Depression and Suicide Countermeasures in Japan

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Japan Medical Association Mental Health Committee*1

Abstract

Various studies have revealed that most patients with mental disorders such as depression initially go to see a primary care physician in their community complaining of a wide variety of physical symptoms. Accordingly, primary care physicians are expected to fulfill the important role of diagnosing mental disorders at an early stage and introducing patients to appropriate treatment. For that reason, there is a need to establish a smooth system for cooperation between those physicians in the community and psychiatrists. A system should not just be established; there is a need for face-to-face relationship building between both sides. Also, while general recognition of depression has been growing gradually, awareness needs to be raised in the future regarding alcoholism. A consistent educational system should be developed regarding mental disorders and suicide prevention for undergraduate education in medical schools, postgraduate education, and continuing medical education (CME) stage. Further, development of an appropriate medical fee system is essential for enabling smooth cooperation between primary care physicians and psychiatrists.

Key words Face-to-face relationship building, Measures against alcoholism, Need for consistent psychiatry education, Quality assurance in psychiatric care

Introduction

While the annual number of suicides in Japan dropped below 30,000 for the first time in 15 years at 27,858 suicides in 2012, that number, which has been hovering around 30,000 since 1998, is more than six times the number of fatalities in traffic accidents.[1] Moreover, it is estimated that the number of survivors of attempted suicide is tenfold that of the number of successful suicides, even at a moderate estimate. Furthermore, when a suicide or attempted suicide occurs, it has a serious effect on many surrounding people. In this way, suicide goes beyond a problem of the 30,000 people who go to their deaths; it has become a serious problem that involves the whole of society. Looking squarely at this situation, the government established the Basic Act on Suicide Prevention in 2006, declaring that suicide prevention is an issue that should be addressed by society as a whole. A variety of social initiatives, including measures to deal with economic problems such as unemployment and heavy debt, are also needed when promoting actual suicide prevention measures.

Looking at the problem of suicide medically, numerous studies have pointed out that the great majority of people who commit suicide had been in a state falling under the diagnosis of some kind of mental disorder before taking that last act. However, since there is still strong prejudice against mental disorders in Japan, many of those people go to see a primary care physician complaining of a wide variety of physical symptoms. Accordingly, it is extremely important for primary care physicians to acquire accurate knowledge of mental disorders in order to introduce patients to appropriate treatment.

Aware of this situation, the Japan Medical Association (JMA) published the Suicide Prevention Manual: Early Detection and How to Deal with Depression in General Medical Insti-

*1 Members of the committee are listed at the end of the paper.

tutions in 2004 and distributed it to all JMA members and that year's medical school graduates nationwide.[2] It has also held study sessions based on this manual. The manual was revised in 2008.

The JMA Mental Health Committee convened eight times from fiscal 2010 to 2011. It examined the present situation regarding initiatives in various regions and discussed challenges for the future. This paper is a summary of the results. The committee focused in particular on the following four points:

1) Primary care physicians need to have appropriate knowledge of mental disorders and need to cooperate with psychiatric hospitals/clinics in the community.
2) Mental, physical, interpersonal relationship, and various other problems occur with alcohol dependence. Although alcoholic patients may go to a primary care physician when physical problems occur, physicians frequently focus only on the physical problems and do not pay enough attention to psychosocial problems. Understanding regarding alcoholism in addition to depression is essential.
3) Education pertaining to mental disorders needs to be implemented in a consistent system across undergraduate education in medical schools, postgraduate education, and CME stage.
4) An appropriate medical fee system should be developed to enable smooth cooperation between primary care physicians and psychiatrists.

Cooperation Between Primary Care Physicians and Psychiatrists

Although the annual number of suicides in Japan fell below 30,000 in 2012, that number was above 30,000 every year for 14 years since 1998.[1] Suicide is a serious societal problem. According to the 2011 White Paper on Suicide Prevention in Japan,[3] the trend in the causes and incentives of suicide has seen health problems being the biggest factor, accounting for nearly half suicides, followed in order by economic and livelihood issues, family matters, work-related issues, love matters, and school problems. Within the breakdown for health problems, worries and effects from sickness (depression) was the biggest factor, for 7,020 people, showing that depression is a major factor out of the numerous causes of suicide. The 2008 White Paper on Suicide[4] points out that each victim "had four risk factors on average at the time of suicide and depression was the highest factor on the risk chain leading to suicide." In any case, measures against depression are positioned as the most important challenge in combating suicide.

Regarding the relationship between depression and medical institutions, depression patients often start by going to see an internist or other primary care physician, not a psychiatrist or other specialist, complaining about physical symptoms such as insomnia, loss of appetite, and general malaise.[5] For that reason, even Outlines for Comprehensive Measures to Prevent Suicides approved in a Cabinet meeting stress the importance of the role played by primary care physicians as the gatekeeper in dealing with depression at an early stage.

Under the leadership of the JMA, workshops to improve the ability of primary care physicians to respond to depression have been held every year since 2008 in various locations around the country with the cooperation of administrative bodies. The workshops attempt to raise the ability of primary care physicians to diagnose depression and respond with initial treatment.

In order to enhance and strengthen the medical system for depression, it is essential to develop a system of cooperation with specialized medical institutions such as psychiatric hospitals/clinics in addition to improving the ability of primary care physicians to respond to depression. First of all, it is important to establish a system that leads to specialized treatment through appropriate referrals, as needed, to specialized medical institutions for many depression patients who go to see a primary care physician.

