosis allowed to Japanese soldiers. Schizophrenia, depression, and neurosis should not be given for the diagnoses to Japanese soldiers.

At the 2nd and 3rd years of WWII, allied forces became dominant. There was a big air raids in April 1944 in Takao. Most of the cities in Taiwan were destroyed by bombings by American air forces. In August 1945, Japan accepted the unconditional surrender to allied forces. My family was also sent back to Japan from Taiwan in February 1946 when I was four years old.

**Building military hospitals for psychiatric patients during World War II**

From 1941 to 1945, there were several unexpected developments related to mental hospitals. More than 100 military hospitals were opened throughout Japan to take care of disabled soldiers by war. Later, those hospitals became national hospitals for the general population and national sanatorium for patients with tuberculosis (TB), the major cause of mortality during and after WWII. In addition, around ten military hospitals were built specifically for soldiers affected by various mental disorders during the war. Those military hospitals became national psychiatric hospitals after the war. The National Center for Neurology and Psychiatry (NCPN), the leading research and training center in psychiatry, was originated from a special military hospital.

**Shortage of food during the war and my personal experience**

During war time, inpatients at public and private psychiatric hospitals experienced the shortage of food and many patients died from hunger. Okada reported the high mortality rate of inpatients in 1945 and 1946 at Matsuzawa Hospital [3].

My family was sent back from Taiwan to Japan in February 1946. It was a hard time for all Japanese people. In February 1947, my father got the job at a prefectural psychiatric hospital in Dazaifu city, Fukuoka (*Chikushi-hoyoin*), at present, Fukuoka Prefectural Mental Health Center) as a psychiatrist. *Chikushi-hoyoin* experienced the similar hardship. In 1946, almost half of the inpatients died from malnutrition. Out of 200 inpatients before the war, only 60 survived the war. Most of the survivors were females. Since 1947, food situation was improved and mortality rate by malnutrition was decreased.
I could not have any idea for my father to be a doctor. He spent much of his time in the field cultivating potato, onion, carrot, and vegetables with patients. Occupational therapy was not for rehabilitation but for hospital community members to survive.

My father wrote a thesis on “Psycho-pathological research of shock therapy” and received his doctorate degree from Kyusyu University in 1950. This was before the discovery of chlorpromazine in 1952 [9]. Shock therapy was the most advanced therapy as the treatment of schizophrenia in that period.

Mental Health Care Changes in Japan from 1946 to 1955

Restoration of psychiatric service in Japan soon after the war

MH service in Japan started from the ash after the WWII. A number of private psychiatric hospitals were closed down during the war. Informal report estimated that the approximate number of all Japanese psychiatric beds including public and private at the end of war was less than 10,000. Occupation by the Allied Forces continued for seven years after the war until the signing of the San Francisco Peace Treaty in April 1952, and the occupational forces led by the USA brought drastic changes to health and social welfare systems in Japan.

Formation of Japan Private Psychiatric Hospitals Association (Nisseikyo) in 1949

During WWII, mental hospitals were severely damaged, and a shortage of psychiatric beds existed throughout Japan. To rebuild MH care system in Japan was urgent. Dr. Junji Kaneko (1890–1979) organized a group of private psychiatric hospitals. In 1949, 81 private psychiatric hospitals formed the Japan Psychiatric Hospitals Association (Nisseikyo). Kaneko became the first president of Nisseikyo. Since then, Nisseikyo became a strong stakeholder to lead the direction of MH policy in Japan. Kaneko and the group played an important rôle to prepare Mental Hygiene Law [10].

Enactment of Mental Hygiene Law in 1950

Soon after WWII, there had been a move to abolish the Home Custody Act of Mental Patients and to enact a new law. The Mental Hygiene Law was presented to the Diet (parliament) in 1950 and adopted. The new law prohibited the home custody of mentally ill patients. zashiki-ro (home custody) had to be closed down within one year after the enactment of the law. There was a big change for the law to be placed under the health sector away from the police sector. Prefectural governments were made responsible for establishing facilities to take care of mentally ill patients.

Under the Mental Hygiene Law, family members could consent to the admission of a psychiatric patient. Familial consent-based admission reflected the family-oriented characteristics of the collectivist culture found in Japan. Nonetheless, this admission form was found to be exploited, resulting in an extremely lengthy hospitalization of many inpatients. Many family members who were exempted from paying medical fees during the hospitalization, were reluctant to have their sick family members discharged from the hospital.

