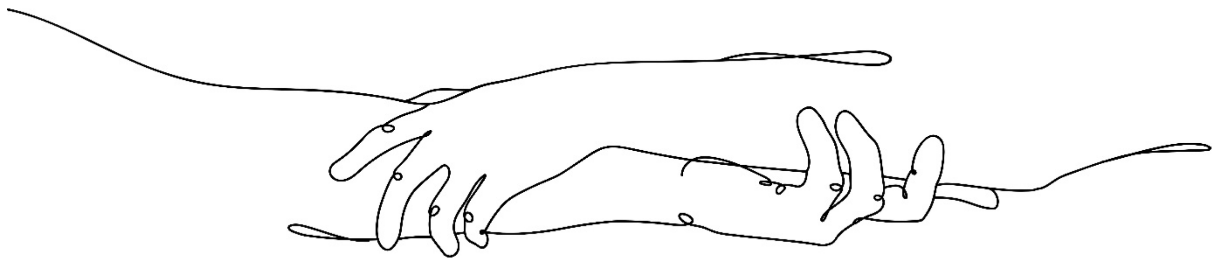
Lessons and Future Implications of Disaster Mental Health Support in Japan:

Reflecting on disaster responses in communities from 1995 through 2020



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Introduction

About HGPI's activities and this case study compilation

HGPI is an independent and non-profit health policy think tank established in 2004. The Institute is rare in Japan, and it has been working to help citizens shape health policy by generating policy options. HGPI's activities include health policy research, recommendations, and advocacy. Of these activities, the Mental Health Policy Project started in 2019, making it relatively new for HGPI. Aiming to improve the quality of life (QOL) of individuals with mental disorders, the project is endeavoring toward a revolution in mental health policy, which increases in importance day by day.

In Japan, the number of patients with mental disorders trends upward annually. A 2017 patient survey by the Japanese Ministry of Health, Labour and Welfare (MHLW) found that approximately 4.193 million people had mental disorders. More people are living with mental disorders than those suffering from the four major conventional diseases (cancer, stroke, acute myocardial infarction, and diabetes). In particular, the number of people receiving outpatient treatment has increased yearly, surpassing approximately 3.891 million in 2017. There are approximately 302,000 patients hospitalized with disorders, and this number has trended downward. Still, Japan's ratio of psychiatric care beds per population is the highest in the world. In fact, according to a 2022 hospital report, the most recent data on the average length of stay in psychiatric care beds has lengthened to 297 days, which is far longer than the average length of stay for general care beds, which is 17.4 days. Additionally, the causes of poor mental health and mental disorders are numerous. Up to today, widespread unease in society accompanying large-scale natural disasters, such as the Great Hanshin-Awaji Earthquake and the Great East Japan Earthquake, or pandemics like the Coronavirus Disease 2019 (COVID-19) pandemic, and socioeconomic factors such as employment-related stress or poor home environments that accompany worsening economic situations have been recognized as significant sources of mental disorders. Thus, efforts that surpass the field of health care and treat mental health as a concern facing all of society are needed. In recent years, the MHLW has focused on integrated community care systems that can respond to and include mental disorders and aims to enact a drastic reform of mental health and medical welfare support systems.

As mentioned above, mental health policy is not a temporary measure against specific conditions, but one constantly involved with our lives, requiring a seamless and multi-layered mental health care framework, a true "life course approach." Due to its many disasters, Japan must address the concern of disaster mental health when considering a life course approach to mental health policy. HGPI recognized that the momentum of discussions on disaster mental health needed to be reinvigorated ten years after the Great East Japan Earthquake and started this initiative on the topic. This compilation of case studies is prepared with some additions and corrections based on a survey of cases conducted by HGPI as part of the MHLW's FY2021 project to promote the comprehensive welfare of persons with disabilities: "Assessing the state of and examining future approaches to municipality mental health and medical welfare support systems when disaster strikes." Therefore, since the purpose of this case study compilation is to provide examples of mental health, medical, and welfare activities related to disaster cases in Japan and to make plans and responses related to disaster mental health and medical welfare in Japanese municipalities more concrete and effective, we have prepared this case study compilation with the participation of those who affected and incorporated their opinions in the hope that it will help those affected to prepare for future disasters.

For HGPI, which is dedicated to global activities, sharing the lessons learned in Japan with other countries is an important undertaking. By offering this compilation of case studies in several languages, including English, Chinese (traditional), Thai, and Ukrainian, we hope that Japan's lessons and efforts will reach a widespread civil society audience, including those affected by mental disorders in many countries around the world, and be used to shape future policies.

In the interest of space, we are unable to list every individual name. However, we appreciate all the experts who participated in this project and the administrative officers and various organizations that cooperated and assisted in this case study. HGPI would also like to express its deepest gratitude to Takeda Pharmaceutical Company Limited, which generously endorsed and supported the multilingualization of this case study collection.

The definition of "disaster" in this case study compilation

A disaster occurs when an event (hazard) damages day-to-day human environments. In addition to natural hazards such as earthquakes and tsunamis, hazards include hazards caused by humans such as nuclear disasters and pandemics such as COVID-19 and are diverse. Disasters cause two types of damage: the direct damage caused by the hazard and the ongoing damage caused by prolonged rebuilding of lives and by the mental and physical effects (Kim, Y., 2012).

Since disasters are characterized by the changing nature of the damage and response over time, no cross-sectional consensus has been reached in the support field on the term "disaster cycle," which describes this period (Tachikawa, et al., 2020). Its definition also depends on the scale of the hazard and damage (Urata et al., 2015). Therefore, in this compilation of case studies, the term "disaster" is defined as "an event in which a great many people face a crisis at the same time, which may include natural disasters, disasters caused by people, pandemics, and other such events." In addition, although this survey covers the medium to long term after disasters, it does not discuss them separately. It focuses on the period immediately after a disaster, roughly 72 hours afterward, and centers its assessment on responses to sustained damage.

1. Disasters and Health Crises in Japan

1) Features of Japanese disasters

Japan is an island nation located in the Asia Pacific, is roughly situated in the temperate zone, and has four distinctive seasons. Its four seasons are marked by severe downpours, especially typhoons and torrential rains. Due to its location on top of the oceanic and continental plates that form the Earth, there are many volcanoes, and the terrain is steep. Hence, its rivers are notably steep, and torrential rains frequently cause floods. Furthermore, due to its characteristic location, the country is prone to such naturally occurring disasters, so it has a long history of earthquakes and tsunami caused by them (Cabinet Office, 2006). In Japan, numerous factors threaten human health, ranging from major accidents attributed to human error, such as train accidents and nuclear power plant accidents, to pandemics of infectious diseases. Consequently, Japan is considered a disaster-prone country (Ministry of Land, Infrastructure, Transport and Tourism, 2022). Disasters are defined according to each of the events noted above (hazards) and the magnitude of their damage. In Japan, many measures and responses have been assessed and implemented in response to the magnitude of damage or crisis threatening human health.

2) A history of disaster response

In 1961, Japan, with its frequent disasters, enacted the Basic Act on Disaster Management to develop and promote comprehensive and deliberate disaster management in the wake of the Isewan Typhoon of 1959 (Cabinet Office, 2012). In the years that followed, volcanic eruptions, earthquakes, torrential rains, and other disasters resulted in loss of life and damage to homes and other property. In response to these disasters, Japan has enacted as many as 18 related laws on aspects of emergency preparedness, recovery and reconstruction, support for disaster victims, and a variety of other disaster measures (Cabinet Office, 2022). With the enactment of these laws, Japan has made preparations for disasters by building infrastructure, drawing agreements between corporations and municipalities, accumulating daily necessities, organizing disaster drills, providing insurance, and encouraging corporations to make social contributions and establish voluntary disaster prevention organizations (Cabinet Office, 2013).

Yet, despite the extensive efforts to prepare for disasters, they strike suddenly and without warning, surpassing all human expectations. Japan has repeatedly enacted legal and systemic reforms without forgetting the inconceivable damage. Its preparations for the next disaster are ever evolving, and its focus is on minimizing the damage.