The fact is, however, that people, especially middle-aged and older men, among whom there is a high prevalence of suicide, still have a deep-rooted prejudice against going to be seen at a psychiatric hospital/clinic, and so referrals need to be made in ways that take into consideration such public sentiment. Also, the recent intensification of mental health problems has led to a sudden rise in outpatients at psychiatric hospitals/clinics nationwide, and the crowded conditions have resulted in more cases where appointments cannot be made on short notice. A challenge, therefore, is to establish a system of

cooperation between primary care physicians and psychiatrists suited to local circumstances while taking into consideration the capacity of psychiatric hospitals/clinics.

There are various other challenges regarding cooperation between primary care physicians and psychiatrists, but here we will give an overview of two initiatives hailed as pioneering models of cooperation: 1) the Fuji Model Project, and 2) the Osaka G-P Net.

Examples of cooperation initiative

Fuji Model Project: depression and suicide prevention for the generation in the prime of life

The Fuji Model Project is an initiative that has been undertaken since 2006 through the cooperation of Shizuoka Prefecture, Fuji City, the Fuji Medical Association, and other organizations. The project mainly targets men in their 40s and 50s, among whom there is a high prevalence of suicide.

The feature of the model project is that it focuses attention on the insomnia symptom of depression in order to increase the rate at which depression is noticed. The two pillars of the project are a sleep campaign using awareness-building posters on which a daughter asks, "Dad, are you getting enough sleep?" and a referral system through which middle-aged men who cannot sleep first consult a primary care physician or occupational physician and are then referred to a psychiatrist as needed (**Fig. 1**).

The union of a referral system, which is cooperation between primary care physicians and psychiatrists, with awareness building of depression is a feature of the Fuji Model Project. The referral system focuses first of all on insomnia lasting more than two weeks and recommends methods for identifying suspected depression patients out of insomnia patients at busy primary care outpatient offices (**Fig. 2**).

In establishing the referral system, a Referral System Exploratory Committee consisting of five primary care physicians recommended by the Fuji Medical Association and five local psychiatrists was formed in 2006. The committee deliberated over time, building up the system

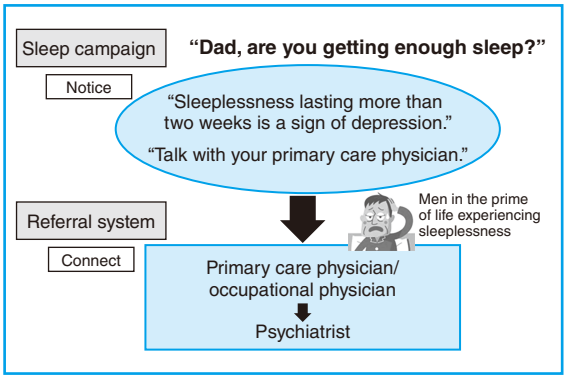

Fig. 1 Outline of the Fuji Model Project

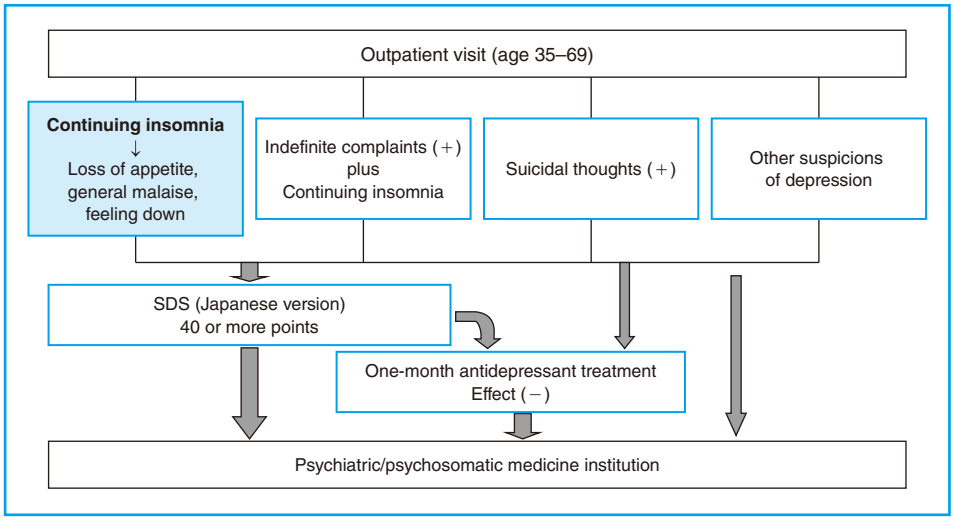

Fig. 2 Referral from primary care physician to psychiatrist

through trial and error, including the development of a special referral letter that makes referrals simple and easy and encouragement of depression screening (SDS: Self-rating Depression Scale), etc. (**Fig. 2**). A trial run of the system began in January 2007 and it was put into full-scale operation from July 2007. Subsequently, city hospital physicians and occupational physicians were added as members of a Referral System Operation Committee, which convenes periodically and reviews the system as occasion calls. All local psychiatric hospitals/clinics are cooperating in this system. The number of reported referrals had topped 600 by the end of 2011. The city of Fuji does not have many psychiatric hospitals/clinics and there was a problem with patient capacity, but a practice was adopted when making psychiatric referrals of giving priority appointments to men in their 40s and 50s, among whom there is a high prevalence of suicide. Later, looking at the status of the system, the Referral System Operation Committee expanded the target for referrals to men and women aged 35 to 69, which is where it stands now.

The essence of the referral system is not in increasing the number of users of the system. Rather, it lies in increasing, through use of the system, primary care physicians' and occupational physicians' interest in and their accuracy in diagnosing depression and also in promoting smooth cooperation by lessening the sense of distance between primary care physicians/occupational physicians and psychiatrists.

