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A Comparative Study of Psychiatric Services in Japan and England

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Psychiatric services in Japan and England are compared using government statistics. In Japan, the number of in-patients per 100 000 population has increased from the 1950s, while that of England has decreased since 1954. Since 1972 the prevalence of in-patients has been higher in Japan than in England. The admission rate is lower in Japan than in England, and there are more long-stay patients. Most Japanese in-patients are admitted compulsorily, whereas most are admitted voluntarily in England. The attendance at out-patient clinics is higher in Japan than in England, but there are far fewer day-hospital places in Japan. Differing government policies are the main reason for these differences.

Many problems exist in the psychiatric services in Japan. Criticisms have recently been made by a British psychiatrist (Fahy, 1987) and a journalist (Cohen, 1988). In addition, the International Commission of Jurists sent two expert Missions, one in 1985 (also supported by the International Commission of Health Professionals) and the other in 1988, which reported in detail on problems in the Japanese situation (Harding *et al*, 1986; International Commission of Jurists' Mission to Japan, 1988). In Japan itself, psychiatric services have been criticised from the viewpoints of psychiatry (Nishizono, 1987; Ogawa *et al*, 1987), public health (Aoyama, 1983) and the law (Totsuka *et al*, 1986). These criticisms can be condensed into three: (1) the harmful effects of large, closed mental hospitals; (2) the poor community care services; and (3) the infringement of the human rights of mentally ill patients in mental hospitals.

In response to these criticisms, the Japanese Ministry of Health and Welfare made recommendations (Koseisho Seishin Hoken Ka, 1988) which led to the reform of the Mental Health Act in 1987 (becoming law in 1988). According to the new law, a rehabilitation system for mentally-ill patients was to be developed, and such patients' human rights were respected. However, there have been difficulties implementing the law since few studies have identified the problems in the psychiatric services clearly.

The situation in Japan can be contrasted with that of other industrial countries such as England. After the Second World War psychiatric services changed notably in England from being hospital-centred to being more community-based. The advent of the NHS and the introduction of psychotropic drugs made it easier to care for patients in the community (Wing, 1985; Gelder *et al*, 1986). At its best, England's mental health system is highly regarded all over the world (Salokangas *et al*, 1985). It is valuable therefore to compare the psychiatric services in Japan with those in England in order to cast light on the former.

Method

The study is based on available government statistics from Japan and England. In Japan these were mainly obtained from the Ministry of Health and Welfare's Kanja Chosa (Patients' Survey) conducted on an annual census day (Koseisho Tokei Joho Kyoku, 1960–85), and are therefore based on patients in a randomly chosen 10% of all hospitals and 1% of all out-patient clinics (the total number of patients being estimated from these). The English statistics were obtained from the Mental Health Inquiry for England (Department of Health and Social Security, 1960–1984). Before 1970, statistics for England and Wales were combined, but since then, figures for England have been published separately. Thus, although our pre-1970 data are for both England and Wales, for convenience, we refer to them all as 'English', as in another comparative study (Salokangas *et al*, 1985).

We compare the following aspects of service use: rates of in-patients per 100 000 population, distributed by sex and age; rates of admission to mental hospitals per 100 000 population; the ratio of admissions to numbers of beds occupied (i.e. in-patients) on the annual census day (Wing, 1972); the duration of stay of in-patients (here we used data from another government survey (Koseisho, 1983) since adequate official government statistics were not available); the duration of stay of discharged patients (the available data for Japan were only for discharge from hospitals with over 19 beds); and rates of psychiatric out-patient and day-hospital attendance per 100 000 population.

In order to calculate the number of patients attending out-patient clinics in Japan, the number of attendances on the annual census day was multiplied by 250, the usual number of working days a year for most Japanese people. The exact number was unobtainable from government statistics. We were also unable to get data on attendance at day-hospitals in Japan.

Results

A comparison of the numbers of in-patients on annual census days is shown in Fig. 1. In Japan, the in-patient rates increased from 32 per 100 000 total population in 1953 to 260 in 1984. In England, by contrast, they decreased from

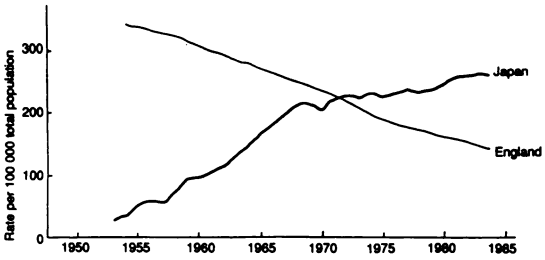

FIG. 1 Rates of in-patients per 100 000 population in Japanese and English mental hospitals on annual census days.

