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Special Feature Article

A Future "Comprehensive Community Care System with a Scope to Include People with Mental Disorders": From the Standpoint of a Private Psychiatric Hospital

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Abstract

The reform of mental healthcare and welfare in Japan up to the present is based on mainly two visions. One vision is originated from the "Vision for Reforming Mental Healthcare and Welfare" (hereinafter referred to as "Reform Vision"). The Reform Vision made public in 2004 revealed policy change in this area, showing basic measures to shift this area "from hospitalization-based to community-based." The Reform Vision focuses on the aspect of promoting hospital discharge, as reflected in the phrase, "About 70,000 patients who can be discharged from hospital will be discharged in 10 years from now on, if the conditions for accepting these patients are met." This vision was concretely realized in the report of the "Study Meeting on How the Future of Mental Healthcare and Welfare should be" (hereinafter referred to as the "Way Study Meeting"). The other vision is the mental healthcare reform in terms of the Medical Care Act and the Medical Care Plan. The Medical Care Act is the law that stipulates the basis of medical care services. The Medical Care Plan is formulated based on the Medical Care Act. In the 6th Medical Care Plan enacted in 2013, mental illness was newly designated as one of the five diseases. This led to the establishment of a medical care coordination system under the Medical Care Plan. In addition, the "Guidelines for ensuring the provision of high-quality and appropriate medical care for persons with mental disorders" was announced in a

public notice issued by the MHLW Minister, based on the revised "Act on Mental Health and Welfare for the Mentally Disabled" enacted in the same year. These two visions were combined to create the "Report of Way Study Meeting." In this report, the establishment of comprehensive community care system with a scope to include people with mental disorders (hereinafter referred to as the "System") was proposed. The report published in 2021 from the "Study meeting on the establishment of a comprehensive community care system with a scope to include people with mental disorders" (hereinafter referred to as the "Study Meeting") showed the basic principle that "Everyone can live in their own way with a sense of security, regardless of the presence or severity of mental illness." This aims at the realization of community inclusive society. In other words, it stipulates how the future of the community mental health and welfare services should be.

Keywords: comprehensive community care system with a scope to include people with mental disorders, Reform Vision, Medical Care Plan, private psychiatric hospitals, function of family psychiatrists

Introduction

On March 4, 2021, the "Study Meeting on the Establishment of a Comprehensive Community Care System with a Scope to Include People with Mental Disorders" (hereinafter referred to as "the Study Meeting") concluded its discussions and deliberations, which had continued for about a year, and the Report of the Study Meeting was published on March 18. In addition, the Working Group on the Development of Emergency Psychiatric Care Systems was established within the Study Meeting, and the results of discussions on the development of emergency psychiatric care systems, important foundations for

supporting the community lives of people with mental disorders, were compiled into a report.

The basic principle of a comprehensive community care system with a scope that includes people with mental disorders, which aims to "enable everyone to live in peace and be themselves, regardless of whether they have a mental disorder," aims to realize a society in which people with and without mental disorders can live together and will define the future of community health, medical care, and welfare. In this paper, I would like to discuss the regional mental health care functions required in this comprehensive community care system,

while looking back on the history of mental health care and welfare in Japan.

I. Impact of the “Reform Vision” and Reform of Mental Healthcare through the Medical Care Act and Medical Care Plans

The Reform Vision for Mental Health and Welfare (hereinafter referred to as "the Reform Vision") of 2004 clearly outlined a series of changes in policy in the field of mental health and welfare, and set out the basic policy of shifting from a focus on hospitalization to that on community life.⁷⁾

The Mental Health and Welfare Law, enacted in 1950 after the pre-war Mental Patient Custody Law and Mental Hospital Law were abolished, was undoubtedly based on the spirit of the current constitution, which marked the beginning of Japan as a democratic nation, and was intended to provide treatment and protection for people with mental disorders. At the time, there was a strong demand to rapidly restore the mental health beds that had been devastated by the war, and save as many mentally disabled people as possible from home confinement and the extremes of social neglect. Despite this, there was a harsh assessment that there was "a law that promotes hospitalization, which clearly reflects the social defense ideology of isolation

from society and institutionalization as its main objective"¹⁾ For this reason, the need for a fundamental revision was called for early on, and there were lots of discussions about revising the Mental Health and Welfare Law. Such discussions took place in a positive atmosphere, with the development of new treatment methods such as the development of psychotropic drugs, and it promised marked advances in mental health, medical care, and welfare in Japan.

