



special article

Psychiatric Bulletin (2005), 29, 309–311

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Lessons from and for Japan on service delivery

On a recent visit to Japan, I saw some good quality care of patients with chronic schizophrenia in a rural mental hospital. The Japanese staff were keen to hear about community care alternatives being developed in Britain. However, being a strong protagonist of community care, who has managed the closure of three English mental hospitals, I found myself recommending caution. There are lessons for Japan from the mistakes we have made; and there may be lessons for us in the ways Japan manages delivery of its mental health services.

A modern mental hospital

The Victorians left us with so many highly durable asylums that there was neither need nor opportunity for designing later 20th-century models. In Japan in 1960 psychiatric bed numbers per 10 000 population were about the same as they are now in the UK. Subsequently, there was hospital expansion to reach the bed numbers there are now, which approximate to what we had in 1960 (Oshima *et al*, 2003). Had we also been building new mental hospitals during this period, what might they have looked like?

The Bungosou Hospital, perched on a hill, 100 km north of Tokyo, was built in 1989 and accommodates 393 patients in a six-storey building that looks like a holiday hotel (Fig. 1). Air conditioning and modern materials allow



Fig. 1. Late 20th-century mental hospital.

for large (unbreakable) window areas that provide spectacular views of wooded hills and sky in every part of the building. They also lend a feeling of open space and lightness to the high-quality internal architecture.

The Japanese health service has a mixture of public and private providers funded by up to 70% by government and 30% by the individual. The Bungosou Hospital, which is privately owned, competes on equal financial terms with public hospitals.

Dr Mamoru Suzuki, the psychiatrist and hospital director who commissioned the building, is as passionate about architecture as he is about mental health. He believes that the two are very positively connected. In every ward there is the variety of furnishings found in today's Japanese households. Many older patients prefer squatting shoeless, in matted and paper partitioned rooms, with minimalist furniture of the traditional Japanese kind. Others prefer to spend their time in 'modern western' furnished areas. Glassed and ventilated smoking tents, as would be found in a modern airport, are evident. Hi-fi sound systems that would be the envy of any music enthusiast are an 'essential' feature. The most solitary patients seem to have no inhibitions about participating in the national sport of karaoke; even if performing only with their backs to the audience.

Cultural considerations

Ward design and daily programmes are very group oriented; but so it appears from observation and informed commentators, is Japanese society. It was only an impression, but there did seem to be more informal, as well as organised, social interaction between these patients than I ever recall seeing in the long-stay wards of British mental hospitals. This may explain why Oshima *et al* (2003) found that length of stay in Japanese mental hospitals was not correlated with increasing negative symptoms, as has so often been found in the UK (Wing & Brown, 1970; Curson *et al*, 1992). In his book *The Anatomy of Dependence* Takeo Doi, a Japanese psychiatrist, explains the value and benefits of greater group dependency in Japanese society (Doi, 2001).

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A modern workforce

Locally determined conditions of employment show that staff are highly valued so long as they perform well. There is a tight individual appraisal system linked to bonuses and opportunities for further professional development. Senior professionals, especially doctors, are headhunted and salaried individually at higher than average levels; in some cases much higher levels. All are convinced that the reputation and success of the hospital depends on them. Some are publishing research in high-quality European and US peer-reviewed journals. Excited by the service developments in care for older adults with mental illness, nurses are being selected for overseas training at prestigious centres like the Karolinska Institute, in Sweden.

Taxis from the train station to work are free, meals are free, food is excellent and is the same for staff as patients. One often heard staff comment 'It is a nice place to work, and such a lovely building'; not the sort of thing usually heard in English mental hospitals, or in the present-day services for that matter.

Things are far from perfect, between imaginative and engaging music therapy, calligraphy and art, carpentry, needlework, etc., there are still long periods in the week when not much is going on except chatter and tea-drinking. However, that can also be the case by choice in many people's lives outside mental hospitals! There are up to six patients sharing a bedroom in some wards with only limited partitioning. However, 'new build' has many single rooms with ensuite bathrooms and that is to be the standard. Nurses, like their colleagues the world over, seem to gravitate to the nursing station to write notes and talk to each other rather than spend more time with patients. However it seemed to be a workforce greedy for new ideas and ready to act on them. This is against a national background of poorly developed undergraduate training and hardly any formalised programmes of post-basic training. For instance, there is no specialist mental health qualification for nurses in Japan.