Visits of WHO Consultant to Japan in 1953 and 1954

During the 1950s, two World Health Organization consultants visited Japan to recommend on developing MH service in Japan. During his visit in 1953, Paul Lemkau from Johns Hopkins University, the USA, recommended the importance of community-based MH services, specifying that public health centers should strengthen their MH activities. A year later in 1954, Daniel Blain, Director of the Mental Health Division in the State of California, the USA, recommended the establishment of day-care services and psychiatric clinics at general hospitals and the training of MH workers.

Their recommendations looked reasonable. But the recommendations of those WHO officials were not implemented soon. Japan’s leading psychiatrists were not yet prepared to follow the recommendations of American psychiatrists. Also, Mortan Kramer, the third WHO-designated official, visited Japan in 1960, and he stressed on the importance of a psychiatric epidemiological survey in Japan.

Nationwide epidemiological survey on mental illness in 1954

In 1952, the National Center for Mental Health was established to collect basic data in developing mental health policy. The government organized a Nationwide survey on the prevalence of persons with mental disorders in 1954. The result showed that the estimated number and the rate of persons with mental disorders are 1.3 million and 1.5% of the population, respectively, and that 170,000 persons are estimated to require hospitalization treatment [10]. In 1954, the number of psychiatric beds was around 40,000, and a sizable number of patients with mental illness were still at home custody. This facilitated to increase the number of psychiatric beds as a national policy [10].

In 1956, the Japanese Ministry of Health, Labor and Welfare (MHLW) started to set up the Division of Mental Health as an independent division under the Bureau of Public Health. MHLW, based on the nation-wide survey on mental diseases, set to increase psychiatric beds. The objective was set at 25 beds/10,000 population. Mental Hygiene Law required each prefecture (48 prefectures in Japan totally) to build at least one psychiatric hospital. The law stated that prefectoral hospitals could be replaced by designated private hospitals. Prefectural hospitals had only been increased from 8 to 30 in 30 years. However, the increase was excessively implemented by private psychiatric hospitals. In 1948, Medical Act had been revised, and private ownership of hospitals was endorsed. Free competition was encouraged in the health sector under the occupation forces. The government provided a special loan with very low interest rate for building psychiatric hospitals.

Pharmacotherapy

The efficacy of chlorpromazine to psychotic patients was discovered by Jean Delay and Pierre Deniker at the University
Shinfuku: A history of mental health care in Japan

of Paris in 1952 [9]. Chlorpromazine was introduced to Japan in 1954 by several pharmaceutical companies, and the samples were tested to patients. At that time, no strict regulation existed on the safety of the drugs. In 1954, the first case report ‘Pharmacotherapy of mental diseases’ was presented at the 54th annual meeting of JSPN in 1957. The report was positive to the use of chlorpromazine. In particular, a case study of more than 1,000 patients has shown the decrease of agitation, problematic behavior, delusion, and hallucinations as well as improved sleep problems [8].

Until 1960, electroconvulsive therapy (ECT) and prolonged sleeping therapy were commonly used in treating psychotic patients. But these treatment methods were gradually replaced with pharmacotherapy from 1957 onward. Japanese pharmaceutical companies had marketed more than ten neuroleptics by 1960.

Mental Health Care Changes in Japan from 1955 to 1970

Origin of hospital-centered psychiatric care in Japan

Starting from the 1950s, the private psychiatric sector in Japan has undergone remarkable expansion. Fewer than 30,000 patients were hospitalized in 185 psychiatric hospitals nationwide in 1953. Starting from 1954, a number of private psychiatric hospital was built with the annual increase of 10,000 beds. In 1961, the number of psychiatric hospitals had risen to 543, providing more than 100,000 beds nationally. The ratio of psychiatric beds per 10,000 people had been increased to 2.30 in 1951, 6.08 in 1956, and 11.27 in 1961. This increase was led by the private sector, and was coupled with the contraction of the public psychiatric sector. For example, the proportion of public psychiatric beds had been decreased yearly from 26.8% in 1955, 20.5% in 1960, and 15.1% in 1970. A “gold rush” for building private psychiatric hospitals started from 1955 to 1970.

Table 2 shows an increase of private psychiatric hospitals from 1900 to 2000. The increase was abnormal from 1955 to 1970. The biggest factor was financial gain. Private psychiatric hospitals were opened not only by psychiatrists, but also by doctors of other disciplines and business-minded lay persons [8] (Table 2).

