Health and Global Policy Institute
Mental Health Project
Policy Recommendations

Recommendations on Three Issues in the Field of Mental Health

HGPI Health and Global Policy Institute

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1   Towards Achieving Personalized Medicine

Terminology

- **Genome** : The genome is the complete set of DNA in an organism, including all of its genes and the non-coding sequences of the DNA. It contains all the genetic instructions needed to build, maintain, and regulate the functions of the organism's cells and tissues.
- **Clinical conditions** : Clinical condition is a patient's specific state of health, encompassing diseases, disorders, injuries, and other health issues, often characterized by recognizable signs and symptoms that require medical attention, diagnosis, and management.
- **Symptoms** : Symptoms are the signs that a disease or an illness is present.
- **Biomarkers** : Biomarkers are measurable biological indicators of biological states or conditions, which can be used to detect, diagnose, monitor, or predict disease processes or responses to a treatment.
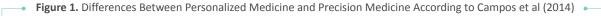
Background

The necessity and initiatives of personalized medicine

What is personalized medicine?

▶ According to the Ministry of Health, Labour and Welfare, personalized medicine refers to treatments (person-centered tailor-made medicine) and prevention methods (personalized prevention) that are **effective, have few side effects, and suit each patient's constitution and clinical condition**[i]**.** Personalized medicine is expected to result in socially favorable outcomes as well as providing optimal treatments for patients. For example, from the patient's point of view, it is believed that individual patients receiving optimal healthcare services for their individual needs leads to **improved quality of life and early reintegration into society**. From the point of view of society, the introduction of personalized medicine is expected to **reduce healthcare cost by cutting unnecessary healthcare services,** while also augmenting **labor productivity** by promoting disease prevention and earlier recovery.

▶ In addition to general treatment information, personalized medicine uses **biomarkers and other means to gather the patient's genomic information and identify their disease condition and then adopt methods which deliver optimum healthcare services to every patient**. In conventional healthcare, the physician diagnoses a disease based on medical examination information from interviews and tests, and then provides a standard uniform treatment (e.g., the standard treatment such as medication) that is known to be effective for the disease. However, the effectiveness and side effects of treatments differ because of individual differences in genomic information, biological composition, social environment, and clinical condition related to a patient's disease, even among patients diagnosed with the same disease. Thus, such issues and advances in the life sciences have led to the promotion of personalized medicine worldwide. In particular, in 2015, then U.S. President Barack Obama announced the "Precision Medicine Initiative" in his State of the Union address, bringing personalized medicine to global attention.

▶ The differences between personalized medicine and precision medicine, and the ideal form of each, have been extensively debated overseas. However, various definitions of personalized medicine exist, both in Japan and overseas, **and no international consensus has been established**.

▶ The U.S. National Human Genome Research Institute, which has played a pioneering role in the field of personalized medicine, defines it as "new healthcare which makes decisions about the prevention, diagnosis, and treatment of disease on the basis of the individual's genetic profile." **It focuses on using biological data to provide the best treatment for individuals**[ii]. This definition is similar to that employed by the U.S. National Cancer Institute, which defines personalized medicine as "an emerging practice of medicine that uses an individual's genetic profile to guide decisions made in regard to the prevention, diagnosis, and treatment of disease."

▶ Focusing on precision medicine, the National Human Genome Research Institute defines precision medicine as "an innovative approach that uses information about an individual's genome, environment, and lifestyle to guide decisions about their medical treatment and management." In addition to biological information, **it also indicates healthcare that takes into account the person's environment and living conditions**[iii].

▶ The same definitions are occasionally employed for both precision medicine and personalized medicine, but research by Campos et al (2014)[iv] graphically represented the differences between the two. (Figure 1)

Figure 1. Differences Between Personalized Medicine and Precision Medicine According to Campos et al (2014)

Type of data

Personalized Medicine
- Genomic information (genomic variants)
- Phenotype (clinical records)

Precision Medicine
- Informal data sources
- Exposome (environmental data)
- Metabolomics (information about metabolites)
- Proteomics (information about proteins)

Characteristics

Personalized Medicine
- Patient-centered: "N=1" patient stratification and treatment focus
  ▶ Clinical Decision Support System (CDSS) using genetic data

Precision Medicine
- Patient- and disease-centered: Disease re-classification
- Diagnosis focus
  ▶ New development of the Clinical Decision Support System (CDSS)

▶ In Japan, personalized medicine in Japanese is in some cases interpreted in ways which differ from the original English meaning. For example, the definition of personalized medicine employed by the International Society of Personalized Medicine is "To extract and provide individualized treatment methods from diverse medical resources, taking into account individualized diagnosis based on biotechnology and environmental factors that influence treatment." At the core of this approach is the creation of **a "medical portrait" that reflects patient-specific information such as lifestyle, life history, outlook on life, and current physical problems,** in addition to pharmacogenomics and biomarkers. **It is oriented toward comprehensive medical care that includes psychological and social factors in addition to biological data.**

▶ With reference to the study by Campos et al (2014), the differences in perceptions of personalized medicine and precision medicine in Japan and overseas can be summarized in terms of subjects, data types analyzed, and objectives as follows. (Table 1) In this policy recommendation, we define personalized medicine as stated below, based on the Bio-Psycho-Social (BPS) model[v], the Bio-Psycho-Social-Spiritual (BPSS) model[vi], which form the basis of the view of illness in psychiatric care, and a dynamic systems model that views mental health and mental illness not as a collection of static elements, but as a system of diverse factors that change and interact over time. **Consider a comprehensive range of environmental, socioeconomic, psychological, and biological determinants,** research and develop methods for the treatment, care, and prevention of clinical conditions and diseases, determine timely and optimal treatment and care policies for each patient in the clinical setting, based on the evidence, and provide healthcare services accordingly.

Table 1. Summary of Definitions of Personalized Medicine and Precision Medicine in Japan and Elsewhere[vii]

	Personalized Medicine	Precision Medicine	Personalized Medicine in Japanese	Precision Medicine in Japanese
Subjects	Individuals	Stratified small groups with certain characteristics	Individuals	Stratified small groups with certain characteristics
Analyzed data type	Mainly bioinformation (genome, examination information, etc.)	Bioinformation Environmental information Lifestyle, etc.	Bioinformation Environmental information Lifestyle Psychological state, etc.	Bioinformation Environmental information Lifestyle, etc.
Main purpose	**Treatment and healthcare policy decisions that are appropriate for the patient** in the clinical environment	● **Development of a new clinical decision-making system** ● **Improving disease characterization and diagnosis**	● Comprehension of the pathogenesis of disease **and develop diagnostic, therapeutic, and preventive methods that intervene directly** ● Treatment and care policy decisions that are appropriate for each patient in clinical settings	Comprehension of the pathogenesis of disease and develop diagnostic, therapeutic, and preventive methods that intervene directly

Personalized Medicine Initiatives in Japan

▶ **Genome analysis is essential** for achieving personalized medicine. **The Action Plan for Whole Genome Analysis 2022** was written in Japan in 2022 to promote elucidation of clinical conditions and develop new therapeutic methods based on whole genome analysis, in order to bring high-quality healthcare to the public. The plan states that the aim is to realize further personalized medicine through advanced and efficient diagnosis and treatment based on whole genome analysis, multiomics analysis[1], and the like.

▶ **The Five-year Strategy for Medical Innovation**, written by the government's Medical Innovation Council in 2012 included the Tohoku Medical Megabank Plan as the basis for achieving personalized medicine. The Tohoku Medical Megabank Plan aims to conduct large-scale health surveys in disaster-affected areas, build a biobank of 150,000 people to help manage the health of residents of those areas, **and promote personalized medicine through analytical research using the biobank.**

▶ In these ways, Japan has been building infrastructure for promoting personalized medicine. However, the Action Plan for Whole Genome Analysis 2022 **mainly targets cancer and intractable diseases.** In addition, the main areas where personalized medicine is currently being researched and practiced clinically are cancer and intractable diseases, and the field of psychiatric care is lagging behind those fields.
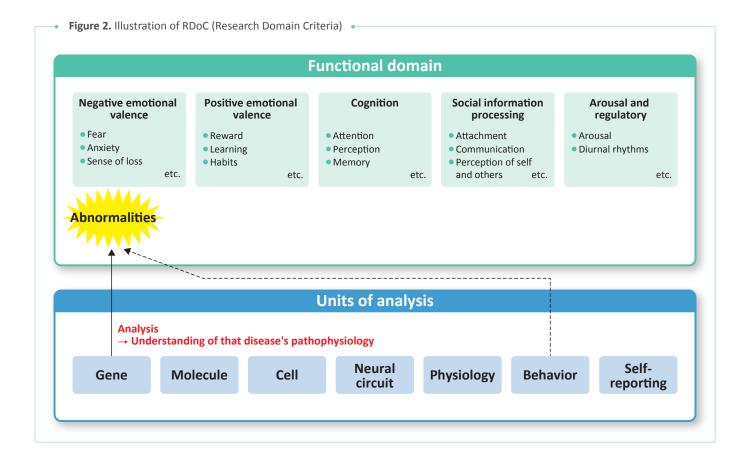
Challenges and Initiatives in Personalized Medicine in the Field of Psychiatric Disorders

▶ **Progress in personalized medicine is lagging** in the field of psychiatry. That is due to the unique nature psychiatric disorders and mental illness, and in particular, the fact that **the etiology and clinical conditions of many psychiatric disorders remain unresolved, making this a fundamental challenge and an obstacle to progress in this field.** The underlying causes of psychiatric disorders are multifaceted and remain unknown; the genetic and environmental factors play a notable role in the onset and development of psychiatric disorders. This delay in elucidating the etiology and pathogenesis of psychiatric disorders **has made it difficult to develop objective biological indicators for diagnosis and treatment, and to establish treatment methods based on the underlying mechanisms of the clinical symptoms.**

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1) This is a method to analyze genes (genomics), RNA (transcriptomics), proteins (proteomics), metabolites (metabolomics), etc. all at once. The term "-omics" refers to comprehensive analysis.

▶ The lack of objective biological indicators that can be used for proper diagnosis and treatment choices means **the diagnosis of psychiatric disorders is currently dominated by the categorical approach**, a method in which patients are classified into disease categories based on their account of their symptoms and the clinician's observations against operational diagnostic criteria. However, the U.S. National Institute of Mental Health (NIMH) has identified the following challenges with the categorical approach: **it has low diagnostic validity and includes individuals with widely varying clinical conditions and treatment responsiveness within the same patient population that has received the same diagnosis**[viii]. As a result, it is difficult to conduct research on homogeneous patient populations in research settings, which also makes it difficult to elucidate the clinical conditions of psychiatric disorders and develop treatments (drugs). In clinical settings, the categorical approach is also **primarily focused on defining standardized patient profiles and treatments,** which hinders the provision of optimal treatment and care for individual patients.