Osaka G-P Net

In Osaka Prefecture, the Osaka Association of Psychiatric Clinics, the Osaka Association of Internists, the Osaka Association of Psychiatric Hospitals, university hospitals, occupational physician groups, and other organizations have come together and moved ahead with the concept of a General Practitioner-Psychiatrist Network (commonly called the G-P Net) based on the recognition that cooperation between general practitioners (primary care physicians) and psychiatrists is important in order to respond appropriately to patients with mental health problems who have gone to see a primary care physician or patients who have attempted a suicide and received general emergency treatment (**Fig. 3**).[6] In the Osaka G-P Net established in 2006, general practitioners and psychiatrists have together reaffirmed the concept that communication does not mean passing the baton but rather forming a treatment team. They hold joint workshops, social get-togethers by area, have established an information network on the Internet, and created a special referral letter.

Essence of cooperation: face-to-face relationship building

In the case of both the Fuji Model Project's referral system and the Osaka G-P Net, the initiatives do not stop at simply establishing rules for referral from primary care physicians to psychiatrists in regards to cooperation between the two; both initiatives place emphasis on face-to-

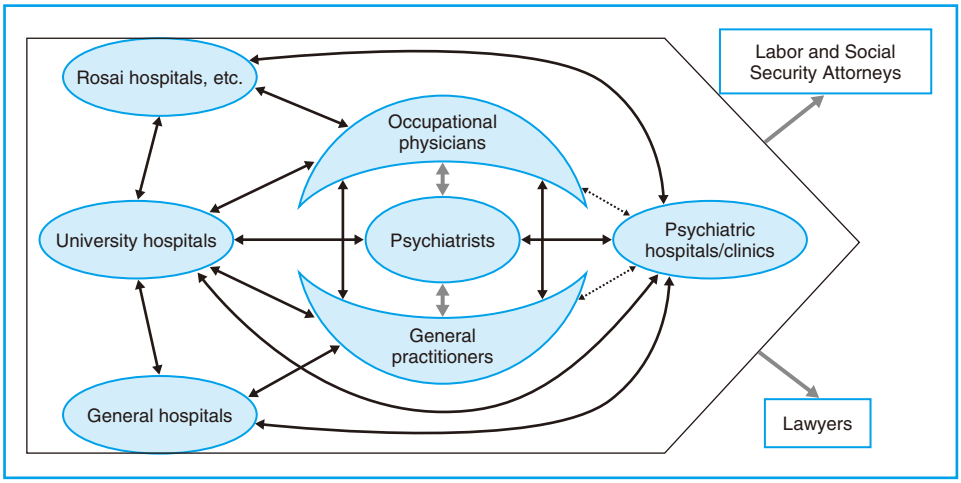

Fig. 3 General Practitioner-Psychiatrist Network (G-P Net)

face relationship building between primary care physicians (general practitioners) and psychiatrists. In the Osaka G-P Net, for example, efforts are made to encourage interaction, such as by holding business card swaps at area-based workshops. It is of great significance for primary care physicians (general practitioners) and psychiatrists to develop face-to-face relationships.

First of all, primary care physicians' abilities to diagnose depression and provide initial treatment can be expected to increase as they interact more with psychiatrists through actual patient referral. At the same time, for patients suffering from depression who are nervous about being referred from a primary care physician to a psychiatrist, it provides a great sense of reassurance to know that one is being referred to "a psychiatrist that my doctor is acquainted with and trust." It is also expected that such networks can function as a hotline in which primary care physicians who have examined a patient with strong suicidal thoughts can contact a psychiatrist who is a familiar face, secure a referral destination, and receive advice about emergency responses.

Besides the Fuji Model Project and the Osaka G-P Net, cooperation between primary care physicians and psychiatrists is starting to spread throughout the country, including a prefecture-wide referral system developed by the Saga Medical Association. However, when establishing a cooperation system, consideration must be given to forms of cooperation suited to the circumstances of each community, including the problem of capacity at psychiatric hospitals/clinics. The key is whether primary care physicians and psychiatrists can establish a place for frank exchange of opinions at the same table and deepen relationships of trust between them while clarifying each other's issues. While cooperation entails various difficulties, it is strongly hoped that primary care physicians and psychiatrists can overcome differences in specialty and talk frankly with each other, leading to effective community medical cooperation with the goals of preventing suicide and protecting lives from suicide.

In the summer of 2011, it was decided to add mental disorders to the list of four diseases and five projects[*2] in priority healthcare planning, making five diseases and five projects. Even in formulating healthcare plans, community medical cooperation between primary care physicians and psychiatrists is indispensable. To start with, the building of face-to-face relationships between primary care physicians and psychiatrists as a measure against depression will likely make a major contribution to the promotion of measures against other mental disorders such as dementia and alcoholism.

Basic Knowledge About Alcoholism That Primary Care Physicians Should Learn

Although public awareness of depression has been increasing gradually, it is a fact that there is insufficient understanding of alcoholism, due in part to a cultural background of tolerance in Japan to alcohol drinking. Mental, physical, and interpersonal relationship problems frequently appear with alcoholism, but it is not uncommon for precious time to pass by and dependence to set in while attention is paid only to physical problems. Accordingly, it is desirable for medical personnel who are not specialists in psychiatry to also acquire appropriate knowledge about this problem.

Epidemiology of alcohol

The term "alcohol-related problems" refers to harm on the whole caused by the harmful use of alcohol; it does not refer only to disease but is a concept that also includes social problems such as driving under the influence and declines in labor productivity. Naturally, this problem is closely linked to amount of alcohol consumption.

The amount of alcohol consumption in Japan continued to increase consistently after World War II but has finally started to decline in the past few years (**Table 1**). It is presumed that this decline is not due to people drinking less but rather a result of beer with a low alcohol content and wine becoming mainstream alcoholic drinks (especially among the younger generation).