Building psychiatric hospitals was encouraged by the Mental Hygiene Law in 1950. The law set the target number of psychiatric beds relatively high of 25/10,000. The law allowed private psychiatric hospitals to substitute prefectoral mental hospitals. Almost all expenses for psychiatric inpatients could be covered by several public financial measures. Those schemes included the financial support regulated by the Mental Hygiene Law, the Livelihood Protection Law, and the National Health Insurance Law. The National Health Insurance Law was introduced in 1961. As such, private psychiatric hospitals were opened and managed by private entities, but financially supported by public funds. It is a private business where profit is guaranteed by public fund. The secrecy of profitable business is to lower the expenses. Patients were gathered in prison-like rooms. Very little consideration is paid to the quality of care. Almost all hospitals are locked. Once hospitalized, the patient was difficult to have free communication with the outside world. Letters from and to the outside world were censored by the hospital staff. No public telephone was available in the hospital. It was a closed world. In some sense, it was a private prison managed by profit-oriented owners. The minimum number of needed nurses and doctors for psychiatric hospitals was set as one-fourth of that at a general hospital. This arrangement could save a considerable amount of expenses for salaries to the staff members. Psychiatric diseases were strongly stigmatized and considered as incurable. Patients could seldom complain. Family members were reluctant to ask for discharge for their family members. Hospitals were keen to keep as many patients as possible and as long as possible to make profit. Few peoples paid attention to the human rights of inpatients.

Personal experience as a young doctor

I graduated from Kyushu University in April 1967 and started my career as a young psychiatrist. After being graduated from the medical school, a young doctor had to complete one year for the internship. Internship was introduced soon after WWII by occupying forces and continued until 1968. Years from 1967 to 1968 were characterized by students’ protests worldwide. Japan was not an exception. Young doctors and students were critical to Japanese government who support Vietnam war. Young doctors formed zengakuren (all students’ association) and protested to internship which used young doctors without

Table 2. Number of mental health staff: a comparison of four countries

<table>
<thead>
<tr>
<th></th>
<th>Japan</th>
<th>Australia</th>
<th>The United kingdom</th>
<th>The USA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per 100,000 population</td>
<td>Beds per staff</td>
<td>Per 100,000 population</td>
<td>Beds per staff</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>9.4</td>
<td>30.2</td>
<td>14</td>
<td>2.8</td>
</tr>
<tr>
<td>Psychiatric nurse</td>
<td>59.1</td>
<td>5</td>
<td>53.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Clinical psychologist</td>
<td>7.1</td>
<td>40.8</td>
<td>5.1</td>
<td>7.8</td>
</tr>
<tr>
<td>Social worker</td>
<td>15.7</td>
<td>18.1</td>
<td>5.1</td>
<td>7.8</td>
</tr>
</tbody>
</table>

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payment. Internship was ended in March 1968. Also, young doctors protested to the authoritarian system of medical schools. This period was also a booming time for private psychiatric hospitals in Japan. Psychiatric hospitals were keen to employ young doctors even as part-timers. They need the list of doctors employed. During my time of internship, I worked at a private 200-bed hospital in the Tokyo area once a week as a part-timer. This hospital had 10–15 patients sharing a big tatami room (Japanese style), and the door of the hospital to the outside was closed. Letters to outsiders were checked. Quality of care was miserable. Patients’ rights were ignored. Inside a hospital, it was like a hell. The cost for a patient could be very low. But the reimbursement from public fund to a hospital might have been adequate and secured.

Socioeconomic factors contributing to hospital-centered mental health care

The proliferation of the poor quality of psychiatric hospitals from 1955 to 1970 has been pushed by many social factors. First was the strong stigma attached to persons with mental illness. The general population was happy to keep them out of their sight. Hospitalization of a family member with mental illness was a great relief to the family. This period coincided with the economical booming in Japan. Reduced average family size and house size driven by increasing urbanization meant that many patients no longer had a place at their home to return.

Patients seldom had the chance to complain and sometimes were easily institutionalized. Psychotropic drugs helped private hospitals to keep patients calm and obedient. In addition, there was a lack of community services. The economic growth of Japanese society could easily support the increasing cost for the long-term hospitalization of persons with mental illness. Nisseikyo became a strongest power holder to decide the national policy of MH in Japan. Nisseikyo and member hospitals were reluctant to change the system which bring them a lot of profit.

Visit of David Clark, a WHO consultant in 1967

In 1967, David Clark from the UK visited Japan for three months as a WHO consultant. He visited many hospitals in Japan with Japanese psychiatrists. He repeated the previous WHO call for a transition to community-based MH services in Japan. He recommended the establishment of a review committee of quality of care of private psychiatric hospitals. He submitted his recommendations to the Mental Health Division of MHLW. But the government was reluctant to follow his advises to treat patients in the communities and to improve the standard of care at private mental hospitals. At this time, the Japanese Society of Psychiatry and Neurology (JSPN) was not functioning well. Nisseikyo had a strong influence to MHLW. The recommendations of David Clark was not welcomed by them at all [11].