▶ In response to the issues of the categorical approach, attention has focused on a shift to diagnostic classification based on the **dimensional approach**, which promotes a comprehensive understanding of patients with mental illness and allows for more flexible diagnosis and treatment. The dimensional approach is an approach that views mental illnesses not in terms of categories (diagnostic names) **but in terms of different dimensions, such as the number of symptoms and their severity and frequency, to quantify and classify the clinical characteristics of patients.** For example, since the 2000s, the NIMH has proposed the Research Domain Criteria (RDoC), a dimensional approach to mental illness classification[ix]. (Figure 2) In this concept, the clinical condition is evaluated **based on the patient's functional domains (symptoms) through the analysis of analysis units such as genes and cells,** rather than the conventional diagnostic categories such as "depression." Specifically, functional domains include **positive and negative emotions, cognitive systems, social processes, and arousal and regulatory systems,** which are evaluated at the level of multiple analysis units: **genes, molecules, cells, and neural circuits.**

▶ The greatest advantage of this approach is that it goes beyond conventional diagnostic categories to **elucidate the biological clinical conditions** affecting abnormalities in a patient's functional domains. This is expected to **facilitate the development of therapies and drugs that act directly on the underlying mechanisms of specific symptom**. Furthermore, in clinical settings, it will enable **the selection of appropriate treatment methods that take into account various factors, including the biological and clinical condition of each patient**, and will greatly contribute to the materialization of personalized psychiatric care.

Figure 2. Illustration of RDoC (Research Domain Criteria)

Functional domain

Negative emotional valence	Positive emotional valence	Cognition	Social information processing	Arousal and regulatory
• Fear • Anxiety • Sense of loss etc.	• Reward • Learning • Habits etc.	• Attention • Perception • Memory etc.	• Attachment • Communication • Perception of self and others etc.	• Arousal • Diurnal rhythms etc.

Abnormalities

Units of analysis

Analysis
→ Understanding of that disease's pathophysiology

Gene	Molecule	Cell	Neural circuit	Physiology	Behavior	Self-reporting

▶ In Japan, a large-scale registry of patients with psychiatric disorders across a wide range of diagnostic categories, **"Mental Illness Registry,"[x)]** is currently under construction, and efforts are underway to realize personalized medicine based on the clinical conditions of mental illness. The National Center of Neurology and Psychiatry and The Japanese Society of Psychiatry and Neurology are playing a central role in this registry development project, and **all-Japan collaboration for the promotion of personalized psychiatric care** is progressing. However, the development of a data infrastructure alone is not sufficient to realize personalized psychiatric care. In order to establish personalized psychiatric care that can actually be implemented in clinical settings, a series of processes are essential: **(1) further advancement of basic and clinical research to elucidate clinical conditions, (2) development of new diagnostic and therapeutic methods based on the results of clinical research, and (3) implementation of research results in the clinical setting.**

▶ Against this background, this year the HGPI has been working to identify issues and formulate recommendations for the promotion of personalized psychiatric care. Specifically, we conducted a survey, interviewed experts from industry, government, academia, and the private sector, held a symposium with representatives from individuals with lived experience of mental illness and their families, and held an expert roundtable discussion based on the symposium's deliberations. Based on these activities, this policy recommendation presents specific recommendations for the promotion of personalized psychiatric care in Japan.

▶ This policy recommendation does not address the universal issues of personalized medicine, such as the high cost of testing and the lack of professional personnel involved in personalized medicine, but deals with related issues and policy recommendations specific to the field of psychiatric care.

Research and Development Issues and Needs

(1) Data collection and utilization: Inefficient collection of large-scale data essential for the promotion of personalized psychiatric care, and the vulnerability of systems for the sustainable operation of patient registries

In Japan, a large-scale mental illness registry, "Mental Illness Registry," is currently being established to elucidate the clinical conditions accompanying psychiatric disorders and to develop diagnostic classification methods and treatment methods based on the findings. The Mental Illness Registry is expected to serve as an important foundation for elucidating the clinical conditions of mental disorders and promoting personalized psychiatric care, as it is characterized by its **"broad cross-diagnostic categories," "collection of diverse data including biological information in addition to general diagnostic information," and "longitudinal follow-up system."**

However, Japan has **lagged behind in the digitization of healthcare (medical DX), and the resulting inefficiencies in data collection have become an issue**. Many patients with psychiatric disorders attend general psychiatric hospitals (clinics) rather than university hospitals, and **the penetration of electronic medical records is insufficient** in such hospitals (and clinics). In addition, even in hospitals with electronic medical record systems, it has become difficult to obtain information directly from the medical records used for medical treatment due to differences in specifications among between development vendors. Therefore, in order to collect data and construct a database for research, medical data must be transcribed manually, and there is concern that **the process would increase the burden on healthcare practices**. Furthermore, The Mental Illness Registry is operated as part of a project of the Japan Agency for Medical Research and Development (AMED), and support for research funding is provided for a period of three years. A sustainable operational structure is currently under consideration, including a self-starting system that generates revenue from data utilization costs. In addition, **the number of people registered with the Mental Illness Registry is still insufficient** (3,300 people are registered with basic information, as of the end of March 2025). More data from patients is needed to increase the reliability of research results, and an **accelerated increase in enrollment** is required.

(2) Research and development: Lack of proper establishment of diagnostic classification by a dimensional approach that can be used in clinical practice

The dimensional approach, which views symptoms on a continuous spectrum, is gaining attention in the study and treatment of psychiatric disorders This approach is expected to deepen the understanding of clinical syndromes beyond diagnostic categories and facilitate the development of treatments and drugs that directly address specific symptom mechanisms. It is also essential to the promotion of personalized psychiatric care, as it provides a more comprehensive understanding of the patients' symptoms and allows for **more flexible diagnosis and treatment**.

In practice, the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD), both of which are diagnostic manuals based on the conventional categorical approach, have begun to incorporate the dimensional approach perspective for some diseases. For example, in the revision of the DSM-5, the diagnosis of a wide range of developmental disorders was unified under the concept of autism spectrum disorder (ASD), and the perspective of **assessing the severity of symptoms on a continuum** was introduced[xi]. The revision of ICD-11 also eliminated the subcategory of personality disorders and replaced it with an **assessment method based on severity and characteristics**.
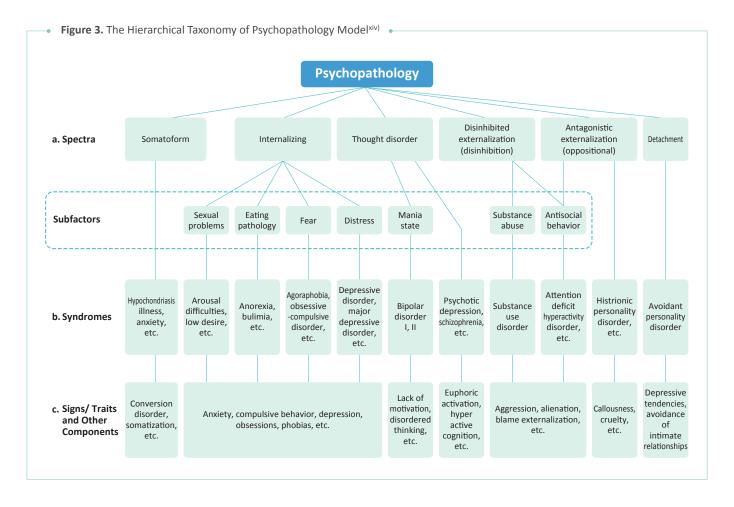
In addition to these efforts to integrate the dimensional approach into the categorical approach, a new method for classifying mental illness based on the dimensional approach, the **Hierarchical Taxonomy of Psychopathology (HiTOP) model**[xii], has been developed in recent years. This model structures the various symptoms into multiple **a. dimensions**, and quantitatively assesses the intensity of each of the components that underlie each dimension: **b. syndromes, and c. signs/characteristics, and their components** (Figure 2). (Specifically, Patient A's internalizing is scored at 50

points, with a breakdown of 60 points for sexual problems, 10 points for eating problems, 20 points for fear, and 10 points for distress, as a numerical expression of the patient's condition). This model is expected to provide **flexibility in diagnosis, counter the issue of duplicate diagnosis, and suggest appropriate treatment suited to the clinical condition, characteristics, and intensity of symptoms of individual patients**[xiii].

Thus, although the dimensional approach is being introduced in the diagnosis of psychiatric disorders, **many challenges still remain in proper implementation of this approach in clinical practice.** For example, the dimensional approach measures and assesses severity and individual characteristics, but depends on a single-method approach with only simple and efficient self-reported data, which presents **challenges to validity and reliability in measurement.** There is also currently a lack of evidence regarding the **efficacy of the dimensional approach in clinical settings.** Unless new treatments based on the dimensional approach are firmly demonstrated to be more effective in guiding treatment than conventional approaches, it will be difficult for clinicians to accept new diagnostic approaches that are complex and take time to learn.

In order to properly utilize the dimensional approach in clinical practice in the future, it is necessary to **establish diagnostic methods based on that approach that can be applied in clinical settings, and to evaluate the efficacy and utility of the resulting diagnoses**.

Figure 3. The Hierarchical Taxonomy of Psychopathology Model[xiv]

(3) Clinical application of research findings: The disconnect between research and clinical practice

The current challenge in psychiatric care is that **treatments that have had their efficacy confirmed in research have not been fully and properly implemented in clinical settings**. In psychiatric care, it is accumulated evidence rather than research which is distilled and summarized into guidelines. Various guidelines have been published in the field of psychiatric care in Japan, including "Guidelines for the Pharmacological Treatment of Schizophrenia 2022," "Guidelines for the Treatment of Social Anxiety Disorder," and "Guidelines for the Treatment of Depression in the Elderly." However, there are still cases where **the guidelines are not properly understood and practiced,** and non-evidence-based diagnosis and treatment are used[xv]. For example, although guidelines for schizophrenia recommend monotherapy with antipsychotics, the monotherapy prescription rate in Japan is reported to be only 57%[xvi].

As long as such gaps exist, even if evidence on diagnosis and treatment is accumulated to promote personalized psychiatric care in the future, it may not be properly utilized in real-world clinical settings. To overcome this challenge, it is essential to **strengthen clinician involvement, and patient and public involvement (PPI)** in research and clinical guideline development, **develop human resources to bridge research and clinical practice,** and **provide education and training opportunities for evidence-based clinical practice,** including guidelines. These measures are expected to narrow the gaps that exist between research and clinical practice and accelerate the realization of personalized psychiatric care.

