An Overview and Observation of Mental Health Care in Japan

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The nation of Japan hosts one of the highest rates of suicides in the world: in 2021, statistics reported 16.8 suicides per 100,000 residents (Statista Research Department & 26, 2022). Suicides in Japan are frequently linked to issues in the workplace, most prevalently the pressure associated with maintaining employment at the cost of mental and physical health. A Japanese term was coined specifically to describe such deaths: *karoshi*, or "death by overwork". A separate term known as *karojisatsu* is used to refer to "overwork suicide". Notable demographics include middle-aged men and the elderly, both of whom face separate but immense societal pressure which dictates the course of their lives. Issues of mental health are highly stigmatized in Japanese society, deeply rooted in the nation's cultural and developmental history, including limited influence from outside nations. Although many reformation efforts have taken place in recent decades, destigmatizing mental health remains a challenge in Japan, chiefly due to two self-sustaining reasons: historically-based cultural attitudes which demand its people to bear their personal suffering in silence and to hide away traces of weakness; and long-standing medical infrastructure, both legal and physical, which pose impressive obstacles both to those seeking mental health care and those currently under care. While these individual reasons are not necessarily unique to Japan alone, in combination they have established Japan's cultural and practical baseline in addressing mental health.

Before the 16th century, Buddhist temples in Japan served as primary care centers for the ailing (Shinfuku 2019). Treatment for the mentally ill was dependent upon religious practices, and the reasons for such cases were typically cited as love-sickness or, more ambiguously, diseases of the heart and mind (*kokoro no yamai*) (Shinfuku 2019). There are also allusions to mental illness in historical folklore texts such as the *Genji-Monogatari* by Shikibu Murasaki, describing states of fitfulness or mental unrest as the result of a spiritual possession (Totsuka

2018). These beliefs are not attributed to states of troubled mental health today, though it has long since served as another basis for which Japanese society might find mental ailments frightening and unnatural. Such pieces of literature, significant to the cultural richness of ancient Japanese history, linger on the fringes of modern-day Japanese consciousness, subtly encouraging a blind eye to crises of mental health.

It was not until the Meiji Restoration in 1868 that major social reform took place in earnest, and the Restoration notably introduced Western medicine, Western-style asylums, and foreign doctors who would come to introduce psychiatry to Japan (Shinfuku 2016). In a sweeping era of modernization, the Meiji government was eager to catch up to other nations after a long period of isolation, though it struggled to integrate certain aspects of Western culture. Notably, Japanese law of the time did not recognize such Western legal concepts as "human rights" and "freedom" (Totsuka 2018), an ominous foreshadowing of the long and arduous road that mental health patients would have ahead of them in their bid for protection and recognition. Eager to prove the strength and legal integrity of Japan to other nations, the Meiji government would come to implement the Law of Enclosure of the Mentally Disturbed, which chiefly served to bolster public security by ensuring that mentally ill patients were kept out of sight (Shinfuku 2016). This legalized the forcible home confinement of family members whom were declared mentally ill. During this era, the overarching attitude towards mental illness was that it was "genetic, incurable, impossible to understand and dangerous" (Totsuka 2018), and it consequently brought shame to entire families which had any members with mental illness. This cultural attitude served to increase the frequency and brutality of home confinement; in 1918, a study published on home custody described "prison-like" practices, with patients frequently kept "securely chained" in their own homes (Shinfuku 2016). At the time, Japanese society as a whole

did its utmost to keep the mentally ill a dark, shameful secret, wanting to present only their strongest side to their fellows as well as to foreigners.

A notable figure in Japanese psychiatric history is Shuzo Kure, who initially studied psychiatry in Germany and introduced German psychiatry as the standard in Japan until the end of WWII (Shinfuku 2016). Kure was instrumental in implementing a number of new practices and policies for the betterment of mental health patients, beginning with the establishment of the Japanese Society of Psychiatry and Neurology as well as the Federation for the Welfare of Mental Health Patients (Shinfuku 2016). Kure and his colleagues were highly critical of legislation surrounding mental healthcare of the time and especially examined the inhumane conditions of mental healthcare patients, many of whom were either imprisoned at home or were kept in inadequately maintained health facilities. They lobbied for the creation of The Mental Health Hospital Law in 1919, which would grant local governments the authority to establish a string of psychiatric hospitals to provide more humane housing for mental health patients (Shinfuku 2016). Although the law called for further establishment of mental hospitals to house patients, development was slow to come due to financial instability (Kanata 2016), and conditions for the mentally ill would continue to stagnate as Japan prioritized public safety over the rights of patients.