The negative response to David Clark recommendations [11] reflected the reluctance of both the government and the general population to treat psychiatric patients in the community. There were several reasons. Such attitudes were inflamed by incidents such as the high-profile attack in 1964 of an American ambassador (RO Reischauer [1]) to Japan by a patient suffering from schizophrenia. At the same time, Nisseikyo became a strong political player to protect the interests of its members. The timing of David Clark’s visit was not good to promote community MH services in Japan [10].

The WHO promoted community-based MH service worldwide. In the rest of the world, community psychiatry became the mainstream of MH services. The USA started to deinstitutionize state mental hospitals and to decrease the number of mental hospital beds in the 1970s. Similar trends influenced Asian countries. Large psychiatric institutions built under the colonial period were decreased their beds and developed community services. In the Philippines, Indonesia, Singapore, and Malaysia, the number of beds of their huge psychiatric asylums was decreased. In this period, Japan paved the unique road, to increase the number of the already oversaturated psychiatric beds. Hospital-centered MH service in Japan had its root from 1955 to 1970 (Figure 1).

My personal experience as a young psychiatrist in 1968

In 1968, I started my career as a young psychiatrist to work at National Hizen Hospital, in Saga Prefecture. The hospital had its root as a military hospital and had around 600 beds. More than 80% of its inpatient population was schizophrenics. There were around 10 psychiatrists, most of them were alumni of Kyushu University. I was in charge of a chronic male ward of 50 inpatients. Most patients were chronic schizophrenic patients who stayed more than 5–10 years. Patients were calm and well-institutionalized. The ward was a closed ward with no or little rehabilitation activities. A few patients received ECT. Most of the patients received 300–500 mg/day of chlorpromazine. Haloperidol was prescribed to those showed active delusion and hallucinations. Antiparkinson drugs and laxatives to prevent constipation were prescribed as routine. Levomepromazine was prescribed to patients with sleep problems. Prescription was changed very seldom. The role of a psychiatrist was to keep the ward calm. Very few admissions and discharges took place. It was a seclusive world

Figure 1. Home custody for psychiatric patients in Japan before World War II. Source: Ministry of Health and Welfare, Japan.
and was separated from the outside world. Pharmacotherapy became the main treatment option for mental illness in Japan because chlorpromazine was introduced in Japan in 1955 and haloperidol in 1964. The sedative effect of these psychotropic drugs made managing inpatients easily, and they were reportedly used at high doses. At Japanese mental hospitals, the major purpose of pharmacotherapy was more for sedation rather than rehabilitation [8].

**Mental Health Care Changes in Japan from 1970 to 1987**

**Confusion at the Japanese Society of Psychiatry and Neurology starting in 1969**

At the 66th annual meeting of the JSPN in Kanazawa, Ishikawa Prefecture May 1969, a group of young psychiatrists (seiiren) proposed the nonconference motion to the board members of the JSPN. They accused senior psychiatrists (most of them were professors) that their research activities were not for patients, and they were responsible for the miserable condition of mentally ill patients. The motion was passed. All executive council members and board members of the JSPN resigned. Young reform-minded psychiatrists took over the leadership of the JSPN as executive board members.

From 1969 to 2001, annual meetings of the JSPN had been filled with accusation to senior professors and all scientific programs were dropped. The number of participants to the JSPN annual congress had been decreased year by year. No international activities existed stemming from the JSPN that became very introverted. Asian psychiatrists bypassed Japan for research and training in psychiatry [12].

The official English journal of the JSPN was *Folia* (later named the *Psychiatry and Clinical Neurosciences* [PCN]). First published in 1933, *Folia* was in circulation until 1975 except for a suspension from 1938 to 1946 during WWII. In 1975, the new board of directors of the JSPN withdrew support for *Folia* as its official journal because many JSPN board members were critical that *Folia* was influenced by the opinions of university professors who did not pay enough attention to the human rights of the mentally ill.

**Stagnation of mental health-care development from 1970 to 1978**

News media reported many scandals at private psychiatric hospitals with poor quality of care. The JSPN was not functioning well due to internal conflicts.

The Japan Association of Families of Mental Patients (zenkaren) founded in 1965 became vocal to criticize the poor quality of care at private psychiatric hospitals where their sons and daughters were hospitalized. Zenkaren became a strong force to improve the care and rehabilitation of the mentally ill in Japan.

**My personal experience as a psychiatrist from 1971 to 1981**

After a few years of clinical experiences in Japan, I got a fellowship to study overseas. I studied psychiatry at the University of Paris from 1971 and 1974 as a scholarship student sponsored by the French government. At that time, I was interested in “sectorization” (French-style community MH care based on geographical area sector) and movements for community psychiatry in European countries. After my coming back from Paris, I wrote a few articles on my experiences on community MH services in Europe. They drew few attention.