Clinical Setting Issues and Needs

(1) Healthcare delivery system: Delay in building a healthcare delivery system that integrates psychosocial support in outpatient settings in response to increased demand for outpatient psychiatric services

In (personalized) psychiatric care, **it is important to have an appropriate combination of pharmacotherapy and psychosocial therapy**. Psychosocial therapy is **a therapeutic treatment method aimed at improving the patient's ability to lead a life in society,** and includes cognitive behavioral therapy, family intervention, and social skill training (SST)[xvii]. However, under Japan's reimbursement system, pharmacotherapy is heavily reimbursed, while **psychosocial therapies receive low or no reimbursement, making their provision difficult**. In addition, under the current reimbursement system, psychiatric hospitals and clinics tend to **give priority to pharmacotherapy, which can be completed in a short time**. As a result, pharmacotherapy remains the mainstay of psychiatric care in Japan.

Under these circumstances, in 2024, comprehensive psychiatric community care wards staffed by occupational therapists, physical therapists, licensed psychologists, and other professionals will be evaluated for medical fees, which is expected to **promote psychosocial therapy and support for hospitalized patients**[xviii]. However, as of 2023, outpatients accounted for 95.6% of the total number of patients, and the demand for outpatient psychiatric services is expected to continue to increase every year. Therefore, there is **an urgent need to strengthen the system for providing psychosocial therapy in outpatient care**.

(2) Diagnosis: Establishment of a dimensional approach in current psychiatric care

In recent years, the dimensional approach has begun to be adopted in diagnostic criteria manuals for some diseases. However, since psychiatric diagnoses have been based on the categorical approach for about 70 years, **many psychiatrists are accustomed to categorical diagnostic criteria and tend to prefer a categorical approach or a hybrid model**. Furthermore, the current dimensional approach to diagnosis is **more complex to evaluate** than the categorical approach, **making it difficult to implement in clinical settings, where decisiveness is required.**

The development of a combination of both dimensional and categorical approach seeing as the categorical approach is standard for psychiatric diagnosis and the dimensional approach can account for the shortcomings of the categorical approach. In order to appropriately utilize the dimensional approach in diagnosis, it is necessary to **develop diagnostic methods using that approach which can be applied in clinical settings,** to **improve education and training programs** on the dimensional approach, and to **ensure sufficient time and opportunities for learning**.

(3) Diagnosis and treatment: Bias toward biological, psychological, and social perspectives in psychiatric diagnosis and treatment

In addition to genetic factors, social factors, including individual characteristics and beliefs, relationships from childhood, living environment, and education and employment, play complex roles in the development of mental illness. Therefore, it is essential to **consider the biological, psychological, sociological, and spiritual aspects in an integrated manner** in the treatment of psychiatric disorders.

Currently, however, psychiatric care diagnoses **do not adequately reflect a biological perspective** because biomarkers have not been developed and rely on patient symptom self-reporting and clinician observation. On the other hand, **treatment focuses on pharmacotherapy,** and the provision of psychosocial therapy is inadequate. This is because the reimbursement system makes it difficult to implement psychosocial therapy.

In order to promote the provision of holistic healthcare that integrates biological, psychological, and sociological factors in both diagnosis and treatment, it will be necessary to **develop biomarkers that can be used as objective diagnostic criteria** and to review the **reimbursement system** to allow psychosocial therapy to be provided.

Issues and Needs Among Interested Parties, Such as Patients and Families, and the Public

(1) Data collection: Concerns about confidentiality in the collection, management, and use of genetic information

In order to advance personalized psychiatric care, it is essential to collect patients' genetic information, brain imaging, biochemical indices, and other bioinformation for research, diagnosis, treatment, and prevention. In particular, **the use of genetic analysis technology and big data will play a major role** in making personalized medicine a reality , such as risk assessment of mental illness and prediction of treatment response.

However, there are strong concerns among patients and the public about the collection, management, and use of such personally relevant information. Genetic information not only affects an individual's future health status, but also relates to family information through blood relationships, and thus risks unauthorized use, leakage, and discriminatory treatment in society.

Unless these concerns are addressed, patients and the public may refuse to provide their own data, which could hinder the advancement of reliable research and personalized psychiatric care. Therefore, it is necessary to **ensure the protection of personal information,** to **develop highly transparent operational rules** at data collection institutions and medical institutions, and to **develop guidelines, laws and basic plans for the proper handling of genomic information** by the government, as well as **concrete measures for protection.**

(2) Clinical: Concerns of interested parties, such as patients and families, the public, and society regarding personalized medicine

Personalized psychiatric care is not only about providing treatment and care suited to the individual. It is also but also positioned as an important factor in **predicting and preventing the risk of developing disease**. Against this background, studies have been vigorously conducted to clarify the relationship between genetic factors and the risks of developing psychiatric disorders For example, estimates based on family, twin, and adoption studies have reported that the contribution of genetic factors (heritability) to the variation in risk of developing bipolar disorder is 60-85%[xix], and that the heritability of schizophrenia is 50-80%[xx]. In addition, it is becoming clear that some psychiatric disorders are associated with changes (mutations) in certain genes. However, such changes are rare and not representative of the disease as a whole.

On the other hand, the results of the Genome-Wide Association Study (GWAS) have **identified hundreds of genes associated with psychiatric disorders,** but most genetic factors remain unknown, and **the discovered genes can explain and are only applicable to a small portion of genetic factors**. This situation is referred to as "missing heritability," and at this time it is difficult to clearly indicate an individual's or family's risk of developing a disease through genetic testing.

However, social understanding of these scientific limitations is not always sufficient. There is strong concern among

interested parties such as patients and their families, and the general public, about the psychological burden, stigma, and discrimination associated with "knowing" the risk of developing mental illness in the future through testing, and the possibility of social disadvantages in areas such as insurance and employment cannot be ruled out[xxi].

Recommendations

Recommendations Concerning Research and Development

(1) Research and development: Evaluating the efficacy and utility of new diagnostic classification methods and implementing practical research with a dimensional approach that involves diverse stakeholders

The challenges in applying the dimensional approach diagnostic model in clinical settings are that **the clinical efficacy and utility of diagnosis by the dimensional approach has not been clinically and empirically verified,** and that **no highly reliable and valid quantitative measurement and evaluation method for symptoms has been established**.

To ensure the efficacy of the dimensional approach and to justify the transition from one approach to the other, it is not enough to simply show cases of improvement in the disease of patients treated according to that approach. It must be scientifically proven that the dimensional approach provides better treatment outcomes when compared to the conventional categorical approach[xxii].

Clinical implementation of the dimensional approach not only requires the construction of diagnostic models and the establishment of quantitative evaluation indices, but also **operational design in the field of healthcare and acceptance and application by frontline healthcare professionals**. To that end, it is essential to actively incorporate the perspectives of physicians engaged in routine healthcare during limited clinic hours and patients undergoing diagnosis and treatment. Thus, actively incorporating the perspectives of diverse interested parties in medical treatment is expected to create a medical treatment model that is easy for physicians to accept and implement promotes common understanding among healthcare professionals and is also comprehensive for patients and highly feasible.

(2) Data collection and application: Advancing healthcare DX[2] (the introduction of electronic medical records, systems for automatic extraction of electronic medical record data, and digital tools)

The collection and use of big data across diagnostic categories is essential to advance the elucidation of etiology and clinical conditions, and to develop diagnostic classification methods and treatments based on them. Against this background, a large-scale patient registry across a wide range of diagnostic categories is being established in Japan.

However, **the introduction of electronic medical records and medical record linkage has lagged behind** in Japanese psychiatric hospitals, and there are concerns about the burden of data collection on healthcare settings. Patients also have **issues with ongoing data collection** because of the burden of responding to periodic registry follow-up questionnaires and hospital testing.

To solve these issues and reduce the burden on healthcare professionals, patients, and researchers, it is **essential to promote healthcare DX (Digital Transformation)***. In addition to the introduction of electronic medical records, the introduction of a system that automatically extracts data from electronic medical records will greatly reduce the burden on healthcare professionals and improve the efficiency of data collection. Currently, the Japanese Mental Illness Registry is converting a system called Cyber Oncology[xxiii] for use with mental disorders (tentative name: Cyber-NP), and introducing a system to automatically extract data from electronic medical records.

However, the high cost of implementing this system makes it difficult to deploy nationwide. In the future, it will be necessary to **consider measures to support the introduction of electronic medical records and the development and introduction of technology to reduce the cost of automatic data extraction systems**.

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2) Medical DX refers to information and data generated at each stage of healthcare, medical care, and nursing care (prevention of disease onset, consultation, medical examination, treatment, drug prescription, preparation of medical certificates, etc., billing of medical fees, care through coordination of medical care, community healthcare coordination, research and development, etc.) through a globally optimized infrastructure (Cloud computing, etc.). It is used to externalize, share, and standardize the operations, systems, and data storage of health and medical care and long-term care professionals, and to change the shape of society and life in order to promote public prevention and better quality medical care.

Furthermore, **digital technologies and tools must be developed and utilized** to support efficient and sustainable data collection. For example, **the implementation of wearable devices** in psychiatric care research is effective in **collecting information on research subjects and patients over long periods** while minimizing the burden on them. Biological data collected and measured objectively and quantitatively using such digital devices are called **digital biomarkers**, and are expected to be utilized for medical research and in clinical practice. For example, a research team at Akita University and elsewhere are currently conducting research to examine the predictability of depression recurrence through monitoring sleep status and lifestyle rhythms[xxiv].

Thus, in order to promote research in personalized psychiatric care, it is desirable to **promote DX**, as well as **the development and introduction of new technologies** and **an efficient and sustainable data collection infrastructure**. The establishment of a data collection infrastructure is expected to **accelerate the elucidation of the clinical conditions of psychiatric disorders and the development of diagnostic and therapeutic methods**, and to realize **personalized psychiatric care** tailored to each patient.

(3) Implementation: Train experts who can build sturdy bridges between research and clinical fields

In psychiatry, **the gap between evidence and clinical practice** is a major challenge. Even if high-quality research results and practice guidelines are developed to realize personalized psychiatric care, patients will not be provided with optimal healthcare unless those results and guidelines are fully understood and properly implemented in clinical settings. In order to bridge that gap, it is essential to **train professional personnel who are familiar with both research and clinical practice, and who can bridge two sides**.