344 in 1954 to 141 in 1984. Since 1972, the rate in Japan has been higher than that in England and the difference between the countries has continued to increase since then.

A comparison of in-patients by age and sex is shown in Table I. The rates for Japan increased in both sex groups, while those for England decreased. In Japan, there are more men than women in mental hospitals, while in England the opposite is true, a tendency similar to that between Finland and England (Salokangas *et al*, 1985). This can be interpreted in two ways. Firstly, since women usually play a major role in the home in Japan, it may be easier for women with mental illness to maintain this in the absence of adequate social support systems than men, whose roles, largely located outside the home, may be more demanding. Secondly, there are, and have been, higher rates of elderly in-patients in England and, since there are more women than men in the elderly (over 65 years) population in England, this may also account for the difference.

Regarding age-specific rates, rates of bed-occupancy (i.e. in-patients) decreased consistently in all age-groups in England. Although rates decreased among those under 35 years in Japan, they increased in groups over 45 years.

TABLE I

Total, sex and age-specific rates per 100 000 population for in-patients in Japan and England

	Japan				*England*			
	1970	*1975*	*1980*	*1984*	*1970*	*1975*	*1980*	*1984*
Total	200	220	245	258	233	188	161	141
Sex:								
male	239	264	288	298	206	166	-	-
female	163	181	203	220	260	209	-	-
Age: years								
15–24	142	133	96	81	48	50	36	29
25–34	324	310	297	264	110	88	74	65
35–44	368	413	412	396	190	131	102	79
45–54	302	362	425	471	292	227	156	114
55–64	244	288	356	406	391	311	253	205
65–74	186	232	329	356	599	479	388	352
75+	141	212	406	484	1208	918	870	775

TABLE II

Ratio of Japanese : English in-patients in given years by sex and age

	1970	*1975*	*1980*	*1984*
Total	0.86	1.17	1.52	1.83
Sex:				
male	1.16	1.59	-	-
female	0.63	0.87	-	-
Age: years				
15–24	2.96	2.66	2.67	2.79
25–34	2.95	3.52	4.01	4.06
35–44	1.94	3.15	4.04	5.01
45–54	1.03	1.59	2.72	4.13
55–64	0.62	0.93	1.41	1.98
65–74	0.31	0.48	0.85	1.01
75+	0.12	0.23	0.47	0.62

Table II shows the ratio of Japanese to English in-patients. The ratios increased with time in all ages except the group under 24 years, and, by 1984, the ratios exceeded four in the groups from 25 to 54 years.

A comparison of admission rates to mental hospitals per 100 000 total population is shown in Fig. 2. In general, the rates in Japan have been around half of those in England. Before 1980, trends in both countries were similar, the rates increasing gradually in the 1960s to a plateau in the 1970s. After 1980, they remained stable in Japan, but increased in England.

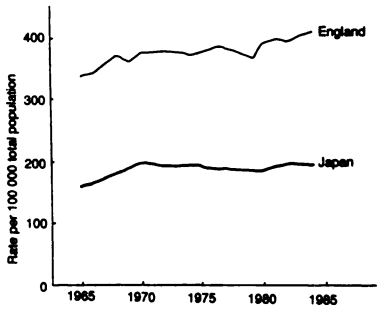

FIG. 2 Rates of admissions to mental hospitals per 100 000 population in Japan and England.

The ratios of admissions to numbers of beds occupied are shown in Table III. This ratio has increased steadily in England but has gradually decreased in Japan since 1970. In 1984, the ratio in England was four times that in Japan.

With regard to length of stay of in-patients in Japan, because of the limited information, we can only give (1) the rates of discharged patients per 100 000 population broken down by the duration of stay in hospital (Fig. 3), and (2) the distribution of length of stay of in-patients, which is available in Japan only for 1983 (Table IV). Figure 3 clearly shows that patients are discharged considerably earlier in England than in Japan. In England, the rate of patients discharged within one month of admission has

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TABLE III
The ratio of admissions : numbers of beds occupied in given years in Japan and England

Year	*Japan*	*England*
1965	0.95	1.28
1970	0.98	1.61
1975	0.86	2.01
1980	0.75	2.41
1984	0.74	2.90

increased steadily, whereas in Japan the increase is recent. Table IV shows how in Japan in 1983, almost 50% of in-patients had been in hospital more than five years and only 25% had been admitted less than one year previously. In England in 1984, the proportion of in-patients resident over five years had decreased by 36%, while those resident under one year had increased by 40%.