Community MH was not an interesting topic to many Japanese psychiatrists during that time. Coming home from France, I worked part time at Fukuoka Prefectural Mental Health Center (FPMHC). It was the time that MHWL started an experiment of “day care for mental patients.” PMNHCs were established in all the 48 prefectures and major cities in Japan gradually. They served as an information and support center for persons with mental illness. At present, they became centers for consultation for addiction and *hikikomori*. From 1975 to 1979, I worked four years at Hizen National Sanatorium (HNS) (Saga Mental Health Center at present). HNS was one of the few national sanatoriums for persons with mental illness. HNS was famous as the hospital started an open-door policy in the 1960s. But the trial was put on halt after a few years because the number of patients was decreased drastically. The reimbursement to the hospital was based on the number of inpatients. This resulted in the decreased income. This further the pressure to decrease number of staff from the Government. Also, they received several complaints from residents in the nearby neighborhood.

After a four-year work at HNH, I moved to MHWL to work at its National Sanatorium Division (NSD) (being a part of National Hospital Division) from 1979 to 1981. During WWII, more than 200 hospitals were built for disabled soldiers. After the war, most of them became national hospitals and national sanatorium. The NSD covered more than 150 sanatoriums for patients with TB and a few for mental diseases. There was a sharp decrease of TB patients, and MHLW planned to change TB sanatorium to hospitals for patients with mental diseases, those with neurological diseases, and those for needing long-term rehabilitation. At that time, NSD also started to set up NCNP. Later, NCNP became a center for research and training in neurology and psychiatry.

After WWII under the guidance of the Occupation Forces, more than 300 health centers were established throughout Japan to serve as primary health-care centers. Their major tasks were vaccination, prevention and control of TB which was the leading cause of mortality. Thanks to the effective drugs and public health works, the number of TB patients was decreased. MHWL shifted the focus of services from TB to persons with mental disorders. Since the 1980s, health centers had become an important player in providing aftercare for those with mental illness.

**My experience as a WHO staff for 13 years from 1981 to 1994**

Japan contributed the second largest amount of money to the WHO at that time. But the number of Japanese staff was
very low. To ease the unbalance, the WHO sent a recruiting mission to MHWL for Japanese staff to work at the WHO. The recruiting committee was keen to get a Japanese psychiatrist experienced both in clinical work and administration. In addition, my experiences in France helped. The recruiting mission recommended me as a potential candidate, and Norman Sartorius, the then director of the Mental Health Division of the WHO interviewed me in 1980. Finally, I was chosen, and I left Japan in 1981, and started to work at the Western Pacific Regional Office of the WHO (the WPRO) in Manila, the Philippines, as a regional adviser in MH. The WPRO worked to improve MH care for more than 30 countries and areas in Asia and Pacific. I found the work very challenging and interesting. During my stay at that office, I started many activities to promote community MH care in countries with limited MH resources. I had worked at the WHO for 13 years from 1981 to 1994. Helen Herrman, Australia, succeeded me after my departure.

**Mental Health Care Changes in Japan from 1987 to Now**

### Utsunomiya Hospital scandal

In 1984, a patient was maltreated by a male nurse and died at Utsunomiya Hospital in Tochigi Prefecture. This incident became notorious as the “Utsunomiya Hospital Scandal.” The news drew attention to the miserable condition of some private psychiatric hospitals in Japan. Several similar violations of human rights were reported at other hospitals. The event also attracted the attention of international human rights groups. Special delegates from the World Psychiatric Association (WPA) and the International Jurist Organization (IJO) visited Japan to investigate. The government was asked to take necessary measures to improve the quality of private psychiatric hospitals.

### Mental Health Law in 1987

In response to pressure generated by WPA and IJO inquiries, the MHLW was obliged to change the system of psychiatric services. In 1987, the MHLW adopted the Mental Health Law with a focus on protecting the human rights of patients treated on inpatient wards and promoting community MH services. Several measures to ensure the quality of MH services were introduced. The hospital staff were no longer allowed to check the personal letters of inpatients. A public telephone was set up inside the inpatient ward. Voluntary admission was recommended as the norm of admission. The system of qualified designated psychiatrists was also introduced. Only qualified designated psychiatrists who had completed training about human rights and had had extensive clinical experience were permitted to hospitalize and treat involuntary patients [13].