3) Health crisis following a disaster

Disasters are only constituted after the above damage to people has occurred. Part of this damage is physical, resulting in direct harm to people's health, such as injuries and illnesses; part of it is mental, resulting in delayed reintegration into society and estrangement from close relatives. To prepare for such health crises, Japan has separated its bureaucratic jurisdiction into three levels: national, prefectural, and municipal. The implementation of emergency measures through disaster mitigation plans is mandated for each level, and prefectures and the designated cities are responsible for leading the implementation these measures (Cabinet Office, 2021). Within this framework, a large number of health care professionals and other health care support groups will provide support for the physical crisis in and outside the affected areas immediately after a disaster, occasionally for a long period, in cooperation with many other organizations (DMAT Secretariat, 2022; Tokyo Metropolitan Government, 2019; Japanese Nursing Association, 2021). For mental support, the disaster mitigation plan mentioned above includes mental health care for disaster victims in its itemized mental health measures, and organizations such as Disaster Psychiatric Assistance Teams (DPATs) actively provide professional support immediately after a disaster (DPAT Secretariat, 2022). However, the realities of mental support, such as collaboration between support organizations, the length of support needed, and the details of the actual support, are not clear (Tachikawa, et al., 2020). It has been reported that those providing disaster support also suffer from mental health crises stemming from disasters and their relief activities(Japanese Red Cross Society, 2004). Identifying the concerns and solutions for coping with mental health crises due to disasters, including those of supporters, is an urgent task to ensure long-term disaster relief.

(Kai Shigeno, HGPI)

2. Survey to Evaluate Mental Health Support in the Medium to Long Term Following a Disaster

1) Overview of survey results

To prepare this case study compilation, we conducted a questionnaire and interview survey of municipalities in Japan about their medium- to long-term post-disaster mental health and medical welfare systems. Additionally, HGPI held four multi-stakeholder discussions and meetings with industrial, governmental, academic, and private sector stakeholders, especially those involved with the issues of disasters and mental health.

◆ Major findings of the questionnaire
- Time: Wednesday, September 8, 2021–Friday, November 12, 2021
- Subjects: 67 locations (departments for mental health in all 47 prefectures and 20 designated cities)
- Response rate: 65.6% (prefectures: 72.3%, designated cities: 50.0%)

◆ Major findings of the interview survey
- Time: November 2021–December 2021
- Subjects: Departments for mental health in prefectures and designated cities and eight organizations including experts who provided mental health support when disaster struck at facilities that conduct mental health and welfare activities when disaster strikes

Prefectural and designated municipal governments are mainly responsible for providing medium- to long-term support for disaster-stricken areas by deciding frameworks for supporting disaster victims, holding training sessions for municipal government officials, and visiting municipal governments to conduct investigations to assess post-disaster support needs and provide logistical support. At the same time, municipal governments are responsible for providing direct support to disaster victims, such as providing constant support to high-risk individuals and organizing events related to health, and cases were identified where municipal governments collaborated with NPOs in these activities.

Thirty-nine percent of the subjects from the questionnaire responded that they had prepared plans and manuals for disaster mental health measures assuming responses over the medium to long term. This revealed that the manuals in use are related to health and hygiene activities and mental health care. Of the municipalities that had prepared plans and manuals, 32% used them in their mental health responses to disasters, and about 80% of the municipalities that had prepared them actually employed them. More than 90% of the efforts related to disaster mental health that were not mentioned in municipal manuals or other documents were initiatives related to COVID-19. Telephone consultation was the most common initiative, accounting for about 70% of COVID-19 efforts. With respect to cooperation with each basic municipality, we found that most municipalities reviewed their systems at regular meetings to assess their disaster responses and countermeasures.

From the interview survey, we found that the concerns that surfaced as part of overall subsistence support in the medium to long term after disasters, and measures against depression, alcohol dependence, and suicide, were the same as during non-emergency periods. After the 2016 Kumamoto Earthquake, the above-mentioned high-risk individuals identified by municipalities were connected to integrated community support centers and welfare commissioners from the outset to support the smooth transition from the disaster back to ordinary life. However, the share of community support taken on by integrated community support centers and welfare commissioners was increased gradually rather than delegating everything to them. A few weeks after the disaster, municipalities conducted disaster support work (needs assessment, individual support, and group support), mental health care centers[1] with many professionals supported the municipalities, and prefectural mental health centers provided backup overall. Furthermore,

[1] A mental health care center is a core facility that has various functions related to mental health care, such as research, training, consultation, and treatment related to mental health when disaster strikes, and is funded by the government after a major disaster occurs (The Hyogo Institute for Traumatic Stress, 2004).

it was suggested that small municipalities should incorporate how they will accept outside support when disaster strikes into their plans to ensure efficient mental health support.

Subsequently, documented cases of medium- to long-term, post-disaster mental health and medical welfare activities of prefectures, designated cities, municipalities with populations between 30,000 and 60,000, and NPOs, obtained through the questionnaire and interview survey, were classified into six categories based on the content matrix that contributes to Kim et al.'s comprehensive guidelines for mental health and medical activities when disaster strikes (2017), as shown below. In this survey's findings, cases that could not be classified into the six categories were classified under "other cases." The voices of the respondents are also a feature of this case study compilation, so they are included in a separate section.

2) Content Matrix-based Classification in Compliance with the Comprehensive Disaster Mental Health Activity Guidelines

① System and Principles

(Summary)

- ◆ Forty-one percent of the municipalities had plans to establish new mental health counseling services and announce them to the public in the event of a disaster.
- ◆ Drawing on past disaster responses, municipalities endeavored to assign organizations to be in charge of the support recipients.
- ◆ Municipal public health nurses took on the primary responsibility for providing health support to disaster victims.
- ◆ Municipalities must decide on systems for accepting support and standards to follow when withdrawing from disaster-stricken areas.
- ◆ In the medium- to long-term post-disaster, it is easier to continue part of the individual mental health support as a part of community health rather than mental health support in response to a disaster.
- ◆ It is preferable to strengthen existing centers' functions rather than establish new mental health support organizations. Planning from start to closure for temporarily established organizations is important.

(Philosophy and principles toward mental health when disaster strikes)

Few respondents felt that mental health support was highly prioritized. Of these, we found that there were many latent mental health problems in the community before a disaster that became apparent after the disaster. Accordingly, there were efforts to raise the priority level of responding to these problems, using the disaster as an opportunity. Drawing on past disaster responses, municipalities also endeavored to assign organizations to be in charge of the support recipients. Several experts pointed out the value of treating disaster response as an extension of normal work. Since municipalities have periodic transfers of employees, it was suggested that personnel who learned about disaster response in one department might contribute to raising the awareness of disaster response across departments following their transfer to a different department.

The 2011 Great East Japan Earthquake

- It would be best to address and implement measures for mental health issues in the community during non-emergency periods. Doing so will enable the allocation of personnel to support mental health immediately after a disaster, conduct health surveys, identify high-risk individuals, and grasp the situation when disaster strikes as an extension of routine public health activities. During the medium- to long-term transition, it was perceived that the mental health of the residents varied depending on how much of the pooled personnel could be retained.
- Municipalities did not assign a high priority to their mental health responses. Recently, suicide prevention measures have become increasingly linked to mental health concerns, and we would like to take this opportunity to have the priority of this concern raised.
- The number of people who will need support when disaster strikes varies by how much effort the

municipalities put into health problems during non-emergency periods.

The torrential rains that hit the Kanto and Tohoku regions in September 2015

- We feel that mental health is not given much attention in disaster mitigation plans. It takes time to change governments from within. So, it is more efficient to bring in a support organization. Therefore, municipalities must decide on systems for accepting assistance and criteria for leaving the area. Also, since different municipalities have different departments in charge of mental health, we feel that it is necessary for them to communicate their chains of command to the outside.