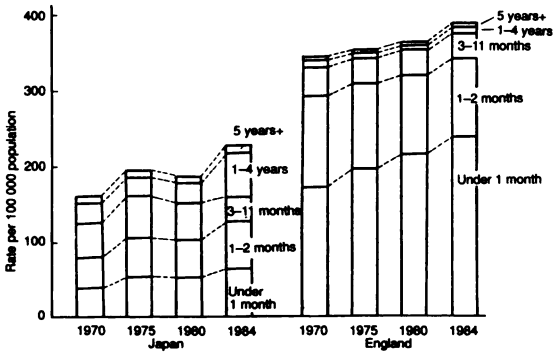

FIG. 3 Discharge rates per 100 000 population from mental hospitals in Japan and England broken down by length of stay in hospital.

These results suggest that in England the numbers of 'old' long-stay patients (over five years) have decreased and the length of stay of discharged patients has considerably reduced. However, in Japan the 1983 data suggest that a large percentage of patients remain in hospital for more than five years. This must mean that many Japanese mental patients are still at risk of 'institutionalism' (Wing & Brown, 1970).

TABLE IV
Length of stay in hospital of in-patients in Japan and England

	Japan	*England*			
	1983	*1970*	*1975*	*1980*	*1984*
Length of stay in hospital: %					
<1 year	24.0	28.2	31.2	36.0	39.9
1–2 years	16.5	13.6	13.7	15.2	15.3
3–4 years	10.1	58.1	7.1	8.2	8.7
5+ years	47.8		47.9	40.7	36.0
unknown	1.6	–	–	–	–
total	100.0	100.0	100.0	100.0	100.0

The legal category of admission to mental hospital is also relevant. Before 1988 in Japan, there were three types of formal (compulsory) admission: compulsory admission by the governor under article 29 of the Mental Health Act; compulsory admission with the consent of the person responsible for care under article 33; and provisional compulsory admission under article 34. Most admissions have been formal and under articles 29 and 33. For example, the proportion of compulsory admissions in 1978 was estimated to be over 80% (Totsuka *et al*, 1986), and, according to a later survey (Koseisho, 1983), was 93.6% (80.1% of in-patients admitted under article 33 and 13.5% under article 29). In contrast, the proportion of informal (voluntary) admissions in England was 82.9% in 1978, increasing to 92.9% in 1984. Moreover, there was no form of appeals procedure for patients detained under article 29 or 33. This raised questions both of the patients' human rights and of policies of treatment. In response, the government reformed the Mental Health Act in 1988, recommending the general adoption of voluntary admission, and regulated the form of appeals procedure for patients detained. In addition, a Local Psychiatric Review Board was established to consider whether an in-patient should remain in hospital and whether he or she has received adequate treatment (Koseisho Seishin Hoken Ka, 1988; International Commission of Jurists' mission to Japan, 1988).

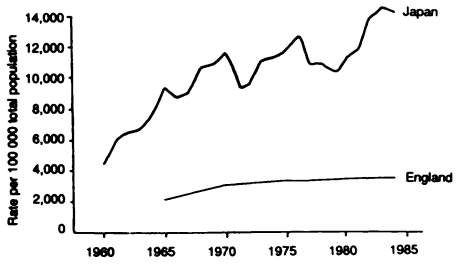

FIG. 4 Rates of psychiatric out-patient attendances per 100 000 population in Japan and England.

A comparison of psychiatric out-patient attendances in Japan and England is shown in Fig. 4. Since the 1960s, the attendance rate in Japan has been more than that in England. However, we must consider two points when interpreting this: (1) the Japanese data are a relatively crude estimate – the number of attendances on the annual census day being simply multiplied by 250; and (2) in England, out-patient visits do not give a correct picture of non-residential care, since there are more attendances at day-hospitals than at out-patient clinics and a large number of patients are also treated by general practitioners.

The number of attendances at day-hospitals increased throughout the 1970s in England, the rate of attendance per 100 000 population being 7 282 in 1982. Non-hospital

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day-centres have also played an important role in community care. However, these are not included in Fig. 4, as in Japan there are no adequate equivalent data. Indeed, there were only 125 officially recognised day-care facilities in the whole country in 1986 (Koseisho Seishin Hoken Ka, 1988).

