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Special Feature Article

Future Community-based Integrated Care Systems for Mental Disorders

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Abstract

A report on the community-based integrated care systems said that "Everyone should feel at ease regardless of the presence or absence of mental disorders." This paper describes how multifunctional mental health clinics are involved in community-based integrated care systems.

There are still many patients who cannot receive sufficient support for recovery and a huge number of withdrawals among 8050 problems. Our proposals consist of the following: first, care management is necessary, which is described in the family psychiatrist function; next, mental health social workers should be placed to manage services; and finally, it is important that local services, home-visit medical care, and multi-disciplinary outreach work together.

Keywords: community-based integrated care systems for mental disorders, multifunctional psychiatric clinic, family psychiatrist function, home-visit medical care, multidisciplinary outreach

Introduction

In March 2021, the report of the "Study Group on the Establishment of

Community-based Integrated Care Systems for Mental Disorders” was published. In it, the basic concept of community-based integrated care systems for those with mental disorders (hereinafter referred to as “the integrated care system”) was presented, and it was deemed appropriate to establish a support system based on multilayered cooperation so that everyone, regardless of whether they have a mental disorder and the severity of their condition, can live in peace and comfort in their community, and it was considered necessary to establish systems and mechanisms to realize a society in which people with and without mental disorders can live together.

Although the report is still mainly based on principles and lacks specific details in some areas, I feel a deep sense of emotion that the time has come when issues related to local communities can be discussed based on this basic approach. As someone who has been immersed in the community for 42 years, and who has gone through a lot of trial and error trying to figure out how to support people with mental illness and disabilities, I feel that attention is finally being paid to mental health care in clinics, and that the light is finally shining on communities where we work.

There are many more patients with disabilities and their families in the

community who need medical assistance, but are unable to speak up and receive adequate support, than we expected. In a society where the “integrated care system” is implemented, it is necessary to create a system that provides the necessary support to those who have been left behind in terms of medical care. For this, we expect a careful and effective system design and operation based on the activities and current situation of the community.

In line with the words of Steve Jobs, “Creativity is just connecting things”, our clinic has been working for many years on medical activities aimed at supporting people with mental illnesses and disabilities in their daily lives. In the process, we have developed a multifunctional psychiatric clinic while procuring the necessary items ourselves. While looking back on our past achievements, we would like to consider what is needed to realize the “integrated care system” that is expected in the future and bring hope to more people.

I. Opening and running a clinic - providing what is needed as it arises

Since starting work as a psychiatrist, I have gained experience in a variety of treatment settings, including closed and open wards, day care, and community living. Over the course of this, I have found that the condition of the patient,

as well as the approach and mindset of the provider, vary greatly depending on the setting. As a doctor at a public health center, I encountered people with mental health problems such as schizophrenia through visits to homes and the center, and I came to the conclusion that the place where they were used to living was the most suitable site for treatment. As a result, I decided to open a clinic and provide medical care to support patients. That was 42 years ago.

1. Working with psychiatric social workers

At the time the clinic was established, there were few places in the community where people with mental disorders could gather and relax, and even after being discharged from hospital, many people had nowhere to go but home, and as they felt ashamed and isolated, they would withdraw into their homes, and many of them ended up being readmitted to hospital after their illness relapsed or worsened. Therefore, when the clinic was established, we set up an open access lounge in a corner. A mental health social worker (MHSW) was assigned to the lounge, and was responsible for connecting patients with their peers and relevant organizations in response to their consultations. In order to respond quickly, a medical kit for home visits was prepared, and home-

visit medical care was provided as needed. Initially, most of the patients who came for their first consultation were referred, and there were concerns about whether the clinic could continue to operate, but the number of patients gradually increased. Among them, some patients recovered through treatment (examinations, medication, etc.) at the doctor's office alone, but there were also many people who had difficulties in their daily lives or were facing various problems in their lives, and it was difficult for them to recover through treatment alone. These patients accounted for almost half of the total. It was considered essential to provide such people with careful and generous support, such as close support and counseling by MHSW, inviting them to join group work and recreational activities, and connecting them with necessary resources. In order to deal with each patient who had problems, we adopted a system of assigning a staff member to each patient; as the number of patients increased, we also increased the number of staff members, and began to focus on providing support for their daily lives, including not only consultations in the hospital, but also home visits, accompanying support, and liaison and coordination with related organizations. The fact that the medical and welfare consultation room was located close to the outpatient clinic

made it possible to provide support quickly, and the lounge allowed us to understand the users' situation in a way that was not possible in the consultation room. In addition, by making home visits or accompanying users to other locations when necessary, we were able to obtain more information needed to provide support, and we could also facilitate referrals to other organizations.