In response to this challenge, **"physician scientists"** have been attracting attention in recent years. A physician scientist is a professional who, while gaining clinical experience as a physician, is also engaged in scientific research, and is expected to serve as a bridge between healthcare and research by applying findings gained through clinical practice to research. On the other hand, there are challenges to the training of physician scientist, such as **the increasing clinical orientation of young physicians** and **the busyness of clinical faculty at universities**.

Against this backdrop, several universities and research institutes, including Tohoku University, Keio University, and Kansai Medical University, are actively engaged in training physician scientists. In particular, Tohoku University established **the SiRIUS Institute of Medical Research**[xxv] on April 1, 2025, aiming to create an environment in which physician scientists with both a clinical perspective and a research orientation can focus on independent research[xxvi].

In the future, Japan as a whole will need to further promote the development of physician scientists who can bridge between research and clinical practice, as well as develop systems and support structures that will enable them to remain active in their fields.

Recommendations Concerning Clinical Settings

(1) Healthcare delivery systems: Evaluation of multidisciplinary deployment for the promotion of psychosocial therapy in outpatient settings (Revision of medical reimbursement systems and establishment of clinic staffing standards)

Despite the fact that integrated provision of pharmacotherapy and psychosocial therapy is essential in (personalized) psychiatric care, **pharmacotherapy remains the mainstay of outpatient psychiatric care in Japan**. One of the main reasons for this is **the delay in developing a system for providing psychosocial therapy in clinics**.

In order to promote psychosocial therapy in outpatient settings, it is i**mportant to have a system of interdisciplinary collaboration among multiple professions,** including nurses, mental health workers, licensed psychologists, and clinical psychologists, in addition to physicians. However, **clinics, which are used by approximately 60% of outpatients with psychiatric disorders**[xxvii]**, have difficulty establishing such a support system due to size and staffing constraints**. A survey conducted by the Japanese Association of Neuro-Psychiatric Clinics in 2018[xxviii] revealed that the staffing structure of a typical psychiatric clinic consists of one doctor, one nurse, and two administrative staff. Only 33% of all clinics have two or more full-time physicians, and the majority have only a single physician. Furthermore, only 31.6% of clinics have

at least one full-time equivalent mental health worker, 45.7% have psychologists, and 63.3% have nurses, indicating that **staffing for psychosocial therapy in clinics is limited**.

Based on this current situation, two measures appear promising. The first is **a reformation of the reimbursement system** to promote the establishment of a collaborative system of among multiple professions. In particular, **"the evaluation of the placement and collaboration of multiple professions in outpatient settings for reimbursement"** and **"the reimbursement of cognitive behavioral therapy (CBT) by licensed psychologists"** must be realized.

In the 2024 revision of the medical fee system, a 13:1 system for comprehensive psychiatric community care wards will be established with the assignment of nursing staff, occupational therapists, mental health workers, licensed psychologists, and other professionals, and **incentives will be provided for the assignment of multiple professions in the wards**. In addition, the reimbursement system is being amended to promote multidisciplinary support for outpatient and home care services, including the establishment of supplementary fees for support for continuing medical treatment, which makes case management by multidisciplinary personnel subject to evaluation for remuneration. However, in outpatient settings, it is difficult to provide psychosocial therapy and comprehensive management, due to **multidisciplinary approach to care and insufficient evaluation of best practice for medical reimbursement**. Therefore, in order to make such incentives for multidisciplinary collaboration effective, it is essential to establish, develop and broaden **the evaluation of multidisciplinary personnel assignments and collaboration in medical reimbursement**.

In addition, under the current system, CBT is reimbursed only when it is provided by a physician or nurse, but it is **difficult for nurses to conduct ongoing interviews** due to time constraints and work schedule restrictions[xxix]. In fact, according to the 9th NDB Open Data, the number of reimbursed cases of cognitive behavioral therapy conducted by physicians and nurses in collaboration in 2022 was very limited, at only 239[xxx].

To address these issues, a system must be in place whereby licensed psychologists with expertise in psychological assessment and support can provide CBT and individualized psychological support in collaboration with physicians and nurses. The licensed psychologist is Japan's first national qualification in the psychological profession, and since the training program includes education on CBT,[xxxi] it is expected that the licensed psychologist will be able to practice it in clinical settings. Furthermore, in 2023, AMED published a "Manual for Multidisciplinary Collaboration in Cognitive Behavioral Therapy," which specifically outlines how physicians, nurses, and licensed psychologists should collaborate in outpatient care. In order to make use of such knowledge in the field, **the reimbursement of individual psychological support by licensed psychologists** should be expanded[3].

Second, **fixed staffing standards should be established when clinics open**. Given the increasing demand for outpatient psychiatric care and the fact that approximately 60% of outpatients with psychiatric disorders use clinics (as of 2023)[xxxiii], **the role of clinics in psychiatric care will become increasingly important**. Currently, psychiatric institutions are required to fulfill the "family psychiatrist function," including case management, in order to establish a comprehensive community care system for patients, including those with mental disorders. In order for clinics to fulfill these functions, the provision of medical care by a multidisciplinary team is essential, and **the staffing of clinics with multiple professions is desirable**. The number of psychiatric clinics has been increasing in recent years; however, it has been pointed out that an increasing number of them do not provide quality medical care that meets the needs of patients, such as not participating in community psychiatric emergencies, giving priority to return patients who require only a short treatment time, or operating with multiple part-time physicians[xxxiv]. In order to achieve personalized psychiatric care, it is necessary to correct this situation by establishing specific staffing requirements from the opening phase and promoting institutional design to ensure that drug and non-drug treatment is appropriately provided under an appropriate personnel structure.

As described above, a system must be established through the **evaluation of multidisciplinary staffing and collaboration in medical reimbursement** and **the establishment of staffing standards** to provide pharmacotherapy and psychosocial

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3) Even under the current reimbursement system, licensed psychologists can be involved as assistants in the implementation of CBT by physicians. Furthermore, supplementary fees for psychological support (for patients with PTSD and other trauma reactions), supplementary fees for support and guidance for children and adolescents (for patients under 20 years of age with mental illnesses), counseling fees for specific pediatric disorders (for mental illness in children), and guidance and management fees for cancer patients (for psychological support for cancer patients) are charged for implementation by clinical psychologists.

therapy in a flexible and effective manner in clinic outpatient settings. This is extremely important as a foundation for the realization of personalized psychiatric care.

(2) Clinical practice: Development of guidelines, educational content and curricula for the practice of personalized psychiatric care, and expansion of diverse educational opportunities

In order to achieve personalized psychiatric care, there is a need to establish a new practice style in the clinical setting that integrates the dimensional approach into the current diagnostic system and further utilizes biological information such as biomarkers, brain imaging, and genetic information for diagnosis and treatment. In order to respond appropriately to these changes, it is crucial that psychiatrists and other healthcare professionals collaborate based on a multidisciplinary approach to care and continue to improve and develop their knowledge of novel treatment and diagnostic methods. However, despite the development of clinical guidelines and clinical decision support tools[xxxv], they have not yet fully penetrated into clinical settings.

In light of this situation, there is a need to create an environment in which psychiatrists can systematically and continuously learn the knowledge and skills necessary to practice personalized psychiatric care. Specifically, the first step is to **develop practical educational programs that focus on the dimensional approach and evidence-based practice guidelines** for diagnosis and treatment, as well as their clinical application.

Furthermore, it is important to provide flexible and multifaceted learning opportunities such as group training, e-learning, on-demand courses, and academic conference courses to meet the diverse working environments and learning needs of psychiatrists. In particular, there is an urgent need to improve training in psychosocial therapy in addition to the pharmacotherapy that is currently the mainstay of psychiatric care.

A study by the National Center of Neurology and Psychiatry has already shown that training about treatment guidelines for mental illness can deepen psychiatrists' understanding of shared decision making (SDM) and significantly improve their understanding of guidelines; this study also suggests **the efficacy of such educational programs**[xxxvi].

In the future, the use of evidence in psychiatric care should be promoted and the human resource base for the implementation of personalized psychiatric care should be strengthened through the development and dissemination of such evidence-based educational resources.

(3) Securing clinic hours: Building a system to ensure availability of appropriate treatment hours according to patient needs, promoting task shifting and sharing, and applying digital technology

The establishment of personalized psychiatric care requires a thorough understanding of each patient's biological, psychological, and social background, and the provision of multifaceted support based on those factors. However, in current psychiatric practice, it is **difficult to secure sufficient treatment time** for each patient due to restrictions in the reimbursement system and growing numbers of outpatients.

As a result, current psychiatric care tends to be biased toward pharmacotherapy, which is easy to complete in a short period of time, and **does not adequately provide psychiatric care according to the individual needs of the patient**. Furthermore, limited clinic time also **hinders the practice of SDM**, in which patients and healthcare providers collaborate to determine a course of treatment. SDM is a core approach to personalized psychiatric care and is predicated on the establishment of a trusting relationship between the physician and patient, but the current institutional and operational framework makes it difficult to provide sufficient time for that to occur.

The following three measures have potential to address these challenges. The first is **a review of the reimbursement system**. The current reimbursement system **does not provide sufficient incentive** for longer consultation times, as a psychiatry outpatient re-examination that takes "more than 5 minutes but less than 30 minutes" is charged 330 points (3,300 yen), while a consultation of "30 minutes or longer" is charged 400 points (4,000 yen). In other words, a 5-minute consultation and a 29-minute consultation are valued at the same amount, while the supplementary fee is only 700 yen even if the consultation exceeds 30 minutes, meaning that medical treatment which takes sufficient time to interact with the patient is not properly valued.

In order to realize psychiatric care that is tailored to the individual needs of each patient, it is necessary to **establish a more flexible and tiered reimbursement system based on the time spent in treatment, or to consider a fundamental reform to a piece-rate payment system, etc., so that medical personnel can secure sufficient time for treatment as needed**. That will contribute not only to the promotion of personalized psychiatric care, but also to **the improvement of quality and patient-centered care in psychiatry**.

The second is **the promotion of task shifting and sharing in healthcare institutions**. This is an agreement among healthcare professionals to transfer and share duties among them to other professions, thereby improving efficiency and sharing roles. The Ministry of Health, Labour and Welfare (MHLW) has compiled the report of the "Study Group on the Promotion of Task Shifting/Sharing" in 2020, aiming to maximize the promotion of task shifting in preparation for the application of overtime work ceiling regulations for physicians starting from 2024[xxxvii]. The Japanese Nursing Association has also published "Guidelines and Guide for Task Shifting/Sharing," and related measures are being promoted[xxxviii].