Moreover, while alcohol-related problems in Japan used to mainly be a problem of middle-aged men, new problems have started to stand

*2 Four diseases: cancer, stroke, acute myocardial infarction, and diabetes. Five projects: emergency medicine, medicine during a disaster, medicine in remote areas, perinatal care, and pediatric care (including emergency pediatric medicine).

Table 1 Per capita alcohol consumption by country (converted to pure alcohol)

(Unit: liters/year)

	1996	1997	1998	1999	2000	2001	2002	2003
Germany	11	10.8	10.6	10.6	10.5	10.4	10.4	10.2
France	11.2	10.9	10.8	10.7	10.5	10.5	10.3	9.3
USA	6.6	6.6	6.5	6.7	6.7	6.8	6.7	6.8
South Africa	4.9	4.8	4.8	5	4.7	4.8	4.7	4.6
Thailand	4.5	4.4	4.3	3.9	4.4	4.5	4.3	4.3
Brazil	4.1	4.1	4	4.2	4.5	4.1	4.2	4.2
China	3.7	3.8	3.7	3.8	4	3.9	3.9	4
Japan	6.7	6.4	6.5	6.6	6.5	6.5	6.5	6.5

(Source: National Tax Agency: Outline of Liquor Tax.)

out, such as the increase in women alcoholics following the establishment of drinking habits among women in recent years, drinking problems among seniors, and the connection between alcohol and suicide.

Underage drinking

At the same time that guidance is provided to adults to drink reasonably, there is a need to focus on drinking as well as smoking by minors and to provide health guidance on their harmful effects in school education as a public initiative. It is noteworthy that alcohol tolerance in minors forms quickly so that it takes only a very short period of several months to two years until alcoholism develops after starting a drinking habit.

Women and alcohol drinking

According to the 2005 National Health and Nutrition Survey in Japan conducted by the Ministry of Health, Labour and Welfare (MHLW), the drinking habits of women were increasing, in contrast to a shift downward from horizontal for men. Compared to men, there were more women who drink every day among the young adult segment and heavy drinking increased as age went down.

In the case of women, the period until alcoholism appears after starting to drink nearly every day is said to be 10 years shorter than for men (10 years for women versus 20 years for men). Also, there are two peak ages when women begin heavy drinking: in their 20s and around 45 (at menopause). Countermeasures are needed, since alcohol-related cirrhosis develops in a short period and with light drinking in women. Developing measures against fetal alcohol syndrome (FAS), caused by habitual drinking during early pregnancy, is also an issue.

Table 2 Goals in the area of alcohol in Healthy Japan 21

(1) Decline in the number of people drinking heavily (more than 60 grams of pure alcohol per day on average)

(2) Eliminate underage drinking

(3) Spread knowledge that reasonable and moderate drinking is about 20 grams of pure alcohol per day on average.

Measures against alcohol-related problems

As with alcoholism, measures against alcohol-related problems are needed in specialist medical institutions, but prevention activities in the community and educational settings basically are at the center of initiatives. The basic policy on prevention activities is National Health Promotion Movement in the 21st Century (Healthy Japan 21) established by the MHLW in 2000 (**Table 2**).[7]

Media and public interest in the harmful use of alcohol, which underlies problems such as driving under the influence, depression, and suicide, has finally started to increase in Japan in recent years. This is a good opportunity to resolve the problem, in response to which relevant associations have decided to strive toward the enactment of a basic act on measures against alcohol-related problems in Japan.

When enacting legislation specific to the problem of alcohol, measures need to be taken divided into primary, secondary, and tertiary prevention of alcoholism, heavy drinking, and alcohol abuse, and given budgetary backing. Measures need to be formulated for:

- Primary prevention (occurrence prevention: "reasonable and moderate drinking" in Healthy Japan 21);
- Secondary prevention (progression prevention: early detection, early intervention); and
- Tertiary prevention (recurrence prevention: one-year abstinence rate of about 30%)

The need for early intervention in heavy drinking

According to a nationwide survey conducted in 2003, the prevalence of alcoholism based on the

diagnostic criteria of the ICD-10*3 was estimated to be 1.9% for men, 0.1% for women, and 0.9% overall, resulting in an estimated 820,000 alcoholic patients in Japan.[8] On a patient survey conducted by the MHLW, there were about 50,000 people receiving treatment for alcoholism.

Features of the medical system

An outpatient medical system for alcoholism has not become established in primary care and psychiatric clinics. While primary care physicians treat things such as secondary impairment of liver function, alcoholism progresses, since patients are returned without guidelines and disease education regarding the underlying disease, which is alcoholism. Often the appearance of serious withdrawal symptoms after repeated doctors visits over about five years since the initial visit to a general practitioner leads to specialized treatment. The number of psychiatric hospitals that accept alcoholic patients is limited, on top of which many patients also have relatively severe physical complications, which means that hospitals have to have full-time radiologists and specialists in internal medicine who can diagnose and treat those conditions.

Cooperation in alcohol-related medicine between general practitioners and psychiatrists

If a patient who cannot stop drinking first goes to see a primary care physician, hepatic damage will likely get better with infusion of abstinence and liver protection drugs during a series of visits to the hospital or hospitalization as a physical disease without education regarding drinking. Immediately afterwards, the patient should be referred to and receive treatment in cooperation with an alcohol-related medicine specialist and self-help group. Practice of the three pillars of abstinence—1) one year commuting to a physician's office as an outpatient, 2) use of an alcohol-aversive drug, and 3) participation in a self-help group—are recommended as responses by psychiatrists. If by some chance the patient fails, a recurrence can be taken as a good chance to move to the recovery step, analyze conditions that led to the resumption of drinking from a slip, and take the time to eliminate those conditions one by one, thereby developing a lifestyle habit without alcohol from some point.