Following Japan's defeat during WWII in 1945, the Japanese Constitution was drawn up under the influence of the Allied Powers, and Japan's laws underwent a massive transformation, notably including a clause for fundamental human rights and popular sovereignty (Totsuka 2018). In accordance with these new principles, a number of legislation related to improvements in psychiatric care would be implemented over the next several decades. The first of such was the Mental Hygiene Law of 1950, which finally prohibited domestic custody of mental health

patients (Shinfuku 2016). This created an even more urgent need to establish hospitals in order to house patients, but Japan was still struggling with financial deficits after the war, which instead necessitated a dependence upon private hospitals that would also exercise profit by housing patients (Kanata 2016). A combination of large subsidies from the national government, low-interest loans for the establishment of mental hospitals, and the resulting financial relief provided to the typically low-income families of mental health patients, private psychiatric hospitals quickly became a profitable business for Japan's struggling economy. As such, hospitalization was heavily encouraged, and the number of psychiatric beds increased exponentially in less than a decade (Kanata 2016), even as other nations were moving towards deinstitutionalization.

As the Japanese government was in the midst of talks about revising the Mental Hygiene Law in order to similarly attempt to deinstitutionalize, an incident in 1964 wholly altered its developmental course. Edwin Reischauer, the US ambassador to Japan at the time, was attacked by a 19-year-old Japanese boy with a history of psychiatric hospitalization (Kanata 2016). The media's reporting on the incident was sensationalized due to the involvement of a psychiatric patient, further reinforcing the stigma especially prevalent at the time that the mentally ill are a threat to public safety. In light of this incident, the Mental Hygiene Law in 1965 was revised to strengthen hospital-based care and to exercise stricter control over the mentally ill (Kanata 2016). This revision further cemented hospitalization as a primary means of care for the mentally ill in Japanese society, strongly encouraging institutionalization in order to, once again, prioritize public safety above all else. Although Japan was visited by World Health Organization consultants in decades before and after the Reischauer incident, their advice was rarely heeded. In 1968, the advice of a visiting consultant included legitimate claims such as the need to

improve the standard of care in psychiatric hospitals, the growth of community-based care rather than institutionalization, and the necessity for rehabilitation of released patients, Japan's Ministry of Health struggled to accept his recommendations as the nation remained rocked by the Reischauer incident (Shinfuku 2016).

Japan's mental health care infrastructure continued to be dominated by private hospitals as the decades progressed. The government only encouraged the construction of these private hospitals due to being inexpensive to operate as well as meeting the legislative quota for psychiatric care. By 1980, there were more than 300,000 patients staying in private psychiatric hospitals, and more than 100,000 of them had been staying in the hospital for over 10 years (Shinfuku 2016). Placing a mentally ill patient into a private hospital was inexpensive and simple for their family members, who merely needed to offer their consent in order to have their patient hospitalized, and it had the added benefit of keeping a shameful family member comfortably out of sight from the rest of society. Additionally, owners of these private institutions stood to generate even more income for themselves the longer and in greater quantities they held patients (Shinfuku 2016). Due to the poor quality of these facilities and the minimal rights grounded in law for mental health patients, many patients were forced to languish in silence, unable to fend for themselves or their rights.

Attention was finally drawn to the poor conditions of psychiatric hospitals in 1984 following the Utsunomiya Hospital Scandal, in which it was revealed that two patients had been beaten to death by the nursing staff (Kanata 2016). It was also revealed upon further investigation that another 222 patients had suspiciously perished under vague circumstances, that countless patients were being illegally detained, and that untrained staff were conducting medical procedures on patients (Kanata 2016). The revelation sparked both a national and international

outcry for improved mental health care as well as intensified scrutiny towards private hospitals, many of which also concealed insidious activities similar to Utsunomiya Hospital (Shinfuku 2016). The Mental Health Law was again revised in 1987 with a number of revolutionary stipulations, including: the creation of a Psychiatric Review Board which would review reasons for involuntary hospitalization and courses of treatment; requiring informed consent in order to admit patients; allowing patients to be hospitalized voluntarily; and the much-needed establishment of rehabilitation facilities (Kanata 2016). Rehabilitation facilities included vocational facilities and daily living facilities marked the beginning of a long-awaited transition from hospital care to community care, though community-based services like the aforementioned remained lacking in number and quality for some time to come.