On the other hand, in addition to a lack of understanding of task shifting and sharing, there are also issues such as a lack of manuals, insufficient sharing of best practices, and difficulties in securing personnel[xxxix]. In psychiatry, in particular, some have pointed out that the introduction of these systems has been more restricted than in other medical specialties[xl]. The promotion of task shifting and sharing in psychiatry requires raising **awareness and encouraging ongoing educational activities for psychiatrists, collection and sharing of practical examples, and the development of guidelines for tasks specific to psychiatry in the future**.

Third is **the use of digital technology** in psychiatric care settings. The introduction of digital technology into psychiatry may contribute not only to **the effectiveness of medical care**, but also to **improving the objectivity of medical examinations, the accuracy of treatment, and the promotion of personalized medicine** based on patients' daily life data[xli]. In the field of psychiatry in particular, the development of digital technology for symptom monitoring, quantitative evaluation, and treatment is being actively pursued both nationally and internationally[xlii]. In terms of **improving the efficiency of medical care**, numerous digital technologies have already been introduced in psychiatric institutions. For example, a psychiatric hospital has introduced a medical document creation support and information sharing system to reduce the workload of doctors, nurses, social workers, and others and to facilitate information sharing within the hospital[xliii]. In addition, automatic medical record entry[xliv] using medical-specific voice recognition AI, and medical care support[xlv] using communication robots, are also expected to complement the work of healthcare professionals and contribute to **ensuring that each patient receives appropriate medical care in a timely manner**. The government has also been promoting the introduction of digital technology throughout the country, including the establishment of the "Medical DX Promotion Headquarters" in 2022 and positioning the "improvement of operational efficiency at medical institutions, etc." by 2030 as a major policy[xlvi]. In the future, **further development of digital technology** to improve operational efficiency, and support for **its smooth introduction in the field**, will be required.

Recommendations Concerning Interested Parties, such as Patients and Families, the Public, and Society

(1) Research participation: Encourage the promotion of research involvement by interested parties such as patients and families, from data collection to clinical application

PPI in research is the involvement of patients, their families, and the public with experience of a disease or disability in the entire research process, either with the researchers or as subjects. PPI contributes to setting research priorities, establishing appropriate outcome indices, and creating research materials and results that are easy for patients, families, and other interested parties to understand[xlvii]. Internationally, including in Japan, there have been efforts to develop systems and take initiatives to promote PPI in research.

However, the practice of PPI in clinical research and insurance welfare service research remains limited in the Japanese psychiatric care field. This is due to **the inadequacy of research institutions and universities to conduct PPI, the technical and ethical challenges** of involving patients with psychiatric disorders as participants in research, and **the difficulty of ensuring representativeness**[xlviii].

In the future, in order to promote PPI in research, it is desirable to **develop PPI implementation systems** at research institutes and universities, as well as **PPI guidelines and training programs,** and **a system for matching interested parties, such as patients and families, with researchers**. Furthermore, efforts must be made not only to improve the hard aspects, but also to create an environment in which both researchers and interested parties have **a deep understanding of the significance of PPI and build relationships of trust**.

(2) Promote proper understanding: Providing opportunities for information and education about personalized psychiatric care

In implementing personalized psychiatric care in society, it is important for patients, families, and other interested parties and the public to correctly understand the basic concepts, significance, and limitations of personalized medicine.

In Japan, pharmaceutical companies[xlix], research and medical institutions such as the Center for Cancer Genomics and Advanced Therapeutics[l], and the Center for Promotion and Education of Personalized Medicine (CPEP), a non-profit organization[li], are currently providing information and educational activities on personalized medicine to the public, mainly in the field of cancer.

On the other hand, in the field of psychiatry, opportunities for providing information on personalized psychiatric care remain limited, in part because the field of psychiatry is a unique field of medicine due to the nature of psychiatric disorders, therefore implementing personalized psychiatric will take time and a multidisciplinary approach. In light of this situation, it is necessary to develop an education and information provision system that supports the understanding of parties, such as patients and families, and the public through the creation of easy-to-understand educational materials and pamphlets, and the provision of information at medical institutions to deepen understanding of personalized psychiatric care, and to obtain cooperation of interested parties and the public.

In designing and implementing these educational materials and activities, it is important to encourage the involvement of not only professionals but also **patients, family members, and other interested parties and the public**. By incorporating the perspectives of interested parties, such as patients and families, and the public, it will be possible to establish an educational and informational system that is easy for the general public to understand and readily acceptable to patients, families, and other interested parties.

It is expected that having interested parties, such as patients and families, and the public correctly understand personalized psychiatry and its significance and limitations will **prevent excessive expectations and concerns, and promote participation in data collection and research for the realization of personalized psychiatric care**. In addition, it may contribute to improving acceptability of the public during future clinical implementation.

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iii)   https://www.genome.gov/genetics-glossary/Precision-Medicine

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viii)   https://www.jstage.jst.go.jp/article/jsbpjjpp/27/4/27_208/_pdf/-char/ja

ix)   https://www.nimh.nih.gov/research/research-funded-by-nimh/rdoc

x)   https://miregistry.jp/council/

xi)   https://www.jstage.jst.go.jp/article/jjpm/57/1/57_19/_pdf

xii)   https://www.hitop-system.org/

xiii)   https://pubmed.ncbi.nlm.nih.gov/31724426/

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xv)   https://www.ncnp.go.jp/topics/2019/20190823.html

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xvii)   https://pmc.opho.jp/koramu/doctor/20200303.html

xviii) https://www.mhlw.go.jp/content/10808000/001330952.pdf

xix)   https://pubmed.ncbi.nlm.nih.gov/14601036/

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xxi)   https://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-11-132#:~:text=In%20this%20review%2C%20we%20summarize%20an%20illustrative%20selection,in%20major%20depressive%20disorder%2C%20bipolar%20disorder%2C%20and%20schizophrenia.

xxii)   https://pmc.ncbi.nlm.nih.gov/articles/PMC7801851/

xxiii) https://www.rwd.kuhp.kyoto-u.ac.jp/project/cyberoncology/

xxiv)   https://www.akita-u.ac.jp/crc/study/pdf/2024/takeshima_m.pdf

xxv)   https://www.sirius.tohoku.ac.jp/

xxvi)   https://www3.nhk.or.jp/tohoku-news/20250402/6000030732.html

xxvii) https://www.mhlw.go.jp/toukei/saikin/hw/kanja/23/dl/suikeikanjya.pdf

xxviii) https://www.mhlw.go.jp/content/12200000/000906082.pdf

xxix)   https://www.mhlw.go.jp/content/12200000/000798695.pdf

xxx)   https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/0000177221_00014.html

xxxi)   https://jact.umin.jp/wp_site/wp-content/uploads/2023/03/%E3%80%90%E6%8E%B2%E8%BC%89%E7%94%A8%E3%80%91%E2%91%A1%E8%AA%8D%E7%9F%A5%E8%A1%8C%E5%8B%95%E7%99%82%E6%B3%95%E3%81%AB%E3%81%8A%E3%81%91%E3%82%8B%E5%A4%9A%E8%81%B7%E7%A8%AE%E9%80%A3%E6%90%BA%E3%83%9E%E3%83%8B%E3%83%A5%E3%82%A2%E3%83%AB_0216.pdf

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xxxiv) https://www.mhlw.go.jp/content/10800000/001256794.pdf

xxxv)   https://decisionaid.tokyo/

xxxvi) https://www.ncnp.go.jp/activities/detail.php?@uid=6T5EGHWYevEKM5R4

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xxxix) https://www.mhlw.go.jp/stf/newpage_15678.html

xl)   https://journal.jspn.or.jp/jspn/openpdf/1220010001.pdf

xli)   https://www.jstage.jst.go.jp/article/jjpm/63/3/63_63.3_208/_pdf/-char/ja

xlii)   https://www.jstage.jst.go.jp/article/jjpm/63/3/63_63.3_208/_pdf/-char/ja

xliii) https://www.hcs.co.jp/casestudy/medical-psychiatry-document-support-system/

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xlvi)   https://www.cas.go.jp/jp/seisaku/iryou_dx_suishin/pdf/dai3_kanjikai.pdf

xlvii) https://www.jstage.jst.go.jp/article/iken/advpub/0/advpub_2023.001/_pdf/-char/ja

xlviii) https://onlinelibrary.wiley.com/doi/10.1111/hex.13529

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li)   http://cpep.or.jp/

2 Encourage Innovation in Healthcare Delivery Systems by Incorporating Psychiatric Care into New Community Healthcare Concepts

The history of past measures in the field of psychiatry

Changing demand from psychiatric patients

▶ In 2020, the total number of patients with mental illness in Japan was approximately 6.15 million, including around 290,000 inpatients and 5.86 million outpatients, and **the total number of patients is rising**[lii].

▶ **The total number of inpatients** currently has a downward trend from 345,000 in 2002 to 288,000 in 2020. With regard to length of hospital stay, the number of patients hospitalized for "1 to 5 years" declined moderately, while the number of patients hospitalized for "5 years or more" declined significantly. With regard to age group, **the number of hospitalized patients in the "20 to 39" and "40 to 65" age groups decreased substantially, while the number of hospitalized patients in the "75 and older" age group increased**. Regarding disease type, **schizophrenia and related disorders (in the ICD10:F2 classification) have the largest number of admissions**, but **the number of such admissions decreased by about 33% (from 197,753 to 134,626)** between 2004 and 2021. On the other hand, **the number of patients with dementia and related conditions (in the F0 classification) has increased by about 23% as the population ages**. In addition, while there has been little change in the number of admissions for mood disorders (the F3 classification), the number of admissions for developmental disorders (the F8 classification) has increased significantly, (approximately 5.5 times).

▶ **The total number of outpatients has increased** from 2,239,000 in 2002 to 5,861,000 in 2020[4]. By age group, the number of outpatients in all age groups is increasing, but **the number of outpatients in the "75 and older" age group is particularly increasing**. Since the 2010s, there has also been **a noticeable increase in the number of outpatients in the younger age group, "0 to 24 years old."** By disease, mood disorders (the F3 classification) and neurotic disorders (the F4 classification) have the largest numbers of outpatients, in that order, and the number of such outpatients is also increasing slightly. In outpatient settings, the numbers of patients with dementia and other conditions (in the F0 classification) are increasing with the aging of the population. On the other hand, the number of outpatients with schizophrenia and other disorders (in the F2 classification) has remained constant .