Infrastructure development

An inappropriate drinking habit is considered a problem when impairment of liver function or other such condition is pointed out at a periodic company health checkup. The most effective alcohol-related medicine cooperation is thought to be early intervention by an occupational physician, commissioned doctor, or the co-medical staff at a general practitioner's office or insistent referral to specialist in psychiatry in conjunction with treatment for the impairment of liver function. For that reason it is important for primary care physicians to practice early intervention regarding the ill effects of alcohol. It is a misfortune for a patient to be told about organ damage from alcohol, go through numerous recurrences at a general practitioner's office, only to undergo specialized alcohol treatment after several years have passed. Likewise in terms of the medical care provided, the waste in healthcare costs deserves to be pointed out. It is crucial for primary care physicians who have seen a patient who has come because of bodily wasting with the presentation of secondary gastrointestinal distress and impairment of liver function as a result of the first instance of continuous drinking, to direct the patient from that early point into specialized treatment for alcoholism, which is the underlying disease.

Alcoholics fundamentally have poor interpersonal skills and are simple people who could hardly lie with a sober face. This is why it is often seen that they are led relatively smoothly to specialized treatment (whether hospitalized or outpatient) and do fairly well at developing lifestyle habits with no alcohol when given a referral letter from an internist or other physician early on.

Undergraduate Education, Postgraduate Education, and CME About Mental Disorders

Japan creates about 8,000 physicians every year. The new residency program that began in 2004 made the conventional two-year clinical

*3 International Classification of Diseases. ICD-10 was endorsed by the 43 World Health Assembly in May 1990 and came into use in WHO Member States from 1994.

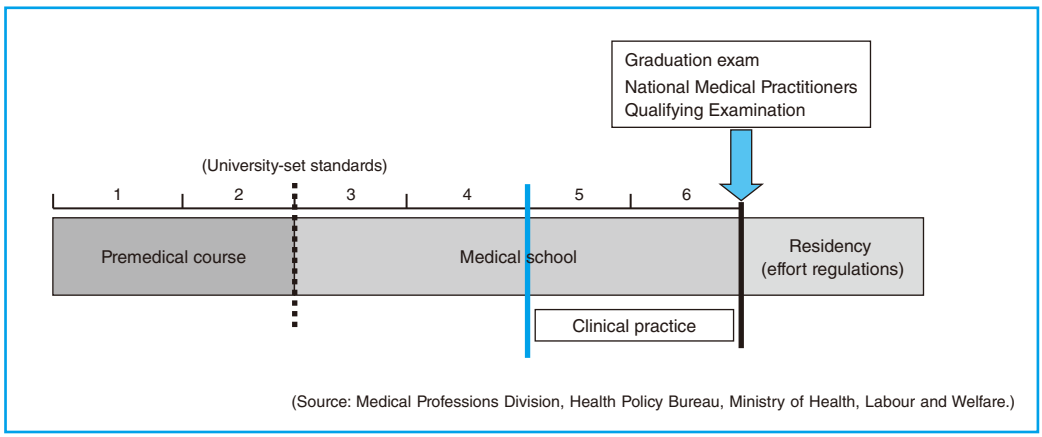

Fig. 4 Educational system until 1991

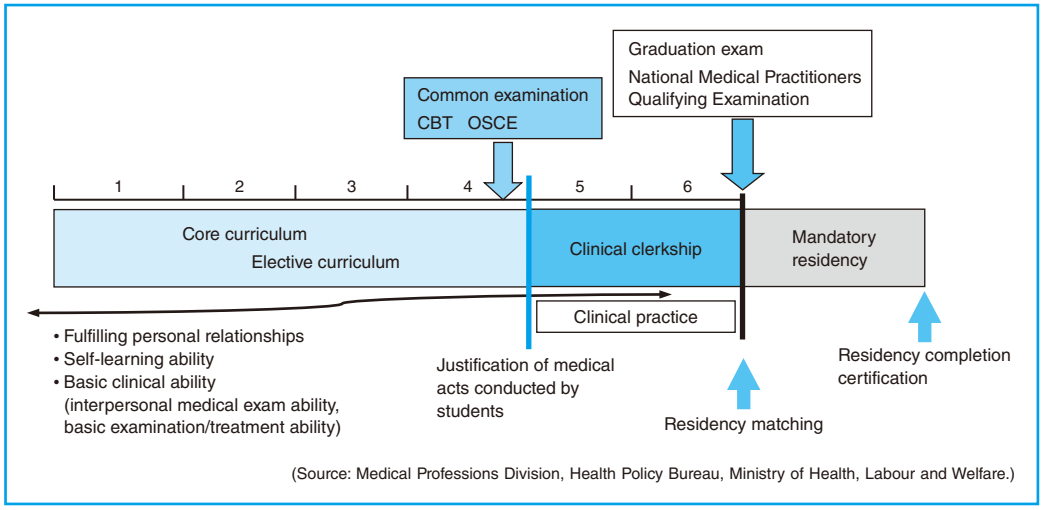

Fig. 5 Educational system from 1991

training after graduation mandatory. All physicians who will engage in clinical practice are required to undergo the training and must be listed in the Physician's Register after completing the training. This reform affected not only the education of physicians during the two years after graduation; it also brought new currents to medical education reform and undergraduate education, affected the career formation of physicians after completion of the new residency program, and also raised a question about senior resident (specialist) training. In other words, the physician-training course in Japan is changing greatly. In light of these trends, this section discusses undergraduate education, postgraduate education, and CME about mental disorders, especially in medical schools.

Medical education reform and psychiatry education (Figs. 4 and 5)

The trend in medical education reform appeared as changes in the educational concept. The new medical education started with the introduction of a new model for undergraduate education reform: 1) core curriculum; 2) PBL (Problem-based Learning) tutorials; 3) clinical clerkships;

4) common examination CBT (Computer-based Testing); and 5) OSCE (Objective Structured Clinical Examination), etc. What the new medical education aims for is the introduction of rational educational methods in conformity with educational theory (especially adult learning theory) and outcome-based education that clarifies the desired results (outcome) of education and has the responsibility to deliver those outcomes. Changes in society's expectations of physicians are what triggered this trend. People want physicians to:

1) Look not only at disease but also at the whole person who is ailing and to solve that problem;
2) Sufficiently explain the condition of disease and the medical acts they try to perform; and
3) Perfectly acquire necessary knowledge and skills.

In other words, holistic medicine, informed consent, and improved knowledge and skills are needed. In this situation, the expected outcomes are:

1) Medical professionals who can practice patient-centered medicine;
2) Medical professionals with excellent communication abilities;
3) Human resources who take ethical problems serious and deal with them appropriately;
4) Medical professionals who have acquired a broad range of quality clinical abilities;
5) Human resources focused on discovering and resolving problems; and
6) Medical professionals who have acquired a habit of CME and who can practice evidence-based medicine.

As a measure to address those expectations, a core curriculum was selected in 2001 in order to carefully select learning goals. The introduction of a core curriculum responds to the diversification of medical science and medical care needs and the expansion of medical science and medical care information and knowledge. It brought about a system in which priority is given to studying basic content carefully selected as the core curriculum in addition to which students independently select course to take from among the elective curriculum. What the core curriculum requires is an integrated curriculum in which the method of teaching content divided up into things like structure and function/pathological condition, which was the case in traditional medical education, is changed so that these are not divided and an approach that emphasizes symptoms and pathological condition makes students acquire clinical and lateral thinking. It also has the features of 1) emphasizing medical ethics, medical safety, issue exploration, and problem solving skills, and 2) exhibiting an essential minimum level in knowledge, attitude, and skills.

Conventional psychiatry education has been unvalued and not many current physicians have groundings in psychiatry while many try to avoid an examination when faced with a mental disorder patient. Given this background, it is highly significant that the field of psychiatry was incorporated into the core curriculum of medical education. With this, minimum requirements for psychiatry education in medical schools have been set forth, such as good patient-doctor relationships of trust, holistic medicine, psychiatric interviews, psychiatric diagnosis classification, law and ethics of psychiatric care, and consultation-liaison psychiatry.

The curriculum is made so that students learn about symptoms and illnesses encountered frequently in daily practice including symptoms such as anxiety; manic-depressive state; insomnia; and hallucinations and delusions, and illnesses such as symptomatic psychosis; dementia; abuse, dependence, and withdrawal from drugs and alcohol; schizophrenia; depression; bipolar disorder; anxiety disorder; stress-related diseases; and psychosomatic diseases (including eating disorders).

Psychiatry education in postgraduate education

Psychiatry education in postgraduate education occupies an important position as junior resident training, and the road to specialist training has been established. This section discusses the junior resident training, with which all physicians are concerned. The basic concept for junior resident training is: 1) development of an environment in which residents can give their undivided attention to training without working part-time jobs during the period for forming a base as a physician; 2) acquisition of basic practice abilities that enable residents to deepen their understanding of primary care and see patients holistically; and 3) cultivate character as a physician. This concept is reflected in the "basic philosophy."

Making psychiatry compulsory in junior resi-

Table 3 Comparison of prevalence and level of awareness on the part of internists in Nagasaki, Manchester, and Seattle

ICD-10F diagnosis	Nagasaki	Manchester	Seattle
Some kind of psychiatric diagnosis	14.8 (18.3)	26.2 (62.9)	20.4 (56.9)
Alcohol-related disorder	2.7 (0.0)	2.3 (66.1)	1.5 (44.3)
Depression	3.4 (19.3)	16.9 (69.6)	6.3 (56.7)
Generalized anxiety disorder	5.0 (22.5)	7.1 (72.3)	2.1 (46.8)
Panic disorder	0.2 (0.0)	3.5 (70.6)	1.9 (31.9)
Neurasthenia	3.4 (10.9)	9.7 (49.8)	2.1 (76.9)

Figures in parentheses show the level of awareness as a percentage (concordance rate for clinical diagnosis by specialists and internists).

(Source: Nakane Yoshibumi. Journal of Japanese Association of Psychiatric Hospitals. 2002;21(11):17–20.)

dent training will give physicians who do not specialize in psychiatry in the future psychiatric groundings and is expected to have such benefits as: 1) acquiring the ability to communicate fully with patients and their families; 2) becoming able to practice holistic medicine—that is, becoming able to provide comprehensive treatment and care from physical and psychosocial aspects; 3) becoming able to practice team-based medicine with many co-medical staff members and learning the role of a coordinator; 4) becoming able to make accurate psychiatric diagnoses of patients who first visit a department other than psychiatry; and 5) becoming able to correctly prescribe frequently used antidepressants, antianxiety agents, and sleeping pills. Furthermore, from the point of view of psychiatrists, it is hoped that this will be a golden opportunity to achieve benefits such as: 6) removing the lack of understanding and prejudice toward psychiatry on the part of other clinical specialties; 7) increasing the number of physicians with an interest in psychiatry, connecting that interest to senior resident training, and thereby increasing the number of psychiatrists in the future; 8) making it easier to provide liaison-consultation psychiatric care; and 9) helping to raise the level of psychiatric care.[9]

What the Seven-party Psychiatry Council stressed as necessary in making psychiatry mandatory was: 1) the diagnostic rate among general practitioners for mental disorders (depression, alcoholism) is low compared to other countries (**Table 3**)[10,11]; 2) even though general practitioners use more antidepressants, antianxiety agents, and sleeping pills than psychiatrists, they have limited psychopharmacological knowledge and there are problems with the way they use these drugs; 3) a bio-psycho-socio-ethical perspective is essential for medical professionals, and for sure this is something that can be learned through psychiatry; 4) the need for mental health care for patients and their families in settings of new types of medical care such as medical transplantation, genetic diagnosis and treatment, and terminal care; and 5) understanding of social rehabilitation activities and community rehabilitation.[7]

It is likely that over the training period residents will be able to achieve the experiential goal of "being able to conduct a medical examination of mental aspects and record it," through: 1) acquisition of the diagnostic and treatment skills for psychological symptoms that are needed in primary care; 2) acquisition of medical communication skills; 3) acquisition of assessment and treatment skills for psychological symptoms of patients with physical disease; 4) acquisition of the skills needed in team-based medicine; 5) experience of psychological rehabilitation and community support systems. Moreover, the public expects "physicians to be able to provide community medicine and participate in society." For that reason, it will likely be of great benefit to see and experience activities that are distinctive of psychiatry such as: 1) social rehabilitation activities; 2) psychiatric rehabilitation; 3) understanding of welfare activities and societal resources; and 4) community rehabilitation.

In March 2006, the first junior residents completed the training. Starting after the summer of 2006, the Seven-party Psychiatry Council's Com-

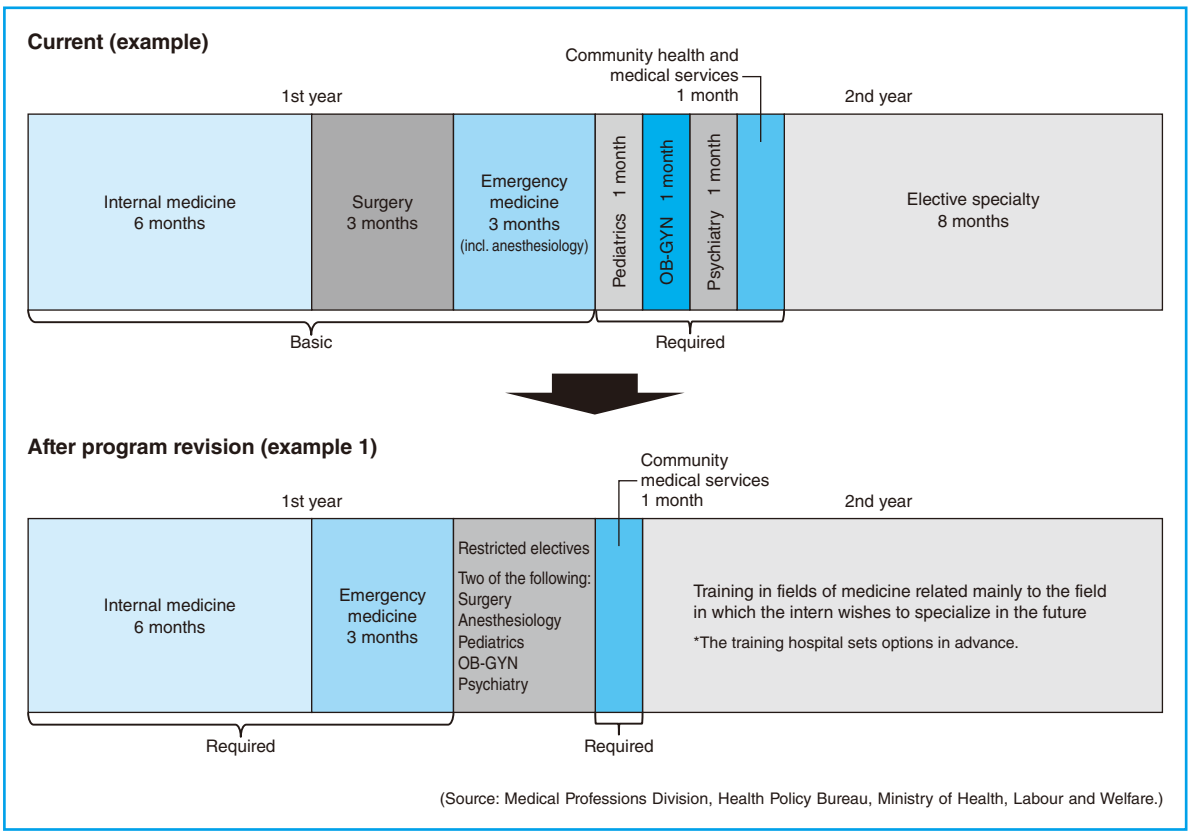

Fig. 6 Overview of changes in the residency program

mittee for Problems of Postgraduate Training, the Japan Psychiatric Hospitals Association, and the National Hospital Organization each conducted questionnaire surveys and other investigations to assess the outcomes of the psychiatry training. The results were high evaluations across the board in effects, level of participation, and usefulness.[9,12,13]

This system was reviewed in 2008. Initially, the MHLW's Medical Ethics Council concluded to only make small modifications. In the fall, however, a committee was established all of a sudden to make an urgent review of the residency system and ended up making sweeping changes (**Fig. 6**). It must be said that these were changes for the worse. There are two objectives of the residency program revisions: 1) respond to the shortage and uneven distribution of physicians; and 2) improve the quality of clinical training. There were three key points to the revisions: 1) introducing more flexibility in the residency program (stressing principles and attainment targets over format); 2) introduction of core clinical training hospitals and strengthening of designated standards; and 3) establishment of recruitment quotas for each prefecture. While there was no change in the curriculum, the designation of psychiatry as a restricted elective has created a big contradiction: what are residents who do not choose category A diseases (schizophrenia, mood disorder, and dementia in the case of the field of psychiatry) for "being in charge of a hospitalized patient and preparing a report," which is a required item in the curriculum, supposed to do? This system was applied starting with new residents in April 2010. The revisions are clearly a step backward and have set off flashing red lights in the development of the kind of physicians expected by the public. The outcomes of this step must be assessed.

Psychiatry education in CME activities

There are extremely few occupational physicians who are psychiatrists.[9] The needs of the times

Table 4 Special editions of the Journal of the Japan Medical Association (Nippon Ishikai Zasshi) related to psychiatry

Subject	Volume	Date (MM.DD)	Year
• Psychiatry Knowledge Needed in Primary Care	112.10	11.1	1994
• Mental Health of Children	113.9	5.1	1995
• Psychiatric Problems of Modern Society	119.9	5.1	1998
• Psychiatric Evaluation	125.9	5.1	2001
• Suicide Prevention Manual: Early Detection and How to Deal with Depression in General Medical Institutions		3.1	2004
• Psychiatric Disorders in Clinical Practice (Continuing Medical Education Series 64)	131.12	6.15	2004
• Mental Health in the Workplace	136.1	4.1	2007
• Good Use of Psychotropics in Primary Care (planning/supervision: Chiharu Kubo and Kunitoshi Kamijima)	136.8	11.1	2007
• Suicide Prevention Manual, 2nd Edition: Guidelines for Physicians Responsible for Community Medicine on Early Detection and How to Deal with Depression		3.1	2008

for psychiatrists have increased in the fields of occupational health and occupational mental health. Several years ago the Occupational Health Promotion Foundation started sponsoring classes on introductions to occupational health and on overwork and mental health measures for general practitioners (especially occupational physicians) and classes on occupational health for psychiatrists who are not occupational physicians. These workshops include aspects that are a part of measures to combat suicide and depression in the field of occupational health. At the level of local medical associations, attempts to establish GP networks—a system for general practitioners (G) and psychiatrists (P) to cooperate—have begun, and study sessions are now held. Additionally, a development has started to conduct psychiatry in primary care (PIPC) workshops, which have been incorporated into specialist training conducted by the American College of Physicians, here in Japan.

Furthermore, local medical associations and administrative authorities around the country have been cooperating to hold training sessions to improve the ability of primary care physicians to respond to dementia and depression. Physicians taking foundational training and lifelong training sessions in the JMA-certified occupational physician program are required to earn credits in mental health. The textbook used in those training sessions—a special edition of the Journal of the Japan Medical Association (Nippon Ishikai Zasshi)—has been widely distributed to members and is helping with CME. Other valuable special editions of the Journal of the Japan Medical Association have been produced since 1994 and have been of use to members (**Table 4**). Developmental disabilities and mental disorders of school children are now brought up as topics at nationwide school health and school physician conferences held every year, and groundings in psychiatry have become important for school physicians as well. School mental health and occupational mental health are not branches of psychiatry; today, all physicians will be involved in these areas. Further, opportunities are increasing for physicians to provide medical care to elderly persons with dementia and mental disorders. Physicians are now required to practice holistic medicine for people of all age groups, including children, adolescents, adults, and the elderly.

Mental disorders were added during the formulation of the 6th regional healthcare plan, requiring community responses as five diseases and five projects. In that sense as well, it is possible that the direction of CME could change greatly in the future.

Proposal Regarding Medical Fee Payment Relating to Depression and Suicide Countermeasures

There are over three million mental disorder patients in Japan and the public's medical needs for mental health have increased in the extreme. Suicide prevention in particular is an important problem. Psychiatric care has a major role to play in suicide prevention. Historically, early detection of mental disorders associated with suicide, including depression, and facilitating the acceptance of appropriate psychiatric care have been stressed as suicide prevention measures.[14]

It has been shown that most depression patients first see a primary care physician that does not specialize in psychiatry.[4] Considering this point, cooperation between primary care physicians and psychiatrists is an important key in depression and suicide countermeasures. It is also extremely important to provide appropriate psychiatric care to patients who go to see a psychiatrist. It is no exaggeration to say that the very act of clinical psychiatry in examining patients who have suicidal thoughts occupies a big part of suicide prevention.

In light of the above, we seek the following in the medical fee schedule:

1) Evaluation for examination of referred patient
   a) Add points also to psychiatrist.
2) Revision of at-home and outpatient psychotherapy
   a) Revision of points: secure payment for medical services commensurate with the time spent with the patient.
   b) Make service billable even when the time spent for the first examination is less than 30 minutes.
   c) Revision of assessable frequency limit: make at least two times per week billable.
3) Revision of at-home and outpatient psychotherapy for families
   a) Make service billable even on the same day as examination of the patient.
   b) Make service billable even for disease explanation and treatment method guidance by psychiatrist.
4) Evaluation of involvement for company personnel, etc.
   a) Make service billable for at-home and outpatient psychotherapy.
5) Evaluation of team-based medicine; evaluation of contribution of psychologists and psychiatric social workers, etc.
   a) Make additional computations for development of recuperative living environment billable at the same time as at-home and outpatient psychotherapy.
   b) Evaluation of involvement (preliminary examination, etc.) of psychologists.
   c) Make points for psychological testing adequate.

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