This mood was completely changed by the Reischauer Incident in 1964. The stabbing of the U.S. Ambassador Extraordinary and Plenipotentiary to Japan by a mentally disabled youth led to a debate on the responsibility of the Japanese government, and the so-called "letting psychotics run wild" theory fueled by the media. As a result, government and public attitudes toward the mentally disabled rapidly hardened, and this had a significant impact on the debate at the time about revising the Mental Health and Welfare Act. The revised version of the Mental Health and Welfare Law that came into force in 1965 had to take a stance that was more focused on social defense rather than on welfare for the disabled, and the Mental Health and Welfare Law subsequently became something that supported the government's policy of institutionalization for a long time.

The so-called "Utsunomiya Hospital Incident" that occurred in 1984 was a unique incident primarily due to the lack of ethics put forward by the hospital's management. At the same time, however, it highlighted problems in the administration of mental health care, such as the shortage of mental health workers and poor division of roles between public and private hospitals, as well as the inadequate monitoring of human rights violations against inpatients, which had been noted since the implementation of the Mental Health and Welfare Law. In response to this incident, and in consideration of the human rights of people with mental disorders, the Mental Health and Welfare Law was revised in 1987 to ensure appropriate medical care and protection, and promote the social reintegration of people with mental disorders. The name of the law was also changed to the Mental Health Care Law. In 1995, it was revised again to the Act on Mental Health and Welfare for the Mentally Disabled, and in addition to the existing mental health care policy, the legal position of welfare measures for the social reintegration of people with mental disorders was also strengthened. However, there were no remarkable results in terms of the social reintegration of people with mental disorders during this period. There had

been much discussion about the causes, with many people pointing to the characteristics of Japan's mental healthcare system, which is dominated by private psychiatric hospitals, but little consideration had been given to the obvious fact that the local support system, including social rehabilitation facilities, is weak.

The Reform Vision drew attention to the point that "over the next ten years, we will work to resolve the issue of those who are able to be discharged (approximately 70,000 people) if the conditions for acceptance are in place." However, there were also criticisms that the policy did not include any description of the basis for the calculations or conditions for acceptance. In 2009, in the middle year of the Reform Vision, the report "Towards Further Reform of Mental Health and Welfare" was compiled by a group of experts to formulate a set of priority measures for the final five years of the plan. In addition to restructuring the mental health care system and improving the quality of mental health care, the report highlighted the strengthening of community life support systems and targeted implementation of public awareness campaigns as important factors in the realization of a community-based inclusive society. However, as benchmark target values, it listed

"reducing the number of inpatients with schizophrenia to 150,000" and "continuing to set targets for the discharge rate of inpatients, etc., and promoting a reduction of approximately 70,000 psychiatric beds," and so the focus remained firmly on promoting hospital discharge.⁴⁾ In addition, the Study Meeting on Specific Measures for the Community Transition of Long-term Hospitalized Persons with Mental Disorders, established in 2014, 10 years after the Reform Vision, stated that support for persons with mental disorders should include "encouraging motivation for hospital discharge," "supporting transition in accordance with the individual's wishes," and "supporting community living." However, in the Study Meeting, it stated that in order to ensure that the quality of psychiatric beds is as good and adequate as that of general medical care, it is necessary to reform the structure of hospitals by optimizing psychiatric beds and reducing the number of beds that will become unnecessary in the future.⁸⁾ Although it advocates the transition of people with mental disorders to the community, in reality it was a pro-discharge measure that set targets such as discharge rates and reductions in the number of inpatients, and did not sufficiently address the development of the

community infrastructure necessary for transition to the community.