The trend of focus "from a focus on inpatient care to a focus on community life" and "also inclusivity"

▶ Since the early 2000s, the high number of inpatients and the trend toward long-term hospitalization have been issues in psychiatric care policy. To this end, in the "Vision for Reform of Mental Health and Medical Welfare,**" the philosophy of "from a focus on inpatient care to a focus on community life"** was presented, **a "community comprehensive care system that also accommodates mental disorders" was established,** and a multi-layered support system was developed so that people with psychiatric disorders can live with peace of mind as members of the community. Due to these measures and a decrease in the number of patients with schizophrenia, who used to make up over a majority of hospitalized patients, the number of hospitalized patients is now on a downward trend.

▶ However, **the total number of patients with psychiatric disorders, including outpatients, is increasing** due to social influences such as isolation caused by the rapidly declining birthrate and aging population, as well as that, the society as a whole need to improve its system of psychiatric care. In addition, **the aging of patients with mental illnesses** is also becoming an issue, and it has become necessary to take measures to support patients with psychiatric disorders not only in hospitals but also in the community as a whole, in anticipation of the year 2040, when the population over 85 years old is expected to have increased, with complex medical and nursing needs that are not limited to mental disorder alone.

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4) In 2020, the survey method for the patient survey was changed, and the upper limit for the calculation of the average treatment interval from the date of the last visit to the date of the survey was changed from 31 days or more to 99 days or more. The number of outpatients was increasing even before that change.

▶ Furthermore, there is a growing international demand for improvements regarding the guarantee of the rights of people with mental disabilities. In 2022, the UN Committee on the Rights of Persons with Disabilities expressed[liii] serious concerns to Japan about prolonged hospitalization, forcible treatment, and frequent use of isolation and physical restraints. It also recommends accelerating the development and establishment of a community life support system as well as reducing the number of psychiatric beds, because the environment in which people with mental disabilities can live in the community while receiving appropriate support is inadequate. In light of these international demands, future psychiatric care policy must further shift from an institution-centered to a community-centered system, and further improve the environment in which people with mental illness can live in the community with dignity.

What is the community healthcare concept?

The philosophy of the community healthcare concept and its future

▶ **The community healthcare concept is a plan for each prefecture to discuss and formulate the number of necessary hospital beds, etc., to ensure a system that can efficiently provide quality and appropriate healthcare.** Based on the community healthcare concept, efforts have been made to promote functional differentiation and collaboration among medical institutions, with an eye to medium- and long-term changes in the population structure and the quality and quantity of medical needs in the community. Focusing on inpatient treatment of physical illnesses, efforts have been made to promote the transition of patients from the hospital to community-centered care by controlling the excessive increase in the number of hospital beds through the use of the hospital bed function reporting system and by setting the numbers of necessary hospital beds.

▶ On the other hand, Japan is facing a rapidly declining birthrate and an aging population, and there is new demand to **formulate mid- to long-term plans in anticipation of the 2040 problem**. Due to the declining birthrate and the ageing population, it is expected that there will be a decrease in demand for inpatient and outpatient care, an increase in demand for home care, widening regional disparities in medical care demand, and a shortage of healthcare professionals. **In the new community healthcare concept, the discussion should not be limited to the number of necessary hospital beds, but also include the healthcare delivery system, including coordination with outpatient, home, and nursing care services and the securing of human resources**, so that patients of all regions and generations can live in the community while receiving appropriate medical and nursing care.

Positioning of psychiatric care in the new community healthcare concept

▶ Psychiatric beds are **not covered by the current community healthcare concept in terms of estimating the future need for beds or reporting on the functions of beds**. However, even for psychiatric beds, it is more necessary than ever to respond to the expected decline in the number of inpatients and the utilization of beds due to the aging of the population, and to develop systems for providing outpatient and home health care and for collaboration, in light of the current trend of increasing outpatients. In transitioning from hospital care to community-based care, which is a major goal of psychiatric care, it is necessary to discuss not only the optimization of psychiatric beds but also the entire healthcare delivery system, including psychiatric care and general care, inpatient care, and home/outpatient care. Therefore, **it was decided to position psychiatry within the new community healthcare concept for 2040**[liv].

Issues

Issues Related to Data for the Inclusion of Psychiatric Care in the Community Healthcare Concept

(1) Lack of quantitative data on psychiatric inpatient beds, etc.

Since the **reporting of hospital bed functions, which is implemented in the current community healthcare concept, is not done in the field of psychiatry**, the development of data on the supply and demand of psychiatric care lags behind that of other fields, making it difficult to formulate policies based on such data. As for data currently collected and utilized, **the Regional Mental Health Resources Analyzing Database (ReMHRAD[lv])[5]), which compiles 630 surveys, NDBs, and other data, compiles data that can be used as reference in formulating community healthcare concepts, such as numbers of patients and current status of medical resources in each region**. However, compared to internal medicine, data is limited, and recognition and utilization of databases such as ReMHRAD are not yet sufficient. In addition, data on psychiatric outpatient and home care is even more scarce than data relating to inpatient beds, and **the actual status of community psychiatric care resources and needs is unknown**.

In addition, **psychiatric care has already been included in community healthcare plans**[lvi], and indicators for structure, process, and outcome have been set for each of the following stages: "awareness-raising and consultation support," "support in the community and crisis intervention," "medical treatment function," and "center functions." In positioning psychiatric care in the new community healthcare concept, it is necessary to support the development of evidence-based data and the use of data for the formulation of community healthcare concepts by local governments, while also employing these initiatives and indicators.

(2) Lack of data regarding the content and quality of care

A particular challenge in the field of psychiatry is **the lack of adequate data collection on the nature and quality of care being provided**. It has been pointed out that psychiatric care in Japan lags behind in the protection of patients' rights and their participation in the policy-making process[lvii]. It is crucial to improve the quality of psychiatric care as a whole by having all hospitals evaluate the quality of care and the patient's point of view. Currently, approximately 60 medical institutions with psychiatric beds are participating in the National Council of Local Authorities Hospital's project to promote evaluation and publication of medical quality and medical safety indicators, and are promoting quality evaluation efforts based on 25 indicators, such as inpatient satisfaction. In addition, the Japan Council for Quality Health Care[lviii] has established evaluation items for psychiatry in four areas, including "promotion of patient-centered care" and "practice of high-quality medical care," and evaluates hospitals. There are 242 hospitals which are currently accredited. While such third-party evaluations are **expected to contribute to an objective understanding of the current situation and improve the quality of healthcare and services, the burden of undergoing the evaluation has kept the number of participating hospitals low**.

(3) Data analysis based on current state projection models

In the overall community healthcare concept, it is said that there are issues in estimating the supply and demand of medical resources, and in the current era of significant changes in disease structures and conditions of medical care provision, estimation based on current state projection models (static methods)[6] is insufficient in certain aspects. The analysis should be changed to dynamic methods[7] that take into account factors that will have significant impacts on the future health and long-term care delivery system. In terms of medical regions, even if the situation of medical resources is discussed and examined in the same healthcare regions as for physical medicine, it can be assumed that the provision

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5) ReMHRAD is a database that visualizes indicators related to mental health welfare, location and address of psychiatric inpatients, distribution of home nursing and welfare service offices, and location of social resources by region (prefecture, medical region, and municipality) throughout Japan.

6) A method for identifying and evaluating the status of medical resources and demand for medical care at a specific point in time. It plans and analyzes based on the status quo without considering changes over time.

7) A method of analysis and planning that predicts and takes into account changes over time (population, disease structures, demand structures, etc.). For example, by taking into account advances in medical technology and other factors, the home shift rate can be analyzed and policy interventions such as mortality improvement can be considered.

of healthcare may be substantially more difficult due to the issue of uneven distribution of psychiatric care. Therefore, it would be necessary to consider a unit of data collection and analysis (district) specific to the field of psychiatric care that is not an existing healthcare area setting.

(4) Publication and utilization of publicly accessible data

Another issue in the publication of the collected data is that it is not in a format that is readily and easily understood by interested parties such as patients and families, and other members of the public. Although each local government has announced its community healthcare concept, most of the plans are in the format of an analytic summary results, which makes it difficult to grasp the actual situation and the medical resource required. On the other hand, since the collected data on medical resources and the actual status of medical care provision can be useful to the interested parties, such as patients and their families, it is also necessary to publish the collected data in a form that can be used by the parties concerned and by the public.

Based on the above, specific consideration of what data on psychiatric care resources is needed and how it should be analyzed and publicized is required.

Challenges in the Institutional Aspects of Psychiatric Care

(1) Numbers of psychiatric beds and clinics are unevenly distributed by region

The number of psychiatric beds per capita is unevenly distributed compared to the number of physical treatment beds, and there is a tendency toward **oversupply, especially in Hokkaido and Kyushu regions**[lix][lx]. The number of psychiatric clinics is increasing, especially in urban areas, but it has also been noted that an increasing number of clinics do not participate in local emergency systems, or do not provide sufficient community cooperation or quality of care. The current situation is that each region faces its own challenges in terms of both quantity and quality regarding its psychiatric care provision system. Although community healthcare concepts are originally intended to ensure a medical care system that meets local conditions, they have not led to practical solutions to regional issues in psychiatry because the number of beds tends to be set at the current level, and because they are only administrative plans that respect the autonomy of medical institutions. The plan is being developed nationally and should enable each local government to resolve local issues by comparing its healthcare delivery system with those of other regions.

(2) Oversupply of chronic psychiatric beds

The challenge is that there is a nationwide oversupply of chronic care beds. In the background, the decline in the number of hospitalized patients is significantly impacting the healthcare system. For hospitals, maintaining numbers of patients leads to business stability, which tends to maintain the number of beds for chronic care. For patients, the structure of disability pensions and the reimbursement system for high-cost medical care makes it less costly to continue hospitalization, with a lighter burden of nursing care. This organization of the health care system may have contributed to prolonged hospitalization.

Considering the recent changes in the number of patients with psychiatric disorders mental illnesses and the state of patients suffering from these disorders, it is necessary to strengthen the system to transition to community care transition, such as conversion of hospital bed functions and strengthening of discharge support, in order to promote the shift to the community.

Issues of the Staff (Internal Aspects) in Charge of Psychiatric Care

It has been noted that **even in psychiatric emergency/acute care, staffing is significantly less than in other medical departments' healthcare systems**[lxii]. Not only physicians, but also nurses, mental health workers, and other staff are unevenly distributed across regions and understaffed. Considering the impact of the future decline in the working-age population and reforms in work styles, securing and training staff is likely to become a major issue in the medium to long term.