The 2016 Kumamoto Earthquake

- As the facilities set up when disaster strikes will eventually close, we believe it is necessary to connect those who need long-term support to existing organizations. Even for assigned temporary housing[2], opportunities for supporters to interact with each other were provided several times a year at each ward office. However, since the participants tend to be fixed, individual support is also necessary.

Torrential rains of July 2020

- While external support and the director of the disaster response department took the lead up to the population approach, the subsequent long-term support for high-risk individuals was handled by existing welfare organizations.

–Advice from our panel of experts–

In the medium to long term after a disaster, latent mental health problems that were triggered by the disaster become apparent, such as domestic violence and neglect, social withdrawal and trauma. Since these concerns will become the standard focus of support in the community in the future because these concerns are everyday problems, an everyday support system is needed instead of a disaster team.

Given the regular transfer of responsible officials that are characteristic of municipalities, it is unlikely that a single person in charge of disaster response for mental health and medical welfare in municipalities will be able to continue to perform these responsibilities. Yet, the training and experience of the responsible official might lead to inter-departmental cooperation after the transfer. Considering that it is desirable not only to promote disaster countermeasures in various departments but also to improve the knowledge, skills, and readiness of the entire municipality related to the community disaster countermeasures in collaboration with departments, continuing education is an effective practice.

(Operations of mental health care centers)

Here we discuss the establishment of dedicated organizations (mental health care centers) based on temporary appropriations by the Japanese government in the event of a disaster. In many cases, such activities begin about a year after the disaster. Moreover, since staff members are hired from outside before they enter the stricken area, they will first have to establish a relationship of trust with local support organizations. Then, their activities will take two to three years to gain traction. On the other hand, even after the program gets off the ground, the window of activity may be shorted if the Japanese government does not sustain its budget. Hence, it is better to enhance the functions of existing centers than to establish new ones. Even so, if new centers are to be established, plans up to their closure are necessary.

The 1995 Great Hanshin-Awaji Earthquake

- The staff members of the mental health care center entered the stricken area after being hired from outside. Therefore, the first step was establishing smooth relationships within the local support system.
- The activities of mental health care centers vary from disaster to disaster, and their roles must be considered and put into practice when they are established.

[2]There are two types of emergency temporary housing following a disaster: Built temporary housing (prefabricated temporary housing) and emergency rental housing (assigned temporary housing). Prefabricated temporary housing is mainly built on vacant lots during emergencies following a disaster, and it resembles a village when completed. On the other hand, assigned temporary housing involves a system in which a government agency rents an existing vacant apartment and provides it to a disaster victim [Miyagi Prefectural Government, 2021].

The 2004 Niigata-ken Chuetsu Earthquake

- The mental health care center took two to three years to get off the ground. It was tasked with conducting training for local public health nurses and municipal public health nurses to encourage and empower them in the field and raising awareness on suicide prevention and depression management for the public. After the midterm, the center held case conferences with municipal public health nurses and provided advice.

The 2011 Great East Japan Earthquake

- When the mental health care center was established, it had difficulty hiring professionals, even though it tried to hire workers through universities, training institutes, and other means. It is better to assume that there is no prospect of an increase in the number of workers immediately after a disaster.
- It was good that the mental health care center took on the work to support the disaster victims for a considerable period of time and that there were many specialists such as psychiatric social workers and public health nurses. Branch offices of the mental health care center were established in municipalities; hence, they were asked to be intermediaries between the municipalities and the public health centers.
- By conducting the health survey with the mental health care center, another benefit was that they could understand the kind with which they were entrusted.
- The prefectural governments and the municipalities have been working on the succession of responsibilities over the next five years until the mental health care center closes since the work of the mental health care center has differed from region to region. The prefectural governments also supported public health nurses in their respective regions as managers. They discussed which projects to consolidate and which to retain while considering their personnel needs.

Torrential rains of July 2020

- When it was difficult to determine the cause of a medical issue, the prefectural governments asked mental health care centers to visit the patients and received advice from them.

–Advice from our panel of experts–
It is better to enhance existing mental health care centers than to establish new ones. Even so, if new centers are to be established, plans up to their closure are necessary.

(Typical work and work resulting from disasters)

Forty-one percent of the municipalities had plans to establish new mental health counseling services and announce them to the public in the event of a disaster. The timing of their establishment and the start and the end of their operations were decided according to the damage to and needs of the affected areas. Also, through our interview survey, we obtained details about additional work related to establishing mental health care centers and the usual work that continues even when disaster strikes.

The 2004 Niigata-ken Chuetsu Earthquake

- After the 2004 earthquake, municipal public health nurses provided health support in evacuation shelters and temporary housing.
- In the medium to long term after the disaster, issues such as depression, alcohol dependence, and suicide prevention become increasingly common as a part of overall subsistence support. Consequently, care is commercialized in the community based on mental health support rather than provided based on disaster victims' support.
- Managing the reception of outside support was one type of work arising from the disaster. However, since the outside support withdrew after a few months, normal training could be resumed afterward. However, since work to manage the support groups started immediately after the disaster, all work that was not specified by law had to be suspended.

The 2016 Kumamoto Earthquake

- The staff of the municipal hospital that had been inoperative following the disaster were asked to

become temporary workers, and community support centers[3] were set up in each ward office.

- With delays in rebuilding the lives of disaster victims and the extension of their stays in temporary housing, the community support centers needed to continue to provide meticulous support to help the victims rebuild their lives. During this period, there were subsidies from the Japanese government, and the duration of the support was optimal.

(Response to the pandemic)
The COVID-19 pandemic, which has been spreading globally since 2020, restricted the flow of people, resulting in a shortage of personnel to respond to support for the torrential rains that occurred during the same period. Municipal officials who responded to the disaster and the pandemic at the same time were aware that the origin of the pandemic was unclear, that it was difficult to allocate resources, and that delays in recovery and reconstruction from disasters harmed mental health.

Torrential rains of July 2020

- Despite restrictions due to the COVID-19 pandemic on the dispatch of municipal public health nurses, which limited them to those who lived in the prefecture, it is believed that there were enough of them to respond adequately to the demand for their services. Yet, we also heard that the number of individual volunteers was limited to those living in the prefecture. So, residents were apparently frustrated by the lack of workers to clean up their damaged houses.
- Because support from family members and from people outside was limited due to the COVID-19 pandemic, some suffered from insomnia, and others were affected by physical symptoms such as elevated blood pressure.

② Psychological Reactions and Treating High-Risk Individuals

(Summary)

◆ Municipalities are planning to implement disaster support for people who require it during an evacuation, such as the elderly or persons with disabilities.

◆ Elderly people not covered by the Long-Term Care Insurance Act and those dependent on alcohol are more likely to be isolated and less likely to get support, which requires supporters to be responsive.

◆ It is necessary to consider the impact of disasters on minority groups such as women and those who identify as LGBTQ.

(Response for individuals)
Although few in number, some municipalities had plans to respond not only to people identified as requiring support during evacuation (during disasters), such as elderly people and persons with disabilities but also had plans to provide support to residents depending on the conditions of the disaster and their needs. While alcohol dependence and social withdrawal often become apparent in the medium to long term after a disaster, people with these conditions tend to be overlooked in the community because they rarely go outside. It was also clear that such concerns are likely to be lasting and that partnerships with existing organizations are crucial.

The 1995 Great Hanshin-Awaji Earthquake

- Among the disaster victims of the Great Hanshin-Awaji Earthquake, many developed post-traumatic stress disorder (PTSD) and required treatment after experiencing flashbacks of firsthand experiences while watching the extensive media coverage of the Great East Japan Earthquake. Their supporters should be aware that even disaster victims who have managed to cope with the issues related to the disaster they suffered from might still be affected by other factors.

The 2011 Great East Japan Earthquake

[3] A community support center is a type of welfare facility created after the 2016 Kumamoto Earthquake. They provide comprehensive support for disaster victims to lead normal lives with peace of mind, such as watching over them and supporting their health and livelihoods, as well as facilitating communal exchange (Kumamoto Prefectural Government, 2022).