2. Opening and reforming psychiatric day care, and employment support¹⁴⁾

As the number of users and their families frequenting the common room increased, a psychiatric day care center was established in response to the institutionalization of small-scale day care services. Supported by the efforts of MHSWs in the outpatient department, the number of users gradually grew. Eventually, the facility became overcrowded, resulting in difficulties in accepting new users. We were faced with a difficult situation that offered no clear prospects for the future. During this time, I was markedly impacted when a patient under my care successfully returned to work after receiving return-to-work support from a counselor at a vocational center for persons with disabilities. This experience motivated me to begin studying employment support, and eventually, an employment support

program was implemented at the conclusion of the day care service. We also changed the day care system to an individual support system, and prepared a number of programs that users could choose from according to their objectives. The day care reform that began around 2002 in this way was a significant change for our clinic. Since then, we have continued to operate a flexible program that matches the objectives of each user, making minor changes as necessary. Furthermore, after the employment support program was introduced, such support became recognized as a local issue, leading to establishment of the "Supporter Liaison Conference" to strengthen relationships with supporters in the community. As a result, collaboration with local employment transition support offices, employment and life support centers, Hello Work, and other organizations advanced, thereby enhancing the role of the day care program as a step-up and transitional service.

Through the people who used the day care service, the path to recovery, including employment, broadened, and cooperation with related organizations deepened. By implementing treatment and day care in parallel, we began to see many people showing diverse forms of recovery. There is no doubt that these experiences became one of my

motivations to actively engage with people who withdraw from society.

3. Outreach

Initially, outreach was provided by MHSWs and outpatient nurses from the Medical and Health Service Welfare Office, but as the need increased, home nursing stations were established and outreach from each department became more active. Home-visit medical care, home-visit nursing care, and home-visit support are important means of medical care at our hospital.⁶⁾¹²⁾¹⁵⁾¹⁷⁻¹⁹⁾ One of the reasons for the increase in our clinic's outreach activities in recent years is that we have begun to actively engage in home-visit medical care for people who withdraw from society. As the background, we have been able to establish a system in which case management is possible not only in the medical and welfare consultation room but in all departments, and we are able to provide support in cooperation with each other. Providing home-visit medical care for individuals who are socially withdrawn requires marked efforts. However, by connecting them with members of a multidisciplinary team at an appropriate time, it has become possible to make more nuanced assessments and provide tailored responses. For example, while providing home-visit medical care, physicians have become able to consider a variety

of support strategies, even for individuals in a state of social withdrawal, by coordinating with day care facilities through home visits and carefully tailored individual introductions, facilitating more future-oriented care planning.¹¹⁾

There are many people in the community who are withdrawn from society and unable to raise their voices to ask for help. As we have been working to reach out to these people, we have also received requests for support from other sources, and have realized that the need for home visits and home-visit medical care from local families and related organizations is even greater than we had imagined. It is in this context that our current activities have been shaped, and in the “integrated care system” study group we have presented the current situation of providing timely support through multi-professional home visits and regional collaboration as reference materials.⁴⁾

Since its establishment, our clinic has been engaged in addressing the needs of service users in outpatient psychiatric care, even in the absence of formal institutional frameworks, by doing what we could within our capacities. Although our efforts may not have been sufficient, we were able to continue them, encouraged by the sight of many individuals who, supported by people both inside and outside the facility, were

recovering, regaining their sense of self, and beginning to lead more fulfilling lives. Looking back, since becoming aware of those for whom medical consultation alone was not sufficient, we have been engaging, together with our staff, with individuals living with various forms of distress. From a contemporary perspective, this can be understood as support directed toward each service user's personal recovery. At the same time, we have come to recognize that this process has also allowed us to walk our own paths of personal recovery.