In addition, there is a current lack of coordination between department staff in internal medicine and psychiatric staff in terms of their respective care content and staff education. In the future, the departments face challenges in terms of both quantity and quality of staff, as the number of patients with psychiatric disorders complicated by or due to physical illnesses is increasing due to the declining birthrate and aging population. **It may become difficult to secure and train staff for psychiatry alone in the face of an overall shortage of healthcare professionals.**

Issues of the Effectiveness of Community Healthcare Concepts

(1) Conflicts of interest between hospitals and the community as a whole

It was pointed out in the report of the study group on the new community healthcare concept that the discussion on the number of hospital beds is the main focus of the concept, and that there is a lack of discussion on the achievement of the ideal future medical care delivery system for communities[lxiii]. When a new community healthcare concept is formulated, it is necessary to **discuss future goals and ensure feasibility**.

The reduction in the number of hospital beds is closely related to the decrease in each hospital's income and posts at hospitals. It has been pointed out that not only private hospitals but also general hospitals operated by municipalities, such as cities, towns, and villages, **prioritize the management of each hospital, and the community healthcare concepts formulated by local governments are not performing their functions**. The lack of transparency[lxiv] in the management responsibility of public hospitals has been pointed out as one of the reasons for this.

(2) Roles of municipalities in the formulation of community healthcare concepts

Community healthcare concepts are formulated by prefectures, and it has been observed that municipalities have not been able to effectively implement their information and expertise. In the current proposed amendment to the Medical Care Act, municipalities have been added as parties to be consulted and are expected to play a role in the process. As for the psychiatric field, the promotion of shift to the community has been raised, and the role expected of municipalities that have jurisdiction over residents' consultation practices regarding mental health, disability welfare services, and long-term care insurance services is considered to be noteworthy.

Recommendations

Gather and Develop Data on Which Psychiatric Care Resources Can Be Based and Strengthen Their Analysis and Application

(1) Evaluate the quality of healthcare and expand evaluation data from the patient's perspective

In developing the new community healthcare concept, it is necessary to organize data in a format that facilitates discussion based on data and indicators collected in existing medical plans, ReMHRAD, etc. In addition, the community healthcare plan as a whole has already indicated a direction to make outpatient and home healthcare a subject for discussion and data collection. In the field of psychiatry, it is necessary to collect new data on local medical and welfare resources, such as home healthcare, outpatient healthcare, and disability welfare services, as well as data on long-term care resources in light of the increase in the number of patients with mental illnesses complicated by physical illness to fortify the transition of psychiatric care to the community setting.

Although the purpose of healthcare plans and the community healthcare concept is to establish a system that efficiently provides high-quality and adequate medical care, the current situation is that quantitative indicators such as numbers of hospital beds are accentuated and **the evaluation of quality is left out of the discussion**. Based on the history and current state of psychiatric care in Japan, in which the human rights of patients has been neglected and the focus has been primarily on hospitalization (confinement), it is necessary not only to simply secure medical resources, but also to **ensure a healthcare delivery system that guarantees the quality of psychiatric care and the protection of patients' rights**. To evaluate the patient perspective and the quality of medical care it is essential to use existing evaluation items,

such as process evaluation items and periodic medical condition reports, which are under consideration in the 8th Medical Plan, and by **newly using patient-reported outcomes**, which have been attracting attention for their use in the psychiatric field in recent years, as well as the actual state of medical care provision.

(2) Promote supply-demand estimation based on dynamic methods and establishment of mechanisms to allow flexible manner to set targets for the number of hospital beds in the community healthcare concept, in accordance with community healthcare plans

Regarding the discussion of the number of beds needed based on collected data, in the field of psychiatry, the number of beds needed is expected to change with the transition from the static method based on the current state projection model that has been used until now, to an estimate of supply and demand that will have a significant impact on the future medical and long-term care delivery system. The latter is based on changes in disease structures, patient age, the progress of regional migration, changes in the public's perspective, and other factors. Although the community healthcare concept is discussed with the year 2040 in mind, it should be reviewed every six years, including the year 2030, when the community healthcare plan, medical fees, nursing care fees, and fees for disability welfare services are reviewed at the same time, without being overly focused on the goals set at the present time. In doing so, it is necessary to discuss the medical supply and demand in each region by taking into consideration the setting of healthcare zones based on the actual provision of psychiatric care, rather than being bound by the existing setting of healthcare zones for internal medicine.

(3) Reinforce the development of evidence-based datasets for the support of local government initiatives by the national government, and support for data usage and analysis

There are many aspects of the data maintenance and analysis that require specialized knowledge, and while reflecting the opinions of local governments and other relevant parties, it is necessary for the national government and academic institutions to collect data, maintain data sets, create a flexible system for viewing and comparing data, and provide support for resources and guidance for analytical methods.

Initiatives to support local governments are already underway through the "Regional Healthcare Delivery System Data Analysis Team Building Support Project" and other programs. However, there are many regions that are not making full use of the data, and the data should be developed because its range will become wider to include not only existing data but also outpatient and in-home data.

The development of data sets with necessary data on the quality of healthcare, evaluation of patients' viewpoints local medical, welfare, long-term care resources, etc., as well as reasonable and feasible data analysis based on the circumstances of each region, will facilitate discussions in each local government in formulating the new community healthcare concept.

(4) Reinforce information disclosure to patients, families, and the public

Although the text of the community healthcare concept and community healthcare plan are posted on the websites of local governments, it is difficult for patients, their families, and other interested parties and the public to fully understand their contents. In many cases, the medical records, treatment results, and quality indicators (QI) for each hospital, etc., which form the basis for planning, are not disclosed to the public. Since this information is important for patients and citizens living in the community to consider future medical visits, it should not only be used for internal hospital quality improvement efforts and planning, but it should also be made publicly available to patients and the public.

Reinforce Stakeholder Collaboration in Formulating the Community Healthcare Concept

(1) Reinforce participation by patients, families, and the public

Currently, medical experts and prefectural government officials play a central role in formulating community healthcare concepts. However, the new community healthcare concept should involve patients, their families, as well as other interested parties and the public, starting from the initial phases of policy formation, in order to create quality psychiatric care delivery system that will optimize the lives of patients and the public.

For example, it is necessary to establish a working group under the Community Healthcare Concept Coordinating Council at the level of practitioners related to mental illness and the patients and their families, and to promote discussions based on the perspectives of the interested parties. At this time, it should be mandated that at least one place in the committee should be reserved for patients, family members, and other interested parties, to create a system that can reflect the diverse current conditions and needs of mental illnesses and facilitate the expression of opinions by the interested parties.

(2) Promote participation in community healthcare concepts by clinics and other stakeholders related to outpatient and home healthcare

Until now, discussions on the community healthcare concepts have primarily centered on hospitals and inpatient clinics. The amendment of the Medical Care Act to provide for outpatient and home healthcare should be taken as an opportunity to encourage medical institutions such as clinics without beds to participate in the discussion.

(3) Clarify the roles and authority of municipalities

Municipalities are responsible for providing consultation services related to mental health in diverse settings, and they also have jurisdiction over disability welfare services and nursing insurance services. The amendment of the Act on Mental Health and Welfare for the Mentally Disabled has simply specified the role of municipalities as entities responsible for supporting persons with mental disabilities. A system needs to be created to administrate the development of municipal consultation support systems, housing and employment support, etc., and to provide the national budget and human resource support to underpin these systems. The proposed amendment to the Medical Care Act also specifies that municipalities are to participate in meetings to discuss community healthcare concepts, and there are high expectations for their active involvement in the future.

Many local governments are also the governing bodies of public hospitals, and as the operators and managers of medical institutions, they are likely to play an important role in community healthcare concepts. However, in the Medical Care Act, there are only a limited number of articles in which the subject is the municipality (mayor) in the description of community healthcare concepts and plans. Further and more thorough discussion is needed on the authority that municipalities and municipal mayors have and the roles they can play in community healthcare concepts.

Reform the Social Security System, Human Resource Development in the Community, etc. from a Perspective Beyond That of the Community Healthcare Concepts

(1) Promote discussion on the national healthcare and social security systems that are disincentives to discharge from hospital

Currently, transition of patients with mental illness to the community is underway, but there are still many patients who have difficulty transitioning to the community. This is as a result of the structure of the reimbursement system for high-cost medical care, which allows hospitalization to continue within the scope of disability pensions and other payments, but places a heavy financial burden on the patient and his/her family when he/she leaves the hospital, due to rent, living expenses, and other expenses. Another aspect is that hospitals also encourage long-term inpatients because they provide a stable source of income. It is necessary to promote an in-depth examination of the social security system and the psychiatric care delivery system from the patient's perspective, including the reimbursement system for high-cost medical care, disability pensions, and disability welfare services.

(2) Encourage discussion on independence of institutionalization, and shift to the community care as well as human resource development

In order to provide safe and quality psychiatric care, it is important to consider the internal aspects of psychiatric care such as the clinical staff not only the infrastructural aspects such as the number of beds. The staff engaged in psychiatric care, including physicians and nurses, regardless of their job titles, are all facing shortages and the need for future educational system development. Hospitals with ample human and organizational resources, such as university hospitals and large acute care hospitals, can secure resources for human resource development, while smaller hospitals face difficulties in that area. While demand for staff is expected to increase due to the declining birthrate and aging population, the number of medical staff in the workforce is expected to decrease and become scarce. Therefore, consideration should be given to the best way to transition from initialization to community-centered care so that, human resource development is left to each facility and to a region-based educational system utilizing regional medical cooperation promotion corporations and other such entities. That shift will contribute to the development of human resources across internal and psychiatric disciplines.

lii)   https://www.mhlw.go.jp/toukei/saikin/hw/kanja/20/index.html?utm_source=chatgpt.com
liii)   https://digitallibrary.un.org/record/3996275?v=pdf
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lxiv)   https://www.jbaudit.go.jp/koryu/study/mag/pdf/j36d05.pdf

3 Promote the Employment of Peer Supporters to Expand Community Consultation Support Systems

Background

Peer support (peer support worker) activities are essential to psychiatric care

Peer supporters have their own experiences with disabilities and illnesses, and they can use their experience to provide support for people with disabilities. Among these, "peer supporters who **intentionally support other interested parties as part of their work or activities** based on their own experiences" are called "peer support workers" and their employment is being promoted[lxv].

In Japan, peer support activities have become more prevalent as the shift from a "medical model" to a "lifestyle model" has progressed since the 1990s. The Community Life Support Program for People with Mental Disabilities (1996) and the Peer Supporter Project to Promote Discharge from Hospital (2003) were launched as model projects, and activities by interested parties as peer support workers have been systematized. Although peer support (e.g., counseling) among family members has been offered since the 1960s, it has not been integrated into the system, and is considered to be informal.