- Among unstable people whose families or support groups sought counsel or those who were originally supported by the health centers, there was a range of cases, such as those not in treatment, in treatment, persons with developmental disorders, social withdrawal, and alcohol dependence. There were no cases of those with trauma or PTSD severe enough to be referred to a hospital.
- One of the ways to support people with alcohol dependence is to wait until there is an opportunity to admit them to a hospital if their behavior is not risky. It is also necessary to take an overall view of the life of the person being supported and wait for the right time for the person to make a change.
- In temporary housing, people dependent on alcohol may easily be seen as a nuisance. Supporters should have the responsiveness to collect information on the hardships of the victim's life in advance and make a referral to a suitable institution.
- Elderly people who have not used services under the Long-Term Care Insurance Act, those dependent on alcohol, those who discontinue treatment, and those uninterested in others are more likely to be isolated and less likely to get support. Social withdrawal is often triggered by school refusal during adolescence or entering the workforce. Such individuals tend to be isolated and, therefore, require assistance during disasters.
- In the early stages of dementia, many families cannot accept their relative's dementia and try to care for their loved ones by themselves. Therefore, they do not receive institutional support, and during disasters, they are more likely to be left out of the support framework. In addition, there were cases in which people with mild dementia were not included in the support framework, and they were unable to stay in the evacuation centers due to changes in their surroundings and abruptly vanished.

The 2016 Kumamoto Earthquake

- It is important to listen carefully to the people who feel left behind, and if they are elderly people, connect them to the local comprehensive support center, nursing support services, welfare commissioners, etc. In any case, they should be connected to the community as much as possible rather than being overseen solely by the disaster response staff.

Torrential rains of July 2020

- When visited, some residents said they "felt down" and "wanted to talk to others" due to the sense of sadness and economic uncertainty caused by their uncertainty about the future due to the disaster.

–Advice from our panel of experts–

When providing mental health support, consideration should be given to the fact that disasters affect women, LGBTQ people, and others differently. On the other hand, most municipal officials who consider these support measures are men, making it difficult for them to notice this point. The Gender Equality Bureau of the Cabinet Office has been working on gender-equal community planning and disaster prevention planning from non-emergency periods, as well as indicating points to consider for each stage of a disaster.

③ Assessment

(Summary)
- Forty-one percent of municipalities were making plans to raise awareness among citizens regarding mental health support in the medium to long term following a disaster, which included mental health care and health consultation services for citizens affected by disasters.
- Fifty percent of municipalities were planning outreach activities to provide medium- to long-term disaster mental health support to citizens.
- The implementation of health surveys at evacuation centers was split between public health nurses from the disaster-stricken areas and public health nurses who came from other areas to lend their support.
- In the medium to long term after a disaster, the concerns faced by disaster victims change over time, and their living arrangements also affect their mental health. Some people feel left behind, seclude themselves, or have depressive tendencies due to delays in rebuilding their lives. They also have difficulty sharing their life experiences during the disaster because their communities are scattered.

(Response for groups)
Forty-one percent of municipalities said they were planning activities to raise awareness of medium- to long-term disaster mental health support for citizens. The activities included mental care and health counseling services for disaster victims and publicizing and announcing the consultation desk for them. Health centers and other organizations that had been engaged in work related to suicide and depression during non-emergency periods carried out these activities. Fifty percent of municipalities were planning outreach activities to provide medium- to long-term disaster mental health support. The activities included consultation support, investigation of mental health concerns, and providing support. Also, professionals (such as public health nurses and psychiatric social workers) who were engaged in mental health activities for residents during non-emergency periods were the driving force behind these activities to raise awareness. Municipalities that experienced a disaster conducted mail surveys and door-to-door visits at each evacuation site (elementary schools, homes, temporary housing, etc.) to uncover the conditions faced by the disaster victims. In all cases, disaster victims tended not to actively participate in surveys concerning mental health support, indicating the importance of support from behind the scenes, such as conducting surveys on mental health in conjunction with other health surveys or working during community gatherings.

The torrential rains that hit the Kanto and Tohoku regions in September 2015
- At the suggestion of a university, support was provided immediately after the disaster. During medical examinations, psychiatric social workers, public health nurses, and university students asked disaster victims about their general day-to-day troubles using a checklist. At the same time, the municipal governments conducted PTSD checks and had officials accompanied by public health nurses visit those with high scores later.
- Municipal governments mailed a checklist questionnaire to home evacuees regarding their general living difficulties. Counselors visited those who requested a visit in their questionnaire and asked about mental health issues and other everyday troubles.
- The work did not take long. This may have been because the needs assessment was conducted by mail and questionnaire during the mental health support process. However, many more details about mental health could be heard if direct discussions, such as visits, had been arranged.
- The prefectures' consultation services activities included physically moving to evacuation centers and visiting bathing facilities to counsel residents. Since residents would go to government offices to complain about money, guarantees, dissatisfaction, etc., it was effective to go out to residents and counsel them about their mental health.

The 2016 Kumamoto Earthquake
- Municipal public health nurses and public health nurses from all over Japan divided their time between designated evacuation centers and welfare evacuation centers as they conducted interviews.
- Disaster victims began to move into temporary housing and assigned temporary housing two months

after the disaster. Together with the staff of the community support center, all 12,000 people living in temporary housing, assigned temporary housing, and public housing were visited door-to-door.

- In assigned temporary housing, because disaster victims are dispersed, it is difficult for them to share their many thoughts and feelings, and there remains a subjective discomfort toward living in such housing. The questionnaires' findings show that many respondents were more stressed than those who lived in prefabricated housing, and many suffered from mental health symptoms. Although disaster victims can move in assigned temporary housing quickly and at a low cost to municipalities, they are scattered and dispersed, making it difficult to build communities and receive support from volunteer groups.
- The content of the door-to-door visits was to inquire about family composition, the condition of affected houses, income status, prospects for rebuilding their lives and future housing needs, and the status of applications for relief funds while asking about health conditions (insomnia, depression, anxiety symptoms, history of illness or treatment, whether the respondents had any disabilities, etc.) and mental health troubles. With each visit, respondents' attitudes were monitored for any changes. Persons with disabilities and the elderly were visited regularly during this process. Hospital staff entered the area and provided expert advice on mental and physical health. However, it took two years before all the residents could move into temporary housing because the homes in the region were old, many homes were damaged by the earthquake, and many of the residents were elderly. As a result, door-to-door visits were time-consuming and took many trips, and if the respondents were unavailable, diligent efforts were made to mail the survey forms and make phone calls. Thanks to these efforts, the survey coverage rate was almost 100%.
- In 2017 and 2018, the prefectural government conducted a mind and body health survey. K6 was surveyed, and nurses from the community support centers in each area followed up with those for whom the need for support was identified because of the survey.
- Over time, whether six months or two years, the attributes of disaster victims change, as do the concerns they face. After one year of living in temporary housing, differences began to emerge between those who can rebuild their homes smoothly and those who cannot. Some people felt left behind, secluded themselves, and felt depressed, while others experienced a gradual decline in their physical condition. The feeling of being left behind was observed among those in both assigned temporary housing and prefabricated temporary housing. Residents of the prefabricated temporary housing were living in groups and watching those who had rebuilt their homes move out one after another, leaving those who had not yet rebuilt feeling restless, leading to isolation. Since such information is difficult for those who live in assigned housing to obtain, it is likely that they experience such feelings more easily on a regular basis.

Torrential rains of July 2020

- At evacuation centers, health surveys were conducted based on a questionnaire prepared by the prefectural government, and health observations were conducted at night by disaster support nurses. Outside support teams made rounds and monitored the progress of those who needed follow-up and connected them to professional organizations when necessary. The DPAT's arrival also brought to light problems that had been latent, such as seclusion and difficulties in interpersonal relationships, and it identified people suspected of being suicidal.
- Three weeks after the disaster, apart from the door-to-door visits, a mental health questionnaire was mailed in cooperation with prefectural mental health and welfare centers to identify those who required special attention.
- After the evacuation centers were closed, the city conducted door-to-door visits and observed changes. Those with emotional stress due to the loss of a family member or families receiving disaster victims who were complaining of stress were connected to the mental health care team.