Discussion

This study is based on government statistics from the two countries which, in general, enable comparisons to be made. However, the data for Japan are less comprehensive than those for England, for example, with regard to the duration of in-patient stay and the attendance at psychiatric out-patient clinics and day-hospitals. However, these differences in the quality of the statistics can not explain the differences in the psychiatric services.

There are three factors that may explain the differences in psychiatric services in Japan and England: (1) the differences in psychiatric morbidity; (2) the differences in government policy; and (3) the differences in public attitudes towards mental illness (Salokangas *et al*, 1985).

On the issue of differences in psychiatric morbidity, although more epidemiological studies are required, the differences in psychiatric services between Japan and England can hardly be explained by this factor. Kato (1969) for example reviewed epidemiological surveys by the Japanese Ministry of Health and Welfare and found no increase in the prevalence rates of mental disorder between 1954 and 1963, in spite of the rapid increase of in-patient rates during this period.

Differences in government policy have clearly contributed to the differences in services. In Japan, the history of mental-health services can be divided into three stages, relating to the enactment of, and changes in, the Mental Health Act, pre-1950, 1950–65 and post-1965. Before 1950, most mentally ill patients were cared for in the community, often not being treated by psychiatric specialists and sometimes virtually detained in the home by family members. In 1950, the Mental Health Act was passed and the basis of the Japanese psychiatric service was established. The incarceration of mentally ill patients by family members was prohibited, and formal (involuntary) admission was legally established and regulated. The government regarded an increase of residential facilities for mentally ill patients as a priority and supported private mental hospitals financially. In consequence, the number of beds for mentally ill patients increased, mainly in private mental hospitals, and the number of resident in-patients began to grow.

After the revision of the Mental Health Act in 1965, the concept of community mental health care was introduced. Under the reformed act, public health centres were designated as the primary basis of mental health services, and mental health centres were established in each prefecture. However, these facilities have not shown good results, mainly because of poor implementation, an insufficient financial base and a consequent shortage of staff. Consequently, psychiatric services in Japan have been mainly hospital-centred, and the numbers of resident in-patients have increased throughout this period (Koseisho Seishin Hoken Ka, 1988; Okagami & Wada, 1985). A fourth stage has just begun following a further reform of the Mental Health Act in 1988.

The history of psychiatric services in England has been described in detail elsewhere (Wing, 1985; Gelder *et al*, 1986). Despite serious criticisms (House of Commons, 1985; Audit Commission Report, 1986), community care has been at least relatively well established in England, and this constitutes the major difference between the two countries.

In the UK, the National Health Service (NHS) has ensured that virtually all mental hospitals and day-hospitals are public. On the other hand, in Japan, 85% of mental hospitals are private and this is a disadvantage for changing policy from hospital-centred to community-based. Moreover, there has been little central government control over the private mental hospital system. However, the Japanese government recently began to play a leading part in the mental health system and to control private mental hospitals. The amendment of the Mental Health Act in 1988 was an expression of this trend.

The results of this study imply that attitudes towards mental illness in Japan are less tolerant than those in England. There are more compulsory admissions and more closed wards in Japan and this situation has been accepted both by psychiatrists and by the general public. Through the new Mental Health Act the Japanese government intends to help reduce the stigma of mental illness, and legal constraints on compulsory admission should become stricter. This is both a cause and a reflection of changing attitudes among Japanese people.

Conclusions

Of the three possible explanations of the differences between English and Japanese psychiatric services, the differences in government policy seem to be the most important, and this is closely related to the attitudes of people towards mental illness.

The data on which this study is based can not describe the quality of care and of life for the mentally ill. An analysis of such factors is essential in developing community-based care for mentally ill patients. In 1988, the amendment of the Mental Health Act in Japan gave government backing to psychiatrists and other mental health professionals to develop better community care for patients. However, among Japanese psychiatrists and other professionals, there is a fear that deinstitutionalisation may occur without the establishment of a community health-care system, leading to homelessness and vagrancy among the mentally ill. None the less, we believe that a community social support system for mentally ill patients can be developed. Such a project can only benefit from comparisons with those of other countries. In particular, Japan can learn both from the successes and failures of England's attempt over the last 30 years to build a better, more community-based system.

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