At the same time, the Japan Psychiatric Hospitals Association announced its "Vision for the Future of Mental Healthcare" in 2012.¹⁰⁾ With regard to the transition of people with mental disorders into the community, it states that "an environment in which people with mental disorders can live in peace is one in which they have access to the necessary medical care while respecting their own wishes, and, if they have life-related disabilities, they can receive the necessary social services and lead a safe social life. On this basis, the necessary human rights protection must be provided. We need a legal system that aims to create a society in which these rights are guaranteed." It also says that: "reducing the number of psychiatric beds can be achieved as a result of first improving the community and developing a social support system," drawing on the lessons learned from the hasty deinstitutionalization that took place in Europe and the United States. In addition, with regard to community-based support, it was stated that "it has been confirmed that the previous system was unable to provide even the minimum necessary mental health and social services, and in the future, in order to ensure that individuals have access to the services they need, it is necessary to develop a system from a

multifaceted and comprehensive perspective, where they can choose from several options. It also mentions the importance of awareness-raising and education, stating that "if public awareness changes, mental health and welfare reform will progress," and it explains the importance of educational activities to increase mental literacy in educational settings. It also proposes a program to train mental health supporters.

The Medical Care Act is the law that defines the fundamentals of medical services. The Medical Care Act also provides the basis for classifying hospital beds into: general, long-term care, and psychiatric categories. Meanwhile, the formulation of medical care plans is also based on the Medical Care Act. In 2011, in the context of discussions on strengthening medical functions and promoting the division of roles and cooperation between hospitals and hospital beds based on the Basic Policy on Social Security and Tax Reform, it was proposed that mental disorders be added to the list of diseases to be included in medical care plans. As a result, the sixth medical plan, which took effect in 2013, designated mental disorders as one of the five diseases, along with: cancer, stroke, acute myocardial infarction, and diabetes, and established a medical cooperation system under the medical plan system.

This is because mental disorders were recognized as diseases that require extensive and continuous medical care, specifically: (i) those that affect a large number of people and are widely relevant to the general public, (ii) those that are politically prioritized, such as those associated with high mortality rates, (iii) those that require detailed responses to the course of symptoms, and (iv) those that require responses and collaboration in line with the functions of medical institutions.²⁾

In addition, based on the revised "Act on Mental Health and Welfare for the Mentally Disabled" that was passed in 2013, the "Guideline for Ensuring the Provision of High-Quality and Appropriate Medical Care for People with Mental Disorders" was established as a public notice by the Minister of Health, Labour, and Welfare. Furthermore, since the 6th medical care plan was formulated, various studies have been conducted on the medical system for mental disorders, such as the "Study Meeting on Specific Measures for the Community Transition of Long-Term Hospitalized Persons with Mental Disorders" (March to July 2014) and "Study Meeting on How the Future of Mental Healthcare and Welfare should be" (January 2016 to February 2017).

Among them, the "Study Meeting on How the Future of Mental Healthcare and Welfare should be" (hereinafter

referred to as the "Way Study Meeting") established the "Subcommittee on the Future of Involuntary Hospitalization for Medical Protection, etc." and the "Subcommittee on the Future of New Community Healthcare Systems." The "Subcommittee on the Future of the New Community Healthcare System" considered: (i) further functional differentiation of psychiatric wards, (ii) the ideal form of health care that supports people with mental disorders in the community, and (iii) the ideal form of health care system for mental disorders. The report of the Way Study Meeting, released on February 17, 2017, states that: "in order for people with mental disorders to be able to live their own lives with peace of mind as members of the community, it is necessary to aim to establish a community-based care system that comprehensively ensures medical care, welfare, and nursing care for people with disabilities, housing, social participation (employment), mutual support in the community, and education," and advocates the establishment of a community-based comprehensive care system that also addresses mental disorders. In addition, based on the "Guideline for Ensuring the Provision of High-Quality and Appropriate Medical Care for People with Mental Disorders," it is proposed that the medical functions of each

medical institution for each disease be clarified and that the division of roles and cooperation be promoted in order to build a medical cooperation system that can respond to a variety of mental disorders.⁵⁾