④ Risk Communication

(Summary)
- After the disaster, existing committees that were convened by public health centers during non-emergency periods were adapted to form disaster countermeasure committees and included parties like professors of psychiatry from universities, chairpersons of psychiatric hospital associations, professional associations, psychiatric social workers, clinical psychologists, and representatives from major health care institutions in the prefecture.
- During non-emergency periods, it is desirable that opportunities for multiple organizations and professionals to meet are used to consider and plan in advance administrative structures and other topics related to mental health support from immediately after a disaster through the medium to long term.

The 2004 Niigata-ken Chuetsu Earthquake
- Committees established in the wake of torrential rains that occurred several months earlier were the foundation upon which the mental health care countermeasure committee was built. It was attended by professors of psychiatry from universities, chairpersons of psychiatric hospital associations, professional associations, psychiatric social workers, clinical psychologists, representatives from major health care institutions in the prefecture such as directors of core national and public hospitals, and the heads of professional organizations. Meetings were held once every three months during the first year and once or twice a year thereafter, with occasional visits by doctors from the National Center of Neurology and Psychiatry and the Hyogo Institute for Traumatic Stress to meetings, the prefectural government, and the affected areas to offer advice. At the meetings, since the participants were mainly leaders of their respective organizations, the main focus was on the direction of support and consensus building while the specifics were resolved at the field level.

The 2011 Great East Japan Earthquake
- In FY2008, municipal guidelines were prepared in anticipation of an offshore earthquake. Later, in response to the Great East Japan Earthquake, mental health action guidelines were created in FY2014 as internal guidelines, with the goal of improving the mental health of the public and preventing or minimizing the impediments to everyday life caused by the stress of the disaster among all those affected by it. At the time of its creation, it was set to be evaluated every three years, with 2019 as the end year. However, given circumstances in which disaster victims' recovery was not progressing as well as originally envisioned, an additional five-year guideline (continued guideline) was created to ensure that support would continue in the future. In addition to the basic municipalities, the mental health and welfare center, its branch offices, children's affairs sections, recovery support sections, and health promotion sections participated in the discussion of the action guidelines.
- Immediately after the disaster, all staff members stopped thinking. At that time, a physician who was also the center of psychiatric care in the community took the initiative and brought up the idea of holding meetings for medical support, mental health, and mental health support with the prefectural government, psychiatric institutions, and public administrative agencies. In the first three months, the meeting was held at least once a week. The main topic of discussion was how to direct outside support teams that come in as disaster relief and share information. As it became clear that the needs on the ground were different in each community, specific instructions could be given to each team. During a disaster, it is not sufficient for a municipality to provide mental health support to its residents with its existing workforce alone. In these communities, it was good that mental health care centers were set up at an early stage and that work could be divided among them.

The torrential rains that hit the Kanto and Tohoku regions in September 2015
- Public health centers had presided over community health and mental health gatherings during non-emergency periods, and during disasters, these gatherings were dedicated to disaster support.

–Advice from our panel of experts–
It is desirable that information sharing regarding medium- and long-term mental health support in disasters be planned from non-emergency times by leveraging opportunities to gather multiple organizations and professionals in each municipality, such as psychiatric emergency system coordination committees, to consider an operational structure for promoting mental health support from immediately after a disaster through the medium and long term.

⑤ **Preparation and Training**

(Summary)
- ◆ Seventy-three percent of municipalities were implementing or planning to implement education and training programs for mental health supporters.
- ◆ The parties at the frontline of disaster mental health support are municipal public health nurses, so plans that are focused on the activities of municipal public health nurses are necessary.
- ◆ The cumulative knowledge regarding the medium- to long-term disaster period in shared stories and experiences from people who have experienced disasters is useful.
- ◆ It is important for municipalities to take the lead in efforts to foster connections among residents during non-emergency periods to encourage them to help each other in the event of a disaster.

Seventy-three percent of municipalities were implementing or are planning to implement education and training programs for supporters who provide mental health support to citizens. The target audience for the training included not only health and medical welfare professionals but also general administrative officers, public safety personnel such as police and firefighters, staff who work with students and children, and other professionals who may actually contribute support to targets. The content of the training was related to supporting the mental health of residents and improving the knowledge and skills of staff and others involved in mental health and welfare administration, as well as DPAT training. In addition, 41% of the municipalities planned to provide assistance to the mental health of the supporters, which included interviews with municipal staff, stress checks and assistance for the supporters by the DPATs, and training on mental health for the supporters. In addition to education and training, we confirmed that municipalities that have experienced the disaster have prefectural officials visit municipalities and public health centers to provide direct project support and supervision of cases. It was shown that prefectural officials' firsthand experience with the problems in their regions would lead to the effective planning of training programs. As for their concerns, some respondents indicated that there was insufficient transfer and accumulation of knowledge and experience, as evidenced by the periodic reassignment of municipal officials involved in mental health support and the periodic addition of fresh staff members at NPOs and NGOs.
In addition, some commented that sharing stories and experiences from people who have experienced disasters was useful for accumulating knowledge regarding the medium- to long-term period after disasters.

The 2004 Niigata-ken Chuetsu Earthquake
- The first line of mental health is municipal public health nurses, and it is practical to develop a plan that assumes municipal public health nurses protect the mental health of the community.

The 2011 Great East Japan Earthquake
- We felt that a wide-ranging committee including health and welfare organizations is necessary, but it is impractical to set up a new committee in the event of a disaster, and it would be good if a committee on mental health and welfare during non-emergency periods could be utilized.
- Municipal mental health and welfare centers preside over the workshops for post-disaster mental health care workers. The workshop is held every other month on a fixed day of week for employees of the ward health and welfare centers. Through lectures and case studies, participants gain expertise in supporting disaster victims, assessment, policy making, and so on. One meaningful

aspect of the training is not only to improve skills and prevent them from deteriorating but also to create connections among temporarily assigned staff members so that they do not become isolated in their respective wards. We feel that this may be one of the reasons why few officials quit immediately. In order to prevent support for disaster victims from becoming too routine, we feel it is important to carefully examine the content of the training and clarify the points to be conveyed. Professionals are spearheading planning, such as public health nurses and psychologists (e.g., those still engaged in support activities). The training is designed with content that considers the situation on the ground and trends in the national and prefectural governments.

- Disaster mental health training is held once a year to improve the ability of welfare staff to provide support to disaster victims. Its content includes lectures on the latest trends in support for disaster victims and group work activities.
- Though separate from mental health support, we feel that training is needed to improve the caliber of each and every municipal official who is a supporter. Besides mental disorders that can be labeled, the content should also incorporate knowledge of the preceding stages, such as suspected plans for suicide, households with multiple problems, alcohol abuse, and social withdrawal. It is particularly necessary for public health nurses to receive such training, regardless of the department they oversee. It is desirable for public health nurses in municipalities to improve their level of skills and expertise, which will lead to training for the entire agency, will have ripple effects such as raising awareness among residents, and will enable them to respond to disaster victims within their own communities.
- Municipal officials are beginning to work on developing basic psychological responses such as psychological first aid (PFA)[4], including care for those with unidentified illnesses and simple psychological education.
- It is important for the mental health care of supporters who are also disaster victims for them to leave the disaster area for a time at an early stage. Receiving training in an outside program will help them recognize their positions as supporters objectively. However, existing support programs for those with mental disorders are designed for people with severe conditions in the U.S. and Europe and are different from disaster mental health programs. We feel that it is necessary to create a new program.