Based on the newly enacted MH law, several measures were introduced to improve MH care. The trend was characterized by gradual changes from hospital-based systems to community-based MH care. The symbolic event was the decreased private psychiatric beds starting from 1994 onward. On the other hand, community-based services were promoted. The number of hospitals with day-care services was increased. Group homes, small-sized occupational centers, and life support centers started from 1988, and their numbers had been increased every year. The above policy changes were facilitated by several financial incentives. Health insurance pays less to long-stay inpatients. Fee for day care was increased [12].

In 1993, a basic law for disabled persons was enacted. The law asked the government to provide the same health and welfare measure for persons with physical, intellectual, or mental handicaps.

### My experience as a psychiatrist from 1994 to 2002

I came back to Japan in 1994 after 13 years of work at the WHO in Manila, the Philippines. My new posting in Japan was a professor of epidemiology and international health at Kobe University School of Medicine. I was not welcomed as a psychiatrist because most Japanese psychiatrists had no knowledge about WHO MH activities.

In January 1995, Japan experienced the Great Hanshin Awaji Earthquake in the Kobe area. More than 6,000 persons died, and more than 2.4 million persons were affected. The earthquake brought disaster MH as an important branch in Japanese psychiatry. American psychiatrists brought the notion of posttraumatic stress disorder (PTSD) which became popular among Japanese psychiatrists and general population through media. This also decreased the stigma attached to mental diseases. PTSD is a rare psychiatric diagnosis with little stigma attached [15].

### Changes from hospital-centered services to community-based services

In 1996, MHWL presented long-term plan to build rehabilitation facilities for persons with mental disorders with specific target number of several facilities all over Japan. They were day-care centers (1,000), life skill training centers (300), short-stay centers (100), welfare homes (300), job training day centers (300), job training homes (100), welfare factories (50), community support centers (650), group homes (920), and social skill training centers (3,300). The Mental Health Law had been amended in 1995, to MH and Welfare Law to include welfare services for persons with mental disorders. The rôle of prefectoral health center was identified to promote the program [16]. Increase of psychiatric clinics was observed from the 1980s.

Small number of psychiatric clinics existed from the 1970s. But their number was very limited because of very low fee in psychotherapy. Psychiatric clinics could not make money. MHWL planned to increase the number of psychiatric clinics as bases for community psychiatric services. In the 1990s, the MHWL introduced a new reimbursement scheme to cover payment for psychological counseling, making the clinic financially sustainable. Outpatient clinics were mushroomed in major cities. They started take care of patients suffering from depression and neurosis. This lowered the stigma attached
to mental diseases. Now the number of psychiatric clinics is estimated to be more than 6,000. Some psychiatric clinics provide day-care services and home visits in addition to their consultation activities.

In the 1970s, occupational therapists started to function as paramedical staff at psychiatric hospitals. Psychologists were restricted to do psychological testing. After 1987, an increased reliance occurred in paramedical staff as experts in the development of community-based care. In 1997, the law on psychiatric social workers (PSWs) was enacted. PSWs became licensed on a national level. A national licensure examination for PSWs started in 2000. Every year, more than 6,000 PSWs had become registered. PSWs became important members to promote community MH care in Japan, working as a multidisciplinary team member with doctors, nurses, occupational therapists, psychologists, and other MH care workers. A detailed description about PSWs in Japan can be found in a 2016 article “Japanese mental health care in historical context: why did Japan become a country with so many psychiatric care beds?” by T. Kanata, published in an online journal Social Work (Stellenbosch) volume 52 (www.dx.doi.org/10.15270/52-2-526).

**British and American psychiatry became dominant in Japan**

Psychiatry in Japan remained heavily influenced by German psychiatry even after the end of WWII. Many senior Japanese professors and leading psychiatrists had studied in Germany before the war. Biological psychiatry was dominant, and philosophical psychiatry was popular among nonbiologically oriented psychiatrists. German psychiatry lost its glory during the 1980s with the revelation that several leading German psychiatrists were members of the Nazi Party [4, 14]. Japanese psychiatry became increasingly influenced by American principles. It was during this time that the International Classification of Diseases and the Diagnostic and Statistical Manual were translated into Japanese and widely adopted. German school professors in psychiatry gradually were faded away and replaced with young professors trained in the USA.

**Suicide prevention**

In 1998, Japan experienced more than 8,000 times increase of suicide cases from 24,391 in 1997 to 32,865. This was the result of hardships faced by middle-aged employees discharged as the result of bankruptcy of many factories. The high suicide rate of more than 30,000 per year had continued until 2011. Several measures were introduced to reduce suicides. Prevention and early detection of depression became a major part of the prevention program. The government enacted Suicide Prevention Law in 2006. The number of persons who committed suicide was marked the highest (34,427) in 2003, which decreased gradually year by year due to the improvement of economic recovery. In 2018, the number was reduced to 20,840. But suicide still remains as the leading cause of death for the population between 15 and 39 years of age. Psychiatrists were recognized as important player for their effective: suicide prevention.