In response to these discussions, the 7th medical care plan was to be formulated. The plan describes the medical system for mental disorders as follows⁶⁾:

- 1) Establishing a comprehensive community care system with a scope to include people with mental disorders: In order for people with mental disorders to be able to live their own lives with peace of mind as members of the community, it is necessary to promote the establishment of a community-based comprehensive care system that also accommodates mental disorders.
- 2) Setting targets for the level of demand for hospitalization and amount of infrastructure development needed to establish a comprehensive community care system with a scope to include people with mental disorders: It is necessary to clarify the targets for demand for admission (number of patients) on psychiatric wards and the quantity of infrastructure development (number of users) associated with community transition at the end of FY2020 and end of FY2024, and to promote the development of infrastructure for community mental

health care and welfare systems while maintaining consistency with disability welfare and other plans.

3) Establishing a medical cooperation system that can respond to a variety of mental disorders: It is necessary to clarify the roles of medical institutions for each type of mental disorder, such as schizophrenia, depression/bipolar disorder, dementia, child/adolescent mental disorders, and addiction, and promote mutual cooperation, as well as clarify the medical functions of each medical institution so that patient-centered medical care can be realized.

II. Discussion at the Study Meeting on Establishing a Comprehensive Community Care System with a Scope to Include People with Mental Disorders

As mentioned in the previous section, the report of the Way Study Meeting clarified a new principle of aiming to establish a comprehensive community care system with a scope to include people with mental disorders (hereinafter referred to as "the System") from the perspective of promoting community development to further promote the community transition of people with mental disorders while maintaining the principle of "community life-centered." To consider the specific details of establishing the system, discussions began at the Study Meeting. Discussions began on March

18, 2020, and continued for approximately one year.

The discussions began with opinions on the concept of this system, such as: "The comprehensive community care system has already been started in the fields of medical care, nursing care, and welfare for the elderly. Is this system an attempt to apply these to mental disorders as well, is it an attempt to create a new system for mental disorders?," or "It is impossible to create a system that is specialized for mental disorders. It is necessary to create a system that supports mental disorders in the community as well." It was then concluded that "the comprehensive community care system, which has been improved based on the field of elderly care, is a mechanism for realizing a community-based society," and that "promoting the construction of this system is essential for realizing a community-based society," and that "it is necessary to build a support system through the multi-layered cooperation of relevant parties, taking into account the various environments of people with mental disorders and their families, and some measures that are to some extent specialized in the field of mental health may also be necessary." In addition, there was discussion, such as: "The discussion has become one that is based on hospitalization, and it ends up being a discussion only among those involved.

We should listen to the needs of local residents and implement measures that are also visible to local residents," and "Because the discussion has become one that presupposes hospitalization, it has become a discussion only among those involved. We should listen to the needs of local residents and implement measures that are visible to them." Furthermore, "There are also many people with mental health problems who are not yet connected to medical or social services. It is also necessary to discuss how to support these people." In response to these discussions, the target population of the system was organized, with comments such as "In this system, it is appropriate to be able to build a multilayered support system so that everyone can live comfortably and authentically, regardless of whether they have a mental disorder and regardless of the severity of the disorder."

The discussions of the Study Meeting took place over a total of nine meetings, and at each meeting, the various elements that make up this system were addressed, with each relevant party reporting on the current situation. The topic of the 7th discussion was community mental health care, and the author reported on the current situation of private psychiatric hospitals and medical functions required of mental health care in this system. The details

of this will be described in a separate section.

With regard to the medical functions required of psychiatric care, the following issue was raised: "The development of a psychiatric emergency medical system is one of the important foundations for supporting the community life of people with mental disorders, but there are many problems that need to be addressed in terms of developing such a system." In response to this, a working group was established under the auspices of the Study Meeting with the aim of organizing and examining the issues surrounding the positioning of psychiatric emergency medical systems in this system and the development of such psychiatric systems.