II. People left behind by outpatient medical care

Up until now, I have continued to provide recovery support for people facing difficulties in life. However, as I see individuals who have successfully entered employment through vocational support coming to the evening outpatient sessions one after another, I am reminded of the changes that were unimaginable before we began working on vocational support. This experience inevitably brings to mind those who have not had the opportunity to receive such support. In theory, everyone should be able to receive the same level of medical care and support no matter which medical institution they visit, but in reality, it still depends on chance and luck.

It has been more than 10 years since the so-called "outpatient NEETs", people who are attending hospital but have no connection to other social resources, came to the fore.²⁹⁾ It is important to support these individuals in living as fulfilling a life as possible by respecting their wishes, assisting with employment, and connecting them with other support services. To this end, it is important for MHSWs and others to offer support and provide case management by engaging with patients at outpatient clinics, which are the only places where patients can be reached. However, according to a 2015 survey by the Japanese Association of Neuro-Psychiatric Clinics, only 25.9% of clinics employed MHSWs, and many of them were assigned to day care services. Consequently, the number of MHSWs dedicated exclusively to outpatient care remains extremely limited. The allocation of staff in medical institutions should not be left to the discretion of individual institutions, and there is an urgent need to create an environment in which all people can receive equal support.

For many years, under a psychiatric care system centered on inpatient treatment, psychiatrists would often say to the families of socially withdrawn individuals: "We can see them if you bring them in", but they made little effort to reach out or offer support to

those who were actually in a state of social withdrawal. There are many families who have wasted 10 or 20 years of their lives because they were turned away when they tried to seek help from medical institutions. The 8050 issue is also a result of the inaction of medical institutions and neglect of psychiatric outpatient care. As those who have primarily provided outpatient care in the community, we must acknowledge that we are in a position to be held accountable for this.

People who withdraw from society often discontinue medical treatment or remain untreated and undiagnosed. They present with a wide range of mental health conditions, including schizophrenia, bipolar disorder, social anxiety disorder, obsessive-compulsive disorder, PTSD, and trauma. Many also have developmental disorders and are in need of medical support. In certain cases, it may be possible for individuals to receive medical treatment or go out into the community if healthcare professionals, such as physicians or MHSWs, carefully listen to them in collaboration with their families and thoughtfully devise appropriate methods of engagement. Although it requires some degree of preparation, psychiatrists providing outpatient care in the community are expected to meet with patients in person, conduct assessments, offer prognoses, and

facilitate connections with appropriate support teams. In fact, more than half of the people who consult about social withdrawal have already visited a medical institution. There is a growing need for medical institutions to strengthen collaboration among clinics, build networks that extend support to those in need, and provide careful, coordinated care through close cooperation with local organizations, rather than turning people away at the door.

III. Toward the expansion of outpatient care

Since I established my practice, systems such as psychiatric day care, night care, short-term care, and home-visit medical care have been formalized. However, the medical and welfare consultations linked to outpatient care, deemed the most essential, were never addressed in the system's design. Consequently, outpatient care has remained stagnant, with no improvements or innovations made to date. Many people who need support, such as those who are socially withdrawn or referred to as “outpatient NEETs”, are being left behind. I believe that many of these problems are caused by the outpatient medical system described above. It can be concluded that this is the result of outpatient medical care, which should support

people's lives within the community, being neglected for an extended period. Each time I face this situation, I am strongly compelled to advocate for urgent system reform.

1. A study on the role of daycare facilities and outpatient services (1992)¹⁾

In 1992, as a representative of the Japanese Association of Neuropsychiatric Clinics, I had the opportunity to participate in “A Study on the Role of Day Care Facilities and Outpatient Services” (Director: Buntaro Omori) conducted by the Health and Welfare Science Research Group. Following a report on our hospital’s outpatient services, the report concluded: “Regarding the functions of psychiatric outpatient care, a system should be in place that not only provides general medical services but also actively responds to patients' handicaps and disabilities. For this purpose, a dedicated outpatient team should be established, including PSWs, CPs, and public health nurses”. Mr. Toshiki Harada, who served as a secretariat member for this research group, wrote in the editor’s postscript: “Ultimately, the goal is that the daily efforts of the many staff involved in psychiatric care be properly recognized and contribute directly to the benefit of individual patients. [...] I sincerely hope that the

purpose and findings of this study group will be reflected as much as possible in the upcoming 1993 revision of the Mental Health and Welfare Act”.