**Special facilities for forensic cases**

In 2001, a patient with a history of schizophrenia entered a primary school in Osaka city and killed eight children and injured 13 children and teachers. After the incident, the government immediately enacted the law “Medical Treatment and Supervision Act” for persons who have caused serious crimes under the condition of insanity. To meet the needs, 30 special beds were established at thirty public psychiatric hospitals totaling 900 beds to take care of difficult patients. Staff were recruited both from medical and judicial sectors. A few Japanese psychiatrists were sent to the UK to learn the needed knowledge on how to build forensic wards in public psychiatric hospitals [13].

**Normalization of the Japanese Society of Psychiatry and Neurology**

The 12th World Congress of Psychiatry in Yokohama with the congress theme “Partnership on MH” was held for the first time in Asia since the foundation of the WPA in 1950. The WPA congress was opened in 2002 in the presence of the then Crown Prince Naruhito and Princess Masako. Norman Sartorius was a chairman of the scientific program committee.

The WPA Yokohama attracted more than 7,000 delegates from all over the world. The congress adopted the Yokohama Declaration and awarded the JSPN with the responsibility of promoting MH care in Asia. At the 12th WPA in Yokohama, the Japanese term for schizophrenia, seishin-bunretsu-byo, was renamed to tougou-shicyyou-syou (integration disorder) to reduce stigma. The WPA Yokohama 2002 also helped normalize the JSPN. Since 2003, annual meetings of the JSPN have included scientific and academic presentations in the program.

The number of participants to the annual meeting of the JSPN has been increasing year by year. At present, JSPN annual meeting is attended by more than 6,000 members.

After the 12th World Congress of Psychiatry in 2002, the JSPN allocated a separate budget to international activities. The budget enabled the JSPN to invite young Asian psychiatrists to its annual meeting and organize international symposia. At the beginning, JSPN allocated one symposium in English and invited young psychiatrists from overseas to participate. The number of applicants was very small at the beginning. But now, JSPN fellowship program has become very popular. JSPN received many applicants to apply for the limited slots. More than 400 young foreign psychiatrists participated at the JSPN annual meeting in the past 20 years. In addition, the JSPN started to have official relationship with national psychiatric societies in Asia. In 2015, JSPN organized an international symposium inviting the presidents of national psychiatric societies from China, Korea, and Japan. As shown in Figure 2, international speakers and young psychiatrists have been invited to participate in the activities at the annual meetings of the JSPN every year.
The JSPN board members suspended the publication of *Folia* in 1975. *Folia* was an official English journal of JSPN since 1933. The *Folia* was resumed by the JSPN in 2007. Later, its name was changed to *PCN*. The impact factor (IF) of *PCN* was below 1.0 at the beginning. But its IF has been increased every year and now, it stands more than 3.5 in 2019. The 12th WPA Congress at Yokohama introduced Japanese psychiatry to the world.

In 2007, the Asian Federation of Psychiatric Association (AFPA) was formed with the blessing of many international and national psychiatric societies. The AFPA now has membership from almost all national psychiatric societies in Asia and Pacific region. The second World Congress of Asian Psychiatry was held in Taipei in 2009. The fifth one was convened in Fukuoka in 2015. Gradually, Japanese psychiatry has overcome its isolation.

**Mental health reform plan from 2002 onward**

In 2002, the MHWL issued the reform vision for “health, medical care and MH and welfare care.” The vision outlined several medical and social services for the mentally ill. The vision proposed a comprehensive care system for patients covering all kinds of medical and social services. Medical services include services such as hospital, clinic, home visit by nurse, and day care. Social services include half-way house, group home, home help, job coaching, and case management. Also, it aimed to discharge 70,000 inpatients from psychiatric hospitals classified as social hospitalization to community services. Many social welfare services are managed privately.

In 2006, new fee schedules were introduced. Totally, there were 30% increase of payments to acute cases and ambulatory cases, staying at hospitals shorter than 15 days. There were lower payments for patients staying more than 90 days. Home visits by nurses to patients were paid with the maximum of five times a week. In this way, the MHWL tried to develop community MH services. In 2006, a law to support the independence of people with disability was enacted to support discharged patients to get employment opportunities. But those efforts were not successful due to several oppositions. For 100,000 population, Japan has 28.1 beds at mental hospitals, but only 0.7 for various rehabilitation services and 0.4 for group home. The reduction of 70,000 beds was not successful [13]. The number of inpatient bed is still very high by international standard. The average length of stay has decreased, but the number is surprisingly high for the outside world (Figure 3).