The report on the Study Meeting⁹⁾ states that: "In establishing the system, it is necessary to proceed on the basis of basic local governments, such as municipalities, which are founded on the area of daily life. In addition, it is important for mental health and welfare centers and public health centers to work with municipalities to understand the needs of the target population and local problems, and build a support system based on multi-layered cooperation on mental health and welfare in units such as disability welfare areas," and it describes the results of the study of each element that

makes up this system, such as community mental health and welfare for people with disabilities, the system for providing mental healthcare, securing housing and residential support, social participation, people with mental disorders and their peers, family members of people with mental disorders, and human resource development.

III. Current Situation of Private Psychiatric Hospitals and Initiatives for Community Mental Healthcare

The author's report and opinions on the theme of community mental healthcare at the Study Meeting are as follows¹¹⁾:

1) The Japan Psychiatric Hospitals Association has 1,193 member hospitals, most of which are private single-specialty psychiatric hospitals. The total number of beds is 280,041, and the average number of beds per hospital is 234.7 (maximum: 804; minimum: 20). Of the 344 secondary medical areas in Japan, 300 are located in secondary medical areas, and they are located almost all over Japan (survey of all members of the Japan Psychiatric Hospitals Association on July 1, 2020).

2) In terms of staff numbers, there are 3.2 doctors (2.4 designated mental health doctors and 0.8 non-designated doctors) per 100 beds, 46.7 nursing staff (23.7 nurses and 10.7 assistant nurses),

3.1 psychiatric social workers (7.7 per hospital, already in place in 99.6% of hospitals), 3.1 occupational therapists (7.9 per hospital; 98.7% of hospitals have occupational therapists), 1.0 psychological technicians (2.7 per hospital; 83.4% of hospitals have psychological technicians) (Japan Psychiatric Hospitals Association Comprehensive Survey, 2018)

3) Care-related services, such as day care, short-term care, night care, and day and night care, are provided at 947 member hospitals (78.6%). The breakdown is as follows: 656 hospitals provide large-scale day care, 296 hospitals provide small-scale day care, 529 hospitals provide large-scale short-term care, 277 hospitals provide small-scale short-term care, 113 hospitals provide night care, and 315 hospitals provide day and night care.

In addition, 957 hospitals (79.4%) of all member hospitals had participated in the psychiatric emergency care system. Of these, 107 hospitals had inpatient psychiatric emergency wards (as of July 1, 2018, according to the membership list of the Japan Psychiatric Hospitals Association).

4) Of the 771 member hospitals that responded, 99.6% were billing for inpatient psychotherapy. Similarly, 97.5% of hospitals were billing for psychiatric occupational therapy, 48.5% (2.5 cases per hospital per month) were

billing for psychiatric pre-discharge home nursing guidance fees, and 21.4% (0.9 cases per hospital per month) were billing for psychiatric home nursing instruction fees.

In addition, there were 6.7 cases of inpatient functional training therapy (within 6 months) per hospital per month, 35.4 cases of the same (over 6 months), 146.8 cases of inpatient psychotherapy I (within 3 months), 138.9 cases of the same II (within 6 months), and 622.8 cases of the same II (over 6 months). Psychiatric home patient support management fees were calculated for 611 cases at 38 hospitals (according to the 2019 Japan Psychiatric Hospitals Association Medical Economic Survey).

5) Of the 771 member hospitals that responded, 18.8% calculated the treatment-resistant schizophrenia guidance management fee, with 1.2 cases per hospital per month. Electroconvulsive therapy I (closed-circuit anesthesia) was 9.2% (anesthesiologist addition 6.4%), and electroconvulsive therapy II (other than D) was 6.5%.