The torrential rains that hit the Kanto and Tohoku regions in September 2015

- Normal operations of the social welfare divisions were halted because the evacuation centers that opened as a result of the disaster were managed solely by their staff. Currently, the plan calls for the entire government to be involved in the operation, and the subsequent opening of evacuation centers due to a later typhoon did not halt the operations of the social welfare sections.

The 2016 Kumamoto Earthquake

- Supporters were dispatched during the torrential rains in July 2018. They had a stockpile of manuals and materials needed for raising awareness because of their experience during the previous disaster. The department in charge had trained to be ready immediately at the time of dispatch.
- Staff were dispatched to a neighboring city during the September 2020 torrential rains. The dispatched staff had received training in PFA and Skills for Psychological Recovery (SPR). The neighboring city remarked that their support was good. When staff were dispatched, they offered to bring pamphlets that could be used for mental health care, so they took the pamphlets with them.

Torrential rains of July 2020

- Schools in the city asked for counsel about students who were unable to attend school after the disaster, had guardians who were indifferent, and did not come in for counsel themselves because they were minors. They received support. The public health nurse from a welfare division who was in charge of the case and the school principal regularly collaborated to provide support to the families, which led to the support provided at that time.
- Since outside support at the time of the disaster in question was basically self-contained, the

[4] Psychological first aid (PFA) is intended to help supporters understand the answers to questions of how to talk to disaster victims and victims of crimes and what to look out for when interacting with them. Several systems of PFA have been developed around the world, but the most widely employed system was mainly developed by the WHO [National Information Center of Stress and Disaster Mental Health, 2012].

municipal government only secured a meeting room that also served as a break room. The neighboring city that had experienced the disaster brought leaflets to raise public awareness, consumables, first aid supplies, etc.

- To address their exhaustion, staff consulted physicians at the prefectural mental health and welfare center, DPATs, and the mental health care center.

–Advice from our panel of experts–
It is desirable to conduct training for all those who will directly provide support to disaster victims and to include in the plan how to utilize basic municipalities, NPOs, NGOs, and other organizations to increase the strength of the community's disaster response. In addition, one way to utilize community labor is to enhance the utilization of welfare professionals, as doing so has not yet become law. For example, it should be possible to educate and prepare welfare professionals for their roles in disasters when training them in non-emergency periods. Content that should be included in education and training programs includes gatekeeper training, mental health for administrative officers, and PFA. There is a need to spread and raise awareness of what professionals need to know, and there is also a need to spread and raise awareness of the community support level that residents of the community need to know, and each should be addressed separately.
It is also important for municipal governments to encourage residents to help each other using the strengths of local communities in times of disaster. Normally, it is important to make regular efforts in non-emergency periods to encourage connections among citizens to create environments where community members can help each other during emergencies, particularly in places community members use and with the people who work there, neighborhood association directors, and welfare commissioners. For example, there is an initiative in non-emergency periods to have each citizen understand in advance the mental changes that occur during a disaster (the Mental Health Supporter Training Project, sponsored by the Ministry of Health, Labour and Welfare), and this can be one of the opportunities to boost the strength of communities. Additionally, by covering disasters in local schools, we can expect to leverage local students who have a keen understanding of the community.

⑥ Institutional Collaborations

(Summary)
- ◆ Fifty-nine percent of municipalities had organizations that they planned to collaborate with for disaster mental health response. Potential collaborators included medical institutions, professional psychiatric associations, administrative agencies, educational institutions, and health and medical welfare-related organizations.
- ◆ Establishing face-to-face relationships within organizations (among departments) and among municipal governments during non-emergency periods leads to the smooth provision of support.
- ◆ In many cases, it is impossible to address concerns related to mental health through a single department. Meetings involving people in health and welfare-related occupations must be held regularly.
- ◆ Since some people with mental health problems attend medical and support institutions outside the community, it is essential to hold regular regional and cross-organizational liaison meetings and share information.

Many municipalities are planning to partner with multiple organizations for disaster mental health support, including medical institutions (including psychiatric day care facilities), professional associations related to mental health and medical care, administrative agencies (including neighboring municipalities), schools (educational institutions), and multiple health and medical welfare-related organizations. Of these, 65% of the municipalities were already partnering with the above organizations during non-emergency periods by assigning roles in times of disaster, training human resources, and establishing inter-organizational

agreements.

The 2004 Niigata-ken Chuetsu Earthquake

- The prefecture took the lead in contacting the affected municipalities and assessing their needs for outside support. Winter came soon after the disaster, and there were concerns about snow. Since the support group would be operating in an unfamiliar environment, they decided from the outset on a policy of withdrawing before the snow fell (approximately two months) and requested support. The municipal office and the activities of the public health nurses, who provided the actual support, were crucial factors in the decision-making process.
- When outside support was requested, it was arranged for support groups to enter the affected area through neighboring cities that had suffered less damage (and could maintain administrative functions), which made it easier to control the collection and dissemination of information, such as the numbers and details of support groups.

The 2011 Great East Japan Earthquake

- Prefectural mental health and welfare centers assisted mental health care centers in their regular duties.
- During the disaster, municipalities were mainly responsible for needs assessments and responding to supporting individuals and groups, while mental health care centers supported the municipalities by bringing in specialists. Then, prefectural mental health centers provided overall backup to support the community's mental health.
- Local psychiatric hospitals ceased to function due to the disaster. Hospitals that do not normally accept psychiatric patients set up temporary psychiatric outpatient clinics (though they were quite reluctant to admit patients) and were supported by the mental health care team.
- By having prefectural officials visit municipalities and public health centers to provide direct project support and case supervision, prefectural officials could gain firsthand experience with the problems in their area and devise effective training content while at the same time building relationships with municipal and public health center officials and reducing their emotional burden.

The torrential rains that hit the Kanto and Tohoku regions in September 2015

- We feel that it is important for face-to-face relationships to be built internally among municipal departments and between municipalities during non-emergency periods to facilitate cooperation during disasters. We feel that if the prefectural government and public health centers would hold a meeting once every three months or so, they could collaborate during emergencies.
- University mental health care teams (physicians, psychiatric social workers, clinical psychologists, etc.) stepped in to provide support. Municipal health promotion divisions served as the liaisons and hosted the teams, which assisted at evacuation centers from the first day of the disaster for about three months, and after that, helped with at-home assistance at the departments dealing with the welfare of the elderly. While the university was asked to lead the mental health activities, the municipal government gave assistance by providing space for the activities, cooperating in surveys, etc.
- HR personnel from the general affairs division were put in charge, and with the cooperation of the university, mental health checkups and lectures were held. They participated in a disaster support training program for officials, which was organized by the prefecture. Since it is not possible for municipal governments to preside over such events due to staffing limitations, they appreciate it when the prefectural government could preside over events.

The 2016 Kumamoto Earthquake

- Community support centers were established in each ward office. The connections between related organizations in the normal course of business made it easy to predict the progress of the work.
- Six months after the disaster, a mental health care center was established, and it participated in the meetings between the prefectural and municipal mental health and welfare centers, resulting in a tripartite meeting four times a year. The meeting initially started with a report on the status of the municipalities after the withdrawal of DPAT support, followed a month later by discussions on the mental health care center system, the mental health care system following the earthquake, and plans for a disaster mental health care training session. One year after the disaster, it became

possible to hold training on earthquake-related deaths of children, a support system for people suffering from alcoholism and trauma, activities to raise public awareness, and training for supporters.

- Psychiatrists and nurses from the mental health care center were asked to visit those who were deemed to need professional support through a door-to-door survey. They were asked to visit each ward twice a year to give advice on cases where the support center was having trouble.
- Educational training on PFA and SPR is still conducted once a year jointly by the prefectural and municipal mental health and welfare centers and the mental health care center for supporters, which was on the agenda of a tripartite meeting of the mental health and welfare centers and the mental health care center.

Torrential rains of July 2020

- The prefectural government dispatched a mental health care team immediately after the disaster, and it has been continuously involved. The team assisted in conducting a mental questionnaire for disaster victims, which resulted in the identification of 37 people requiring special care—the city's welfare facilities continue to provide support to them.
- The public health nurses in the city were divided into two groups, one to patrol the evacuation centers and the other to receive support so that city officials could recognize that, if they had any problems regarding the details of support, they could contact the public health nurses in charge of receiving support who would respond to their needs in some way. This unified consultation services. In addition, general officials were stationed at each evacuation center 24 hours a day, and public health nurses made rounds so that information could be shared and issues could be resolved throughout the community. This system made it possible to share most cases by having public health nurses attend morning and evening meetings.
- The roles of the outside support groups were listed and assigned by the municipal government and shared with each group during morning meetings. However, the past support performances of each organization were already well-known, so the municipal government did not attempt to come up with assignments from scratch.
- A neighboring city that had experienced the disaster took the initiative by supporting public health nurses as a counterpart[5]. They also took the initiative to start dispatching registered dietitians and dental hygienists, which was followed by the affected city's sending out its own registered dietitians. Because conditions were in disarray internally, it was encouraging to have outside people with disaster experience proactively offer their insight.
- Visits to those identified as requiring special care through a questionnaire survey in the early stages of the disaster and who were residing in temporary housing were undertaken. Through the visits, those who needed continuous support were assigned to welfare facilities or ward public health nurses who would take over, and those considered to need urgent care were connected to the prefectural mental health and welfare center.

[5]Counterpart support is part of a system in which each disaster-affected municipality is assigned a prefecture or designated city, in principle, as a counterpart to ensure that personnel is promptly and surely secured in the event of a disaster. Counterpart support organizations are basically responsible for completing the work and dispatching support staff themselves [Ministry of Internal Affairs and Communications, 2021].

–Advice from our panel of experts–

To ensure that disaster preparedness is addressed daily, having medical institutions, public health centers, and city health centers participate in DPAT training and other events provides an opportunity for the administrative agencies to raise awareness of the receipt of support as well. Given the reality that DPATs enter and work in the community, an emphasis is placed on collaborating with public health centers and health centers daily.

In many cases, it is impossible to address all concerns related to mental health through a single department. It is necessary to form a wide-ranging and periodic forum for meetings that include welfare and health issues. However, since it is not realistic to establish a new one in the event of a disaster, it is desirable to stipulate how conferences on mental health welfare that are held during non-emergency periods will operate in the event of a disaster and to plan so that face-to-face relationships can be leveraged in the event of a disaster.

Many community members want to hide problems related to mental health or do not want others to know about them, so they use health care institutions and support organizations outside of their communities. Under such circumstances, it is desirable that regular meetings are held in which municipalities engage in wide-ranging cooperation that spans local communities, especially those that have been affected by disasters, including at the prefectural level or going beyond prefectural boundaries so that information on methods for responding to residents can be shared and support across regions can be provided.

Outreach activities in the medium to long term after a disaster require sufficient staffing. It is desirable to plan how to secure health, medical and welfare professionals who cannot work because they are affected by the disaster.

⑦ Other Cases

(Summary)

- There have been cases where disaster victims are isolated and need long-term support, such as when they are the last residents of temporary housing, or unemployed or alcohol-dependent residents of public temporary housing.
- Because people with mental health issues rarely take action on their own, it is important to create an environment that facilitates their participation at gathering places in temporary housing and other locations.
- Since NPOs are nimble, they can listen to the voices of those in the field and immediately apply these voices to disaster support.

(Characteristics of medium- to long-term disaster support and disaster victims)

The characteristics of medium- to long-term disaster support include support for people who are socially withdrawn or dependent on alcohol, as well as support for their families. In disaster-stricken areas, the strength of local communities is tapped to encourage disaster victims to help one another, such as by revitalizing communities, providing places where people can gather, and raising awareness through local events. Such activities are now commonly conducted by support groups and administrative agencies and have attracted media attention in the aftermath of disasters. In this context, activities in the field of mental health and medical welfare include support whereby disaster victims are looked after through the strength of the local community, which is unique to this field, to investigate problems from behind the scenes and encourage mutual support among disaster victims.

The 1995 Great Hanshin-Awaji Earthquake

- At the gathering places of temporary housing, efforts were made to revitalize the community through massage, tea drinking, yoga, qigong, and other activities.

The 2011 Great East Japan Earthquake

- A retired public health nurse from the Tokyo Metropolitan Government came to the city for support, and a system was established whereby difficult cases were proactively referred to mental health

care centers. This person arrived at the city through a solicitation for a public health nurse to support it, as the prefecture recognized the need for the city to receive support in resolving their health issues.
- In many cases, people dependent on alcohol are still being supported (looked after) as they cycle between improving and worsening. In other cases, children who had lost their families were watched over until they entered the workforce.
- In one case, a father with a disability notebook to certify his disability and his daughter, who was in her second year of junior high school and socially withdrawn at the time, did not know that the surrounding residents had been evacuated because of the disaster. The daughter was in a state where she could not understand the information she obtained very well, and she continued to receive support (supervision and day-to-day support) until she was 20 years old.
- People considered to have disabilities are linked to support, but people with problems that are difficult to be recognized by the public are less likely to be linked to support. Hence, NPOs, NGOs, and other organizations are providing flexible support. There have been cases of isolation that required long-term post-disaster support among people who were the last residents of temporary housing and those who had quit their jobs while staying in public temporary housing and became dependent on alcohol.
- Because people with mental health issues rarely take action on their own, an environment that facilitated their participation at gathering places in temporary housing and other locations was created.

(Collaboration with NPOs, NGOs and other disaster support organizations)
NPOs specializing in disaster support were nimble in implementing their responses for groups, such as conducting awareness-raising activities, and handling high-risk individuals. In the 2016 Kumamoto Earthquake, a liaison council was established for organizations that harness the unique characteristics of NPOs to provide disaster support and work with municipalities.

The 2011 Great East Japan Earthquake
- Since NPOs can be very nimble, it is beneficial for them to be utilized for disaster support. It is best for the municipalities to take the helm and coordinate the activities, as it would be easier for NPOs to conduct such activities.
- NPOs distributed pamphlets and conducted campaign activities related to mental health awareness together with the parties concerned (the elderly, those with alcoholism, mental health issues, etc.). Making use of the website and word of mouth were also effective. Getting TV and other media coverage in advance was highly effective in building relationships, as it made it easier to have people understand the organization’s activities. Supporters will become aware that they are being watched and will be motivated to do good activities.
- Working with organizations that are trusted by the community makes it easier to gain the trust and participation of the locals in the activities to raise awareness. Handing out pamphlets together with daily necessities was also effective. It was also meaningful to combine awareness-raising activities with events rooted in local culture, such as firework festivals and traditional *Bon Odori* dances.
- Among people with alcohol dependency, men are particularly vulnerable to isolation. That is why, since 2016, a men-only meeting that continues to work to prevent their isolation was created.

The 2016 Kumamoto Earthquake
- Immediately after the disaster, a committee was established, and an NPO served as its secretariat. This committee had the advantage that it was easy to hear the voices of staff members who are in direct contact with the disaster victims and the field since it was facilitated by an NPO. Participants included the prefectural and municipal governments, their respective social welfare councils, the head of the ward offices in charge of evacuation center management, the community activities promotion section of the main office with jurisdiction over the disaster volunteer center, and the city’s reconstruction department (starting around two months in). The details of the meetings were (initially) to share information on the operation of evacuation centers and the intake of volunteers and (after two months) to share information on the troubles and conditions of disaster victims in temporary housing.

Although the organizations made use of this information in their own activities, it was not possible for the government to ask volunteers and NPOs to provide direct support to disaster victims from the standpoint of protecting personal information. Nevertheless, they could cooperate in projects organized by volunteer groups, and the NPOs understood this. Accordingly, they compromised and worked together.

