SPECIAL ARTICLE

Recent Developments in Community-Based Mental Health Care in Japan: A Narrative Review

Последние достижения амбулаторной психиатрической помощи в Японии: нарративный обзор

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Review

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ABSTRACT

BACKGROUND: Since the 1950s, mental health care in Japan has been hospital-centered. A set of legislative initiatives were undertaken in 1995, emphasizing the importance of community-based mental health care. However, despite these attempts to develop a community-based mental health care system, the rate of inpatient-based treatment has remained high and the shift from hospital-centered care to community-based has still not fully materialized.

AIM: This study aims to conduct a review of the available literature on the development of community-based mental health care in Japan between 2010 and 2020.

METHODS: We conducted a standardized literature search in the electronic database Igaku Chuo Zasshi, aiming to identify original studies published between 2010 and 2020 that explored community mental health care in Japan. The included studies' outcomes were categorized as performance surveys, service user reports, service provider reports, and educational activities. A descriptive-analytical method was implemented in the current review.

RESULTS: A total of 25 studies were examined. Six studies reported surveys assessing the performance of community-based mental health care on the assertive community treatment (ACT), compulsory treatment, home-visit nursing care, physical complications, and a welfare medicine collaboration on a remote islands. Four studies investigated the perspectives of service users or their families on home-visit nursing care, social participation, community program, and legislative revision. Ten studies focused on social withdrawal, service providers perspectives on local population needs, supporting skills, care programs, and the professional growth of psychiatric social workers. Five studies focused on educational approaches for future healthcare professionals and efforts to improve mental health literacy among adolescents.

CONCLUSION: This paper provided the first comprehensive review of Japan's community-based mental health care. Between 2010 and 2020, community mental health care in Japan evolved in many directions, with the understanding that various needs should be met. Home-visit nursing care and ACT can be considered as the most thoroughly investigated and better developed. Research that adopt rigorous methodologies such as randomized controlled trials is required if the goal is to achieve solid conclusions.

АННОТАЦИЯ

ВВЕДЕНИЕ: С 1950-х годов психиатрическая помощь в Японии была главным образом сосредоточена в стационарах. