‘Opening doors’ for long-term institutionalised patients with schizophrenia in Japan

Letters to the Editor

‘Opening doors’ for long-term institutionalised patients with schizophrenia in Japan

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To the Editor,

Whereas the term ‘deinstitutionalisation’ being obsolete in the West, the prolonged hospitalisation of patients with schizophrenia remains a major public health concern in Japan. According to the Organisation for Economic Cooperation and Development (OECD), Japan had 2.61 psychiatric beds per 1,000 persons in 2018, which was much higher than in other OECD countries (mean: 0.61 psychiatric beds per 1,000 persons; range: 0.03–1.35).[1] This figure is almost identical to the number of beds in Japan in 1998 (2.84 per 1,000 persons)[1] and shows that there has been no active movement to reduce the number of psychiatric beds in the last two decades. The Japanese Ministry of Health, Labour and Welfare (JMHLW) indicated that there were 272,100 inpatients in psychiatric hospitals or units as of 30 June 2019; more than half of these patients had schizophrenia (n = 143,600). Furthermore, about 45% of inpatients with schizophrenia (n = 64,600) had been institutionalised for more than 5 years. **Naturally, a question may arise about why costly inpatient care has been maintained in Japan, while almost all other developed counties abandoned such care systems and shifted to community-based care to reduce the expenditure linked with hospitalised treatment, thereby fostering deinstitutionalisation. The reason why Japan did not follow the movement in Western countries toward deinstitutionalisation is not clear. However, Japan’s government appears to have opted for continuing financial support for the medical costs of patients hospitalised in for-profit privately owned hospitals (90% of psychiatric hospital beds)**

as well as in general hospitals. The lack of radical reform implicates that deinstitutionalisation has stagnated in Japan.

Institutionalised care provision still plays a major part in mental health services in Japan, especially for patients with severe mental illness. **At one time, there was temporary momentum to provide accommodation (e.g., halfway houses) for patients with mental illness that had been in long-term hospitalisation. In addition, schizophrenia (originally called 'mind-splitting disease') was renamed in Japan as 'integration dysfunction disorder' (togo shitcho sho) to reduce stigma. However, the renaming campaign that aimed to reduce stigma among the general populace failed to ameliorate their attitudes towards people with mental illness. This is exemplified by the fact that construction of halfway houses, especially for patients with schizophrenia, encountered immutable strong resistance from community residents. Furthermore, Japan's family associations for mental illnesses, which should intrinsically welcome the motive of deinstitutionalisation, appear to have been less devoted to accelerating deinstitutionalisation than expected.** As a result, blueprints to pave the way for deinstitutionalisation are lacking. There is solid evidence that deinstitutionalisation, together with proper provision of community-based mental health services, improves social functioning and stability, and leads to positive changes in patients' quality of life.[2] Therefore, insufficient provision of societal support to release long-term hospitalised patients *per se* presents a major challenge.

An additional problem in medical practice in Japan that hinders deinstitutionalisation is the high prevalence of treatment-resistant schizophrenia (TRS) among long-term hospitalised individuals. It has been established that clozapine is effective for TRS. Furthermore, many medical economic studies have demonstrated that clozapine is superior for treating patients with TRS and is more cost-effective than other antipsychotics.[3] Long-term administration of clozapine can help reduce the number of admissions and length of hospital stay, leading to decreased medical costs. However, the clozapine administration rate in Japan is 0.6 per 100,000 persons, which is substantially lower than that in other countries (41.8–189.2 per 100,000 persons).[4] Clozapine was first used in Japan in 2009, but continues to have minimal use in Japan 11 years on. In 2020, the JMHLW introduced compensation for hospitals to admit patients for clozapine treatment to promote the use of clozapine, but this compensation was not available for hospitals that assist in transferring inpatients for treatment. Therefore, the effect of such compensation may be minimal, as there are no benefits for private hospitals that discharge patients to other hospitals.

A fundamental obstacle to clozapine administration is Japan's Clozaril Patient Monitoring Service (CPMS) system. Unlike the CPMS in the West, Japanese CPMS has stringent stipulations. First, clozapine administration must only be started during hospitalisation, and at least an 18-week period of admission is required for initiating clozapine treatment. In Western settings, clozapine can be administered at an outpatient clinic from the outset. Second, haematological monitoring must be

implemented weekly for 26 weeks after admission, followed by permanent biweekly monitoring thereafter in Japan, compared with monthly monitoring in Western countries. Third, attending physicians in Japan must be trained psychiatrists, whereas general practitioners (GPs) are allowed to prescribe the agent in countries such as the Netherlands, the U.K. and the U.S.[5] For example, in the U.K., a GP-based monitoring system is well established for treating outpatients with clozapine as part of a suite of community-based services. The Japanese CPMS demands that relevant facilities accommodate full-time haematologists who can deal with the emergence of agranulocytosis, which occurs in 1.1% of individuals treated with clozapine. This regulation requires facilities that administer clozapine to have specific capacity to deal with agranulocytosis via strategies such as commencing emergency administration of granulocyte-colony stimulating factor and appropriate antibacterial agents. This stipulation that cases with agranulocytosis must be treated by specialists in the same facility or *aligned facilities when available* precludes most private psychiatric hospitals (which generally do not accommodate any full-time physicians) from offering clozapine treatment to their inpatients. Because the mindset of treating individual patients living in the community with a medical professional team is underdeveloped in Japan, an aligned system of providing optimal care outside facilities is not yet in operation. Therefore, the use of clozapine is constrained to general and university hospitals, which have limited psychiatric beds. The present nominal CPMS system should be revised to conform to global standards and broaden its use to ensure that clozapine is more widely distributed

across Japan. **However, the reported higher prevalence of clozapine-induced agranulocytosis in Japanese (1.1%) compared with Caucasians (0.3%–0.9%) may become a barrier to broadening its use. Further, a high proportion of clozapine poor metabolisers has also been pointed out in Asians, although the link between poor metabolization and occurrence of agranulocytosis remains unknown. Thus, research is required to elucidate the mechanism (e.g., genetic composition) underlying ethic differences in drug-specific metabolisation and identify risk factors for clozapine-induced agranulocytosis in Japanese and possibly other Asians. In addition, preparation of practical prevention and therapeutic intervention manuals is necessary for patients who develop agranulocytosis in the community care setting. The nationwide dissemination of a type of assertive community treatment would attain these goals. Therefore, current service provision that relies on facility capacity should move towards *modern* well-integrated community-based services that involve physicians monitoring and treating patients in the community.**

To achieve a realistic solution to the problem of deinstitutionalisation in Japan, emphasis should be placed on improving quality of life and optimal care for inpatients, especially those with TRS. Authorities should implement effective measures to improve the quality of healthcare and provide optimal care, set authentic short- and long-term goals and subsequently check whether these goals have been achieved. Throughout this process, policymakers should formulate measures for

deinstitutionalisation from a broad, long-term perspective that extends to medical economics, and simultaneously hasten the dissemination of community-based mental health care provision[2] across Japan to provide a safety net after deinstitutionalisation. Policymakers must also consider the principle that health policies should be developed from patients' perspectives, not from third-party perspectives.

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