Based on these current conditions, the following medical functions are considered to be required for psychiatric care in the system:

(1) Fulfilling the so-called "family psychiatrist" function, including case management

(2) Role in community psychiatric care

(i) Providing routine treatment for common diseases and collaborating with local general practitioners

(ii) Acting as a base for collaboration in the community in response to new psychiatric needs

(iii) Being involved in policy-based medical care

(3) Participating in the psychiatric care system

(4) Acting as a base for collaboration that contributes to the system

IV. Role of Community Mental Healthcare in a Comprehensive Community Care System with a Scope to Include People with Mental Disorders - Towards the Development of New Mental Healthcare

The report and opinions presented at the meeting mentioned in the previous section will require further explanation. While providing this explanation, I would also like to discuss the future direction of mental health care.

1. Fulfilling the so-called "family psychiatrist" function, including case management (Figure)³⁾

As shown by the fact that the "average number of days living in the community" was newly introduced as an indicator in the 6th Disability Welfare Plan, the future aim will be to increase the proportion of time spent living in the

community over a certain period of time. To achieve this, it will be necessary to oversee a team made up of a variety of professionals that can provide support from admission to discharge and even after discharge, and support for living in the community. This multidisciplinary team is expected to: (i) create and utilize clinical paths for each stage of the illness, (ii) create crisis plans to ensure that patients receive the necessary medical care in the event of a sudden deterioration or exacerbation, (iii) act as a consultation service in the event of a sudden deterioration or exacerbation, and (iv) manage home visits and home nursing care as necessary and in accordance with the needs of the patient. The "family psychiatrist" function is responsible for overseeing all of these activities.

2. Fulfilling the roles required for community mental health care

First of all, common diseases such as schizophrenia, mood disorders, and dementia are areas where there are many patients and treatment is always provided in general psychiatric medical institutions, but because there are also many cases where patients are referred from physical medicine departments or are treated for physical complications in physical medicine departments, it is important to cooperate with local physical medicine doctors.

In addition, although the number of patients with new types of disorders such as child and adolescent mental disorders, behavioral addictions, stress-related disorders including PTSD, higher brain dysfunction, and eating disorders is not as high as that of common diseases, they require advanced treatment and specialized knowledge for this. It is expected that each medical institution will make the most of its characteristics and fulfill its function as a base for collaboration in the community in response to these new psychiatric needs.

Involvement in policy-based medical care, including disaster medicine, psychiatric emergency medicine, measures for physical complications, and responses to depression, stress-related disorders, and perinatal patients, including suicide prevention, as well as medical care related to the Medical Treatment and Supervision Act, is an important element of a comprehensive community care system with a scope to include people with mental disorders.

3. Participating in the psychiatric care system

In addition to their daily clinical work, they are expected to play roles as: (i) a gatekeeper for mental health care in the community, providing pre-consultation services, (ii) a so-called "family

psychiatrist," providing non-hospital care (e.g., telephone support, after-hours care, home visits, home nursing), and (iii) a hospital group on-call system or a 24-hour medical facility, providing necessary inpatient care.

4. Acting as a base for collaboration that contributes to the comprehensive community care system with a scope to include people with mental disorders

It is expected to play a role in participating in consultation meetings with people involved in health, medical care, welfare, etc., participating in and cooperating with activities to raise awareness among local residents, and disseminating information to organizations related to this system and being involved in training.

Conclusion

On October 11, 2021, a new "Study Meeting for the Realization of a Mental Health and Welfare System that Enables People to Live Securely in the Community" was launched. At this study group, discussions will be held on: (i) the construction of a "Study meeting on the establishment of a comprehensive community care system with a scope to include people with mental disorders," (ii) how to construct a regional mental health and welfare system based on the philosophy of: "Study meeting on the establishment of

a comprehensive community care system with a scope to include people with mental disorders" with a view to revising the medical plan, and (iii) how to address the problems that have been called for consideration in relation to inpatient care (decision-making support, rights protection) from the perspective of constructing the "Study meeting on the establishment of a comprehensive community care system with a scope to include people with mental disorders" and effectively supporting patients' community lives. As expected, a "comprehensive community care system with a scope to include people with mental disorders" may be an important keyword when considering the direction that mental health, medical care, and welfare should take in the future.