The mistakes we made

Escalating costs of healthcare in Japan, although mainly in the general hospital sector, has meant pressure to reduce beds is beginning to be felt in mental health. The British approach is being recommended. However, before extolling the potential virtues of moving to a community system of care, I found myself impelled to warn about the mistakes we made.

In Britain we decided to close mental hospitals without any clear ideas on how alternative community care services should be designed. Ward nurses became community psychiatric nurses without any clear ideas about what they should do, never mind the right training for them to be able to do it. For a decade or more we neglected development and training for acute in-patient wards. They became demoralised, overcrowded, and dangerous places, trying to cope with the many failures of community care and burgeoning new problems like dual diagnosis. Financial planning was poor, money was

often in the wrong places, double running costs were underestimated, naïve assumptions were made about community services not needing much capital for buildings and equipment, health authorities and some whole district trusts got away with bailing out deficits in the acute sector by stealthily transferring capital and revenue released from their large mental hospital estates.

Although optimism about a community-based system is growing in Britain with the analysis of its essential components in the National Service Framework (Department of Health, 1999) and National Health Service Plan (Department of Health, 2001), it has taken us 25 years to get there. We have a great deal still to do in staff training and service development to make sure it delivers. At least crisis resolution and home treatment is looking a safe bet – delivering results beyond expectations in many areas. Early intervention just might alter the whole complexion of mental health services if it engenders greater trust and adherence to professional advice and heads off the social handicaps accrued in the 1–2 years before diagnosis and treatment of psychosis. The weakest link may turn out to be assertive outreach for those most challenging patients with chronic and severe psychosis who readily disengage from care. Despite the best efforts of dedicated teams, early results seem unimpressive for some patients whose lives remain squalid and marginal. Mental hospitals used to be the 'glue' that held together all requirements to meet their social, physical, psychiatric and recreational needs. They did so successfully, if at a high cost of regimented lives low down in organisational hierarchies, within asylums built more like prisons than hotels. But supposing asylums for these patients could be much smaller and totally different animals from the ones we remember in Britain, with inspired architecture?

Public or private provision?

A visit to a public, government-managed Japanese mental hospital was revealing. For the same money, the conditions appeared to be far inferior to those prevailing in the privately managed hospital. There are more staff but dilapidated buildings, and interiors with communal sleeping on the floor without the least attempt at privacy. Barred windows, locked doors and fenced airing courts seemed to be everywhere. Neglected 1950s architecture looks even worse than poorly maintained Victoriana.

I was told that staff in public hospitals have great job security and no incentives for good performance. The relatively high staffing levels mean there is no money for building maintenance or training. Requests for maintenance work go through a prolonged bureaucratic process, and decisions (usually to do nothing) are taken by people far removed from the action. Ideas for improvement and development are not worth having, because nothing ever comes of them. The only forward plan was to close another two wards as deaths of older long-stay patients reduced occupancy. All very familiar territory for the

visiting British psychiatrist who experienced UK mental hospitals in the 1970s and 1980s.

In conclusion – the possible lessons?

We in Britain are about to embark on foundation trusts that are supposed to have greater freedom from central control and planning. Such freedoms in Japan seemed to be capable of delivering a workforce with higher morale and a superior quality of care when compared with the more centrally controlled hospitals with equal funding. The contrast between centrally managed public services and locally managed private psychiatric services in Japan was so profound as to make a case for mental health providers seeking foundation trust status; so long as promised freedoms are real. Greater freedom for imaginative capital investment in modern design, and materials for buildings, large or small, could transform or replace the drab facilities that are so often associated with mental health services.

It is with the greatest caution that one offers any advice to such a distinctly different culture as Japan. However a shift to a less institutionally based service is on the Japanese government's agenda for mental health. The history of the past 20 years in Britain provides many salutary lessons about what can go wrong as well as a

growing experience of the conditions required for community care to work.



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Acknowledgements

I thank Dr Mamoru Suzuki, Director of Bungosou Hospital, Ibaraki Prefecture, Japan and all his staff for their hospitality and many stimulating discussions.

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