–Advice from our panel of experts–
Symposiums that bring together support groups are useful from the perspective of mental health care for supporters. In fact, after the torrential rains in July 2018, Hiroshima Prefecture and the City of Hiroshima's mental health and welfare centers collaborated to hold a symposium to review the state of mental health care at the time of a torrential rain disaster, with the aim of providing mental health support to those affected by the torrential rains. The symposium provided an opportunity for supporters to deepen their understanding of psychological support and responses to disasters and to learn how to provide ongoing support.

3) Views of People with Mental Issues

Under the slogan "achieving health care policies that are centered on citizens," the HGPI is working with patients with various conditions and involved parties to provide policy options to society. Even in the project that served as the basis for this collection of case studies, parties involved in mental health were invited to participate, and we received numerous comments on the challenges and future prospects for mental health measures in their communities.

- Leading with the words "mental health care," "mental," and "psychiatry" makes it hard for people who have been affected by a disaster to accept care. Coupling initiatives with improving physical health and having local public health nurses or home care nursing teams and mental health professionals who work from behind the scenes work collaboratively leads to acceptance. Steps must be taken to dispel feelings of resistance toward mental health among citizens.
- Being able to believe that there is a way forward and find joy and pleasure in social connections in the community is important for preventing and recovering from mental health problems. This requires people to find a place where they belong socially and they find enjoyment and people they can depend on.
- It will be important to collect information on efforts and services from municipal governments that have proven useful for people with mental health issues who have experienced large-scale disasters and to share that information among municipal governments. It will also be essential to disseminate information by making active use of peer support and other activities which allow people affected by mental health issues to engage in mutual support and connect them with mental health professionals.
- It is especially easy for people with mental health issues to be affected physically and mentally by a disaster. This is why it is important during non-emergency periods to establish systems to prevent disaster-induced worsening or progression of symptoms and to enable people, as much as possible, to continue their social lives as they did before the disaster struck.

3. Discussion and Recommendations

1) Inter-Municipal and Municipal Interdepartmental Collaborations

(Strengthening collaboration by sharing disaster response experiences)

According to our survey findings, few municipalities anticipated collaborating with neighboring municipalities or other municipalities. Some 90% of all municipalities did not anticipate inter-municipal collaborations in mental health support in the medium to long term after a disaster. However, according to our interview findings, prefectural and designated city governments were mainly responsible for providing medium- to long-term disaster support by holding training sessions for municipal government officials and providing logistical support, such as visiting municipal governments to conduct investigations. We can infer from these findings that municipalities that have disaster experience are actively working with basic municipalities to conduct support activities, thus strengthening the support capabilities of the entire community. In particular, hosting regular study sessions not only improves knowledge sharing but also provides an opportunity for sharing thoughts and feelings, which contributes to the mental health care of the supporters themselves. Preserving and passing on the disaster experience as a valuable social memory will contribute to preparation for potential future disasters (Yamori, 2009). Furthermore, sharing the events, responses, thoughts, and lessons learned by those who experienced the disaster can be a valuable record for the next generation. In the expert committee meeting held under this project, it was also mentioned that because sufficient evidence has not been accumulated for medium- to long-term disasters, it is important to create such forums for sharing the authentic voices of those who have experience in providing medium- to long-term mental health support.

(Building face-to-face relationships)

Our survey resulted in many responses that mental health support was not prioritized by the municipality. On the other hand, we found that there were many latent mental health concerns in the community before the disaster that became apparent afterward. Accordingly, we heard that the priority level of responding to these concerns should be raised by using the disaster as an opportunity. Still, municipalities face many challenges in addressing as part of their normal operations the issues that emerge during disasters, not least of which is the fact that different departments are in charge of different tasks. In the professional meeting, it was noted that, in response to the revision of the Basic Act on Disaster Management in 2021, the Japanese government has begun to prepare for disasters as a systemic part of its efforts during non-emergency periods, referring to the case of Beppu, Oita Prefecture, where welfare professionals participate in the preparation of disaster care plans as part of their duties. The implementation of these initiatives during non-emergency periods across departments will lead to the creation of face-to-face relationships, which was the subject of many comments made during the interviews. Face-to-face relationships not only refers to knowing each other's faces but also refers to relationships of trust (Morita, 2012). It was also noted holding cross-departmental meetings and leveraging regular transfers to build face-to-face, credible relationships throughout the organization based on the topic of disasters, even during non-emergency periods, is useful to effectively prepare for disaster support.

2) Use of Local Resources

It takes time to change the internal (organizational) structure in administrative agencies. That is why bringing in a nimble external support organization is efficient and useful in times of disaster when every minute counts. Municipalities must decide in advance the systems to accept support and standards to follow when withdrawing from disaster-stricken areas. Experts noted that it is better to enhance the functions of existing centers than to establish new mental health care centers, and if new centers are to be established, planning up to their closure is necessary. Currently, municipalities that have responded to the COVID-19 pandemic had difficulty allocating resources and felt that delays in recovery due to the situation harmed mental health. It is foreseeable that novel infectious diseases and regional disasters will continue to make it difficult for support to be received from a broad range of areas. To support the mental health of residents in the medium to long term after a disaster, municipalities need to not only build relationships with personnel and organizations that can provide support in the area but also provide education about support.

It was indicated that targets for this education and training include not only professionals in health and medical care and welfare but also general administrative officers, public safety personnel such as police and

firefighters, and those who work with students and children, all of whom are routinely active in the community and might be involved with the subjects of support in the event of a disaster. To achieve this, the experts also suggested that it will be useful to make efforts during non-emergency periods to strengthen connections among citizens and create environments where community members can help each other in the event of a disaster, particularly among places community members use regularly and the people who work at them, neighborhood association directors, and welfare commissioners, and emphasized the importance of municipalities encouraging this kind of mutual support among citizens.
The experts noted that about 60% of municipalities were planning collaborative efforts for disaster support with organizations connected to the residents, including various psychiatric professional associations, administrative agencies, schools, and multiple health and medical welfare-related organizations. Half of those municipalities had already planned responsibility sharing, human resource development, and organizational agreements in the meetings and training they actually held during non-emergency periods. Moreover, detailed procedures for municipalities to receive support, as well as the state of the medium- to long-term disaster mental health support committee, its constituent members, and the content of its meetings, were also described. Organizations in various fields intricately connected to residents should regularly hold meetings and training sessions related to mental health during non-emergency periods. In fact, it is also important for them to collect information on efforts and services from municipal governments that have proven useful for people with mental health issues who have experienced large-scale disasters and to share that information among municipal governments. Another valuable approach is to disseminate information by making active use of peer support and other activities which allow people affected by mental health issues to engage in mutual support and connect them with mental health professionals. In the medium to long term after a disaster, it is desirable to consider a system that can provide support to those who need it in cooperation with preexisting interpersonal networks and organizations already in place while maintaining the normal operations of municipalities.

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5. Conclusion

We confirmed through these case studies that past disaster response experience in Japan is applied to mental health support in subsequent disasters. As one of the most disaster-prone countries in the world, Japan has experienced many kinds of disasters. We expect that this case study compilation, which is a collection of actual responses to these disasters and considerations on the state of preparedness, will help to implement existing manuals and guidelines in a more detailed and pragmatic manner. The voices of individuals are a distinctive characteristic of this case study compilation, and even the experts found them invaluable in developing more concrete support. Moreover, a discussion was raised on the fact that merely creating manuals and guidelines was not sufficient preparation. The purpose of this case study compilation was to reflect on mental health support during disasters. However, there are diverse ways individuals are affected by disasters, such as those who have suffered bodily harm, those who have suffered mental harm, and those who have suffered social harm. Nowadays, given the ease of access to information, even those not in the stricken area can also be affected. Continuing to listen to, compile, and publish the voices of individuals will lead to more concrete and practical support in fields related to disaster support. Hazards contributing to disasters can differ between countries and regions. Under these circumstances, we hope that this compilation of disaster response experiences in Japan will be useful for disaster support in other countries. Despite the unpredictable threat of disasters, we hope this case study compilation will be useful for addressing the mental health concerns of as many people as possible.

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Health and Global Policy Institute
Mental Health Policy Project Team

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