Peer supporters being trained by the Peer Support Specialist Training Organization, which provides educational opportunities, and by local governments

In FY2020, the "Peer Support Training Program for Persons with Disabilities" was established to train peer supporters, and for managers and others to learn how to consider and employ peer supporters. It became eligible for government subsidy through the subsidy for community life support projects. The Japan Mental Health Peer Support Specialist Training Organization works with various professionals to train peer support specialists for the mentally disabled who can assist in recovery. In addition, according to the report on the results of "Survey and Research on the Situation and Measures for the Participation of Persons with Disabilities in the Peer Support Training Program for Persons with Disabilities" of the 2023 Comprehensive Welfare Promotion Project for Persons with Disabilities by the Ministry of Health, Labour and Welfare[lxvi], **43.5% of local governments are implementing** peer support training programs for persons with disabilities as of 2023, while 26.6% of the local governments had not yet implemented the program but had a concrete implementation plan, and the other 29.7% had not yet implemented the program and had no concrete implementation plan. Training is divided into three categories: basic training, specialized training, and follow-up training. However, follow-up training is not included in the supplementary fee calculation requirements for business supplementary fees, so the number of cases in which this type of training has been conducted is low.

The revision of remuneration for welfare services for persons with disabilities established a supplementary fee for employing peer supporters

The 2021 revision of remuneration for welfare services for persons with disabilities newly established the "supplementary fee for peer support system" for consultation support services, etc. that are considered to be particularly effective in providing peer support to users by providing consultation and advice from the same perspective as the users, and **the "supplementary fee for implementation of peer support" for Type B continuous employment support**. In addition, the 2024 remuneration amendment also added a supplementary fee for the implementation of peer support for training-based services. The expanded remuneration system could be considered a catalyst to encourage employment at businesses.

Effects related to the employment of peer supporters are highly regarded by both employers and users

In the 2018 Comprehensive Welfare Promotion Project for Persons with Disabilities, "the Survey and Research on the Utilization of Human Resources for Peer Support by Each Type of Disability Welfare Service," a questionnaire survey of 36 businesses that employ peer supporters, found **high ratings for the following items: "I can feel close enough to talk to people who have the same experience," "I can pass on the wisdom of life that only those with experience have," and "Users' anxiety and loneliness are eliminated**[lxvii]**."** Regarding the effects hiring peer supporters has on other staff members at the same place of business, it has been reported that working with colleagues who are people with disabilities can have positive effects, such as increasing respect and understanding of people with disabilities. Based on these and other results, the previously mentioned supplementary fees were added in the 2021 amendment of remuneration for disability welfare services.

In addition, **60.8% of psychiatric institutions responded that the use of peer support workers is "desirable"** in the "Report on the Results of the Survey on the Current Status and Use of Peer Support in Psychiatric Institutions[lxviii]," confirming the need for such services in workplaces. The items for the 23 facilities that have hired peer support workers indicated that the expected positive impacts of hiring peer support workers included: "Promotes the patient's hope for future," "Experience-based advice attenuates the patient's difficulties and challenges," "More extensive information can be gathered about patients," and "They will give a better understanding of disability and recovery." Responses tended to be similar to those for the disability welfare service field.

Local governments for some municipalities are also implementing initiatives to hire peer supporters

Various forms of peer supporter employment have been implemented by local governments. For example, in Sendai City, the Disability Support Division of the Health and Welfare Bureau employs two peer staff members, who provide individual support and other services, in addition to the activities for increasing awareness in hospital wards. In addition, Arakawa Ward allows the assignment of peer support specialists for the mentally disabled in the commissioning of consultation support services. In Fukushima, Toyama, Chiba, and Osaka prefectures, peer support training graduates have been dispatched to hospitals, offices, family associations, and other groups within the prefectures to share their experiences and recovery stories. In addition, peer support workers are also expected to be employed as visiting support workers for the Inpatient Visiting Support Program newly established by the 2022 amendment to the Act on Mental Health and Welfare for the Mentally Disabled.

Municipalities are required to strengthen and improve consultation support systems due to the amendment of the Act on Mental Health and Welfare for the Mentally Disabled and other laws

The Act on Mental Health and Welfare for the Mentally Disabled was amended in 2022 and came into effect in April 2024. At that time, **municipal mental health consultation services (including persons with mental health issues as well as persons with mental disabilities) were changed to mandatory provision**. In its report[lxix], the Study Team on Promotion of the Consultation Support System for Mental Health in Municipalities organized the functions required for consultation support into five categories: "Acceptance," "Noticing," "Assessment," "Planning and Implementation," and "Collaboration and Coordination," and also categorized the systems required to fulfill these functions. The report also proposes developing a system to fulfill these functions, with reference to the above.

Status of the Peer Support Provision System and Issues Related to its Implementation

Only a few peer supporters are assigned to consultation support offices, etc., and the number of peer supporters who have obtained supplementary fees has remained low. According to the Ministry of Health, Labour and Welfare's report[lxx] on the implementation of consultation support business for people with disabilities for FY2022, there are 714 peer supporters assigned to 11,472 designated consultation support offices and designated consultation support offices for children with disabilities nationwide (including 235 persons with mental disabilities). As of December 2022 service provision, **only 1.2% of all planning consultation support offices have calculated supplementary fees for the peer support system**.

In the survey on the actual status of employment-related welfare services for persons with disabilities[lxxi] (2,000 cases were randomly selected), 17.2% of the labor transition support offices and 10.1% of all offices answered that they have "established a system to enable users to receive peer support."

Issues Related to the Use of Peer Supporters and the Medical Reimbursement System in Psychiatric Institutions

In hospitals, the percentage of peer supporters affiliated with psychiatric institutions remains low, at 7%. This has the problem that **placement in hospitals does not receive supplementary fee reimbursement and personnel costs cannot be obtained, so incentives do not work**. According to the "Report on the Results of the Survey on the Current Status and Use of Peer Support in Psychiatric Institutions[lxxii]," 7.0% of all psychiatric institutions have peer support workers. On the other hand, 60.8% of psychiatric institutions answered that the use of peer support workers is "desirable," confirming **the need for them in medical settings**. The same survey found that "**Improved training for peer support workers** (work etiquette, counseling and support techniques, precautions for working at medical institutions, etc.)" received the highest percentage, picked by 69.1% of the respondents, followed by **"Evaluation of medical fees for assigning peer support workers"** (61.5%) as matters necessary for the future use of peer support workers. Of the hospitals that were positive about the future use of the system, 72.3% indicated that evaluation of reimbursement was necessary. At present, there is no supplementary fee for employment of peer supporters at psychiatric institutions, and hospitals are voluntarily bearing the cost of employing them. This clearly impedes the employment of peer supporters.

Regional Disparities in Mental Health Consultation Systems in Municipalities and Issues Related to Securing Professional Human Resources

Municipalities are expected to strengthen and expand their support systems for mental health, but it has been **difficult to secure specialized personnel such as public health nurses and mental health professionals**, resulting in **regional disparities** in the status of system development.

Municipalities have been providing mental health consultation services as part of their various services to residents, but since they were obliged to make an effort, there was no legal support to improve the system, and the lack of financial resources and professional human resources resulted in large regional disparities in the consultation support system. In particular, among municipalities with populations of 10,000 to 50,000 and 50,000 to 100,000, more than half of the respondents indicated that they are able to provide some level of mental health counseling, but however, struggling to do so. Regarding the desired system for resolving service delivery difficulties, there is a strong demand for an expanded staffing structure, including the assignment of specialists, regardless of the municipality's population size. Although efforts are being made to strengthen the training and recruitment of public health nurses, mental health workers, and mental health welfare counselors, there are still many local governments that do not receive any applications even though they are recruiting[lxxiii].

Recommendations

Recommendations for Remuneration for Welfare Services for Persons with Disabilities, etc. and for Medical Treatment

(1) Expansion of supplementary fees for peer support systems and implementation at consultation support offices, etc.

The direction of expansion has already been taken with regard to the supplementary fee for the peer support system and the supplementary fee for the implementation of peer support. However, in order to promote further employment, the number of supplementary fee points should be augmented and an addition should be provided for the employment of more than one peer supporter.

(2) Reimbursement for the employment of peer supporters in psychiatric institutions

In order to promote the employment of peer supporters in hospitals, a supplementary fee for the peer support system should be evaluated and integrated into the framework of medical fee evaluation. Peer supporters are expected to serve as role models for patients in places such as day care and short-term care, and to provide advice and information based on their experience. In addition, further consideration should be given to the needs of interested parties working at psychiatric institutions from the perspective of protecting the rights of those parties.

Recommendations for Consultation Support Systems for Local Governments

(1) Promote peer supporters' employment in local governments as important "experienced professionals" who provide consultation support and human resource development

Municipalities and other local governments should promote the employment of peer supporters as "experienced professionals" in order to build a mental health consultation system. In particular, the strengths of peer supporters can be utilized in the "acceptance" and "noticing" aspects of consultation functions.

In addition, it is difficult for municipalities to secure specialized staff such as public health nurses and mental health workers, and due to personnel transfers, administrative staff with no knowledge of the field of mental health and welfare. In a questionnaire survey conducted on the occasion of the employment of peer supporter personnel in disability welfare services, the effects of peer supporter support on other staff members in the offices were found to include a greater respect and understanding of persons with disabilities, gained by working together with colleagues who are themselves persons with disabilities. Among the measures to develop human resources involved in consultation support in local governments, opportunities should be created to hire and collaborate with peer supporters.

Recommendations for Promoting the Employment of Peer Supporters (Establishment of Comfortable Working Environments and Reasonable Conditions)

It is advantageous to promote the employment of peer supporters as "experienced professionals" in the field of disability welfare services such as consultation support offices, in medical settings such as psychiatric institutions, and in public institutions such as municipalities. However, the following points should be taken into consideration when promoting employment, as they have been raised in past employment results.

(1) Clarification of the position and role of peer supporters as experienced professionals, their specific job descriptions, areas of responsibility, and career paths

(2) Assigning multiple peer supporters and holding liaison meetings between peer supporters in the community

(3) Introduction of flexible workstyles and appropriate remuneration for experienced professionals

(4) Development and implementation of in-office training to promote understanding between collaborating staff

lxv)   https://www.mhlw.go.jp/content/12200000/000963578.pdf
lxvi)   https://www.mhlw.go.jp/content/12200000/001319878.pdf
lxvii) https://www.mhlw.go.jp/content/12401000/000689218.pdf
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These policy recommendations are based on discussions at meetings HGPI held for this project and has been compiled in HGPI's capacity as an independent health policy think tank. It does not, in any capacity, represent the opinions of any participating expert, speaker, related party, or organization to which those parties are affiliated.

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