Note: This special feature article is based on the symposium held at the 117th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Masato Usuki (Accident and Emergency department, National Disaster Medical Center) as the representative.

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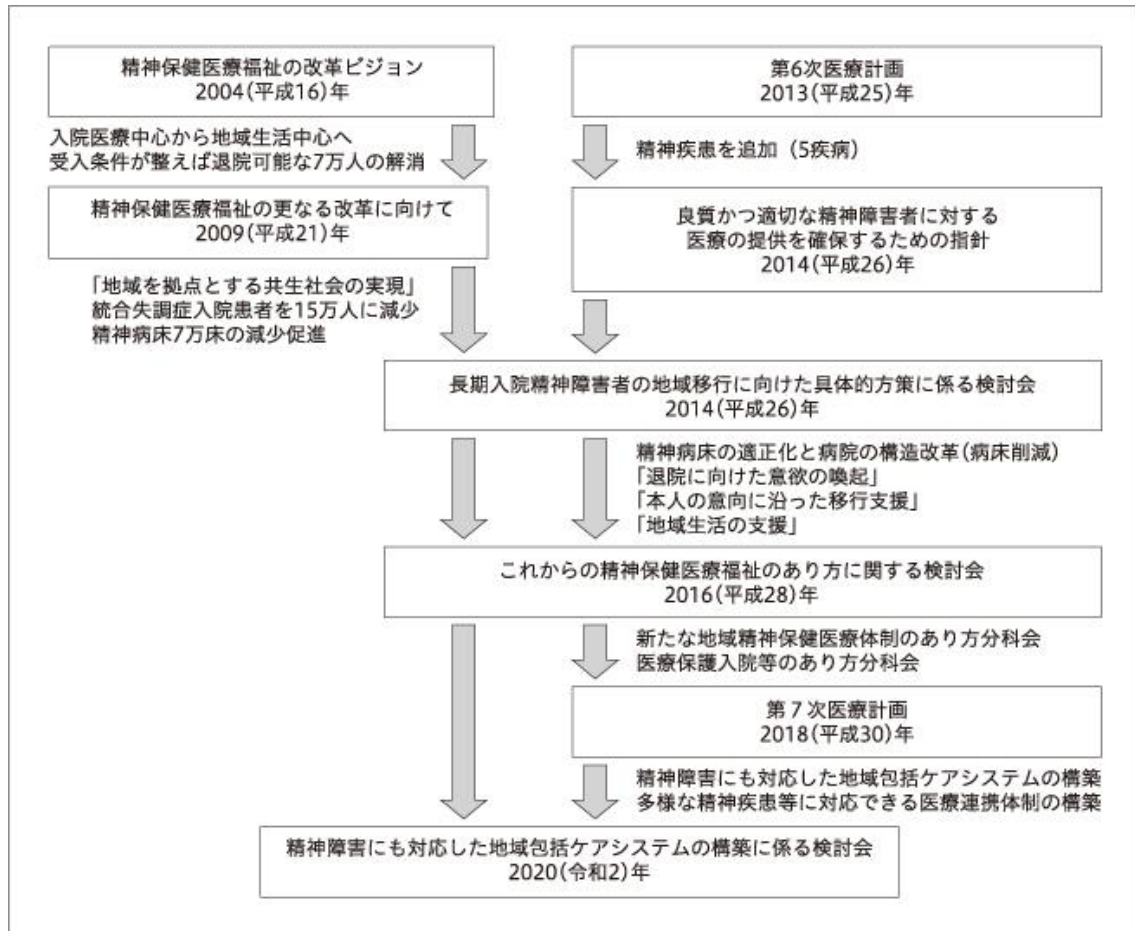


図 精神保健医療福祉検討の変遷
(医療法人桜樹会地域活動支援センターまいか作成)

Figure: Changes in the study of mental health, medical care, and welfare (created by Maika Community Activity Support Center, Sakuragikai Medical Corporation)