**Mental health service in Japan in 2018**

Continuous efforts have been carried out to develop community-based MH services away from hospital-centered services over the 30 years since 1987. This has resulted in the decrease of psychiatric beds to 40,000. But more than 100,000 patients remain hospitalized in private psychiatric facilities for more than five years in 2018. Almost 200,000 patients stay more than one year. The average length of stay was decreased from 496 at 1989, to 274 in 2018. This figure is still extremely high to compare with that of other countries (Figure 4).

The MHWL has introduced several measures to reduce the long-stay patients by lowering the payment to providers for...
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long-stay patients. Private psychiatric hospitals are private business. They are reluctant to discharge the patients which are the source for their revenue. They could no longer keep new patients with schizophrenia for long period due to human right issue. The average age of these long-stay inpatients became extremely high. Most of the long-stay patients are at present over 60 years of age. In 2017, a news media reported that 1,773 patients had stayed at psychiatric hospital more than 50 years. This caused a scandal. There was a shift of the demographic profile of private psychiatric inpatients. For example, the proportion of inpatients diagnosed as schizophrenia was decreased from over 80% to fewer than 60% from the 1980s to the 2010s. Group homes near hospitals have been built to accommodate these patients with chronic psychiatric condition. Conversely, the proportion of patients with Alzheimer’s disease and other forms of dementia has sharply increased to almost 20% of the inpatients. According to 2014 MHLW statistics, 77,000 patients with the diagnosis of Alzheimer diseases and dementia were hospitalized out of 300,000 psychiatric inpatients in Japan.

In the past 20 years, the MHWL has made a number of reforms to increase the workforces to provide services by multidisciplinary team. But the MH workforce are still lacking comparing to those in other Organization for Economic Co-operation and Development (OECD) countries (Table 2).

OECD in its report in 2014 pointed out several characteristics of MH services in Japan. Among others, the lack of primary health care, the lack of psychotherapy, high-dose prescription of psychotropic drugs, physical constraints, human rights violation at psychiatric hospitals, and social hospitalization were mentioned.

Mental health of the aged and dementia

Japan has the world’s longest living people, with Japanese men living on an average of up to 81 years and Japanese women up to 87 years. More than 25% of the population is over 65 years of age, and more than 70,000 people are over 100 years in 2018. This projection increases every year. A growing elderly population is a major health and welfare problem faced by many Asian countries. Among those who are over 70 years old, 10% are suspected of having dementia; the proportion increases to 20% for people over 80 years and 40% by people over 90 years. Currently, more than 4 million people have been diagnosed with Alzheimer’s disease and other forms of dementia, Care for those with dementia has become a social issue beyond the realms of medicine and psychiatry. This rapidly aging population is accompanied by a reduction in the birth rate. A few decades ago, Japanese women had on an average between two and three babies. At present, women have on an average of 1.3 babies. This demographic change means that the age group of people supporting the elderly is rapidly shrinking.

History of psychiatry in Japan


In addition, Japanese MH services were reported in English chapter of book [16]. Shinfuku contributed a chapter “MH system in Japan after the Meiji Restoration: Historical observation” in a book edited by Minas and Lewis [7]. Suda et al. wrote “history and perspective on psychiatry in Japan” in a Rutledge Handbook of Psychiatry in Asia edited by Bhugra et al. [5]. Shinfuku wrote two articles in the Taiwanese Journal of Psychiatry. The first one was “What is happening in the MH system in Japan: Some observations” in 2012 [12]. And the second one was “Japanese culture, social events, and MH law: My personal observations” in 2016 [13].

The contents of this current review overlap with those in some of my previous papers on related topics. Also, I am grateful to the authors of those of the aforementioned books for me to add more information in this review.

Conclusion

MH care in Japan after WWII started relying heavily on private hospitals. This led to hospital-centered services and has caused many scandals. The tide was changed in 1987 with the enactment of MH law with the focus on protecting the human rights of inpatients and promoting community-based care.

Since then, a certain progress existed to move away from hospital-centered to community-based care. But there are a lot of rooms for improvements, and Japanese psychiatrists are now making special efforts to improve. For example, special attentions have been emphasized on psychiatrists’ training in restraining inpatients as seen in the recent programs of the JSPN annual meetings.

In 2019, Japan has still the biggest number of psychiatric beds in absolute and relative terms in the world. Many patients are still treated in closed wards. Their average length of stay is extremely long for international standard. Many challenges exist for Japanese psychiatrists to improve the quality of MH care.

It is important for Japanese psychiatrists to communicate with the outside world, to learn the shortcomings of its services, and to continuously improve their services for the mentally ill.

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References