2. “Reform vision for mental health and welfare” (2004)⁵⁾

More than ten years have passed since then, and the “Reform Vision for Mental Health, Medical Care, and Welfare” compiled in 2004, outlined the policy of 'shifting the focus from inpatient care to community-based living. However, there was little mention of outpatient care, which should have supported community life, and medical reform was carried out with a focus on hospitals, leaving outpatient care behind. As someone who had been actively involved in the community with a focus on outpatient care, I was keenly aware of the need to expand these services, so I felt deeply disappointed by this omission. Had outpatient care been included in the reform, I cannot help but believe that the lives of many patients could have been vastly different.⁸⁾ The objectives of the research group mentioned above were entirely disregarded, and no institutional reform was implemented, resulting in no outcomes that would benefit individual patients.

3. “Guidelines for ensuring provision of high-quality and appropriate medical

care for individuals with mental disabilities” (2014)³⁾

These guidelines were announced in 2014 following the revision of the “Act on Mental Health and Welfare for the Mentally Disabled” in 2013. The guidelines define the direction that all parties involved in health, medical, and welfare services for individuals with mental disorders should aim for, in order to shift from hospital-centered psychiatric care to mental healthcare that supports community living.

Finally, the reform vision clearly outlines the direction to be pursued, explicitly addressing the point omitted in the previous version: “towards the realization of psychiatric care that supports community life”.

In the overview, I, involved in community-based clinical practice, place particular emphasis on “Section 2: Matters concerning the provision of health care and welfare services for people with mental disorders in their homes, etc.”, and highlight the following four points:

- 1) Enhancing outpatient care systems and promoting inter-facility collaboration to enable community-based living while receiving appropriate care through outpatient and day care services

In the past, during an era when the focus was primarily on inpatient care, individuals were considered adequately

treated as long as they were attending hospital. However, this led to insufficient outpatient care systems, resulting in frequent relapses, readmissions, and exacerbation of conditions among outpatients. Consequently, this situation also contributed to a loss of employment opportunities, social isolation, and the emergence of a large population of outpatient NEETs.

In addition to medical treatment provided by physicians, it is essential for MHSWs, who support the reconstruction of patients' lives during recovery, to be actively involved and facilitate access to appropriate medical and welfare services. Ideally, outpatient treatment should be provided by a multidisciplinary team; however, even the assignment of a single trained MHSW can significantly improve the quality of outpatient care and coordination of community medical and welfare services. This, in turn, is expected to raise the overall standard of psychiatric care in the region.

Furthermore, to ensure equitable access to high-quality medical care for all members of the community, it is essential to actively promote collaboration among medical institutions. Institutions that do not offer services such as day care, home support, or employment assistance are particularly in need of MHSWs who can

provide case management with a focus on lifestyle support. There is also a need to establish a system that facilitates connection to appropriate support services.

2) Establishing a system for outreach by multidisciplinary teams to ensure access to community support for individuals who have discontinued treatment

The development of an environment conducive to outreach involves ensuring the placement of a multidisciplinary team based at outpatient clinics. In response to the situation in which home-visit nursing services remain closed-off and merely fulfill a quota of “three visits per week” without clear coordination with medical institutions, it is necessary to strengthen collaborative systems, such as by making case conferences with medical institutions mandatory. Going forward, there is a growing need to actively provide outreach-based medical care and support, particularly for individuals who have difficulty attending outpatient services, those who remain untreated or have never sought care, and those who have discontinued treatment. To manage such support appropriately and ensure timely coordination with day care services and related community agencies, MHSWs, capable of fulfilling these roles, are essential.