Many more pieces of legislation unfolded over the following decades, slowly expanding the rights related to the mentally ill as well as more cohesive protective measures for patients. In 2004, the Vision for Reform of Mental Health and Medical Welfare was the Japanese government's official declaration to transition from hospital-based care to community-based care (Kanata 2016). This included the dissolution of a practice known as social hospitalization, which refers to long-term inpatients who remain hospitalized due to being deemed socially unfit, particularly in cases where family members are ashamed to reveal a mentally ill relative to their community. Although the Japanese Ministry of Health implemented various projects in two-year increments, many of them fell short due to uncooperative private hospitals and financially unstable local governments (Kanata 2016).

Despite efforts made on the behalves of both the people and the government of Japan, efforts to improve mental health care in present day continue to stagnate. This result is the culmination of three factors which have long dominated Japan since its era of modernization

during the Meiji Restoration, and which are further rooted in ancient precedents of Japan's history: the emphasized protection of public safety; the desire to continually improve their small nation's economy; and the intense dependence on institutionalization. All three of these factors intertwine to create a perfectly self-perpetuating machine from which Japan struggles to extricate itself, given how deeply it is meshed with the nation's foundational workings.

The emphasis on public safety is tied to a notion known as "social defense thought" in which the sacrifice of a small minority is necessitated to protect the majority of society (Kanata 2016). This was demonstrated time and time again by mental health patients being continually swept out of sight and out of mind, the reason being that their mere existence posed a threat to society as a whole; an idea which was only further reinforced over time with inciting incidents such as the Reischauer incident. Furthermore, mental illness is seen as a dire genetic shortcoming in Japanese society, one that is inherently dangerous as well as irreparable. Given that social defense thought is rooted in eugenics, the mentally ill saw widespread stigmatization against them, an attitude that sought to justify keeping the mentally ill confined and away from society.

Hospitalization quickly became a profitable industry in Japan, which was desperately needed by the defeated nation following WWII, and the promotion of institutionalization was a massive boon to their economy during a time when other nations were still struggling in the wake of the war (Kanata 2016). Involuntary hospitalization sparked a chain reaction for the economy, one which the government saw as beneficial and would continue to encourage: caretakers of mentally ill family members were freed from their responsibilities and able to go to work; rural areas were depopulated by the ensuing industrial growth; the government used these newly-empty areas to inexpensively construct private psychiatric hospitals; and these private hospitals would offer new low-wage employment opportunities in these otherwise low-income

areas (Kanata 2016). By indiscriminately accepting large quantities of involuntary patients and low-wage employees, the nation as a whole and psychiatric hospitals briefly enjoyed a symbiotic relationship which fostered their rapidly growing economy.

Unfortunately, the dependence on these hospitals would just as quickly prove detrimental to Japanese society. Deinstitutionalizing private hospitals proved time and time again a much greater effort than hospitals which exist in the public sector, as they did for Western nations which had long since transitioned to community-based care. Many patients also refused to be discharged from hospitals because it is the only place in their lives where they have felt welcomed as members of a community (Kanata 2016) - an unsurprising sentiment, given the persistent cultural bias against the mentally ill in everyday Japanese society. As such, the solution is not as simple as reducing the number of psychiatric facilities. In order to foster a more compassionate society for the mentally ill, the process of rehabilitation needs to be further expanded upon. Many mental health patients struggle to reenter society, and those that do are frequently subject to harsh biases and conditions that tend to worsen preexisting mental health issues (Kanata 2016). It is unquestionably challenging to uproot centuries of deeply ingrained preconceived notions of mental health, and Japan has needs to remain ever the more persistent in their efforts to recognize and care for the mental health of its citizens.

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