In addition, the current situation where home visits are limited to patients' homes is not in line with the reality and necessity of support, and is a hindrance.

3) Establishing a psychiatric emergency care system to respond to acute exacerbations in individuals with mental disorders living in the community

Developing an emergency medical system in outpatient care involves establishing multi-disciplinary support teams capable of linking individuals to various community resources, preventing psychiatric emergencies, and enabling a rapid response to relapses, thereby ensuring continuity of outpatient treatment without requiring hospitalization. A past survey conducted by the Osaka Association of Psychiatric Clinics found that, in many cases, the presence of medical staff capable of providing consultation in outpatient settings enabled the de-escalation of emergency situations and continuation of outpatient treatment.⁷⁾

4) Promoting collaboration with medical institutions and disability welfare service providers, along with advancing policies related to housing support

To promote effective cooperation between medical institutions and disability welfare service providers, it is essential to assign MHSWs to medical institutions; mere discussion of

collaboration is insufficient. Establishing a formal liaison function is critical, and urgent measures should be taken to facilitate such assignments.

I found that the intended direction was clearly indicated for all of the above items and there were no particular objections. However, there was no mention of who would be responsible for implementation in practice. Without this being specified, the proposals risk remaining purely theoretical. As I have discussed elsewhere,¹³⁾ assigning MHSWs to outpatient settings is a common solution applicable to all issues addressed, something I have long advocated for.¹⁰⁾

IV. The so-called “family psychiatrist function”, including case management, within “the integrated care system”

The so-called “family psychiatrist function”, including case management, as described in “the integrated care system”, is exactly what our hospital has been implementing in cooperation with MHSWs since it opened. It is impossible for a single psychiatrist to handle these tasks. To realize the multi-layered collaboration and linkage support envisioned in the “integrated care system”, the presence of MHSWs who work in partnership with psychiatrists in outpatient settings is indispensable. In the future, more

effective and layered collaboration will likely be achieved through the formation of multi-professional support teams and involvement of multiple MHSWs, enabling more responsive and coordinated connections to appropriate care based on individual needs.

In addition, within the “integrated care system”, unlike traditional discussions of emergency medical care, the importance of interventions during normal times was emphasized. Psychiatric emergency care, which does not necessarily involve hospitalization and is not limited to after-hours responses, was highlighted as a key issue for outpatient care. This should be highly praised, but the importance of the presence of MHSWs in emergency responses that are not after-hours was also made clear in my previous surveys.⁷⁾

For myself, it is difficult to imagine conducting outpatient care without MHSWs. The presence of MHSWs opens up the outpatient service to the outside world, expands its scope, and improves its ability to respond. In outpatient services without MHSWs, it is considered that the range of what can be done is limited, the necessary support does not reach the people who visit, and the path to personal recovery becomes distant.

To play a part in the system and connect to the community-based

integrated care system, it is essential to play a role in acceptance and linkage on the side of medical care, which is the gateway. If MHSWs can be assigned to general psychiatric clinics through government measures, the community-based integrated care system will be accessed by more people, and the local network will undoubtedly undergo significant changes.

Conclusion

First and foremost, community life is the priority, and everything starts with the place where we live our daily lives. Psychiatric care must return to its foundational role: being rooted in the community and protecting the health and daily lives of those who live there. Medical treatment and support should be provided based on this principle. Although psychiatric care policies have long been promoted under the slogan of “shifting from inpatient-centered care to community-based living”, in reality they have remained grounded in inpatient care. As a result, some individuals have been left behind, disconnected from this shift and effectively abandoned in the community. This is a pressing issue we must confront, and one that should be addressed as a top priority in implementing the integrated care system. The basic policy of the “integrated care system” encourages us to do so.

Through this practice, I hope that we will be able to question the way psychiatric care has been provided up until now, and that it will provide an opportunity to realize a society in which medical support is provided equally to everyone, without anyone being left behind.

In the community, who will take responsibility and act, and how will individuals be connected to the care and services they need? What roles are we expected to fulfill? It is the responsibility of all involved to ensure that the inclusive society envisioned by the “integrated care system” is realized in practice and not left as an ideal that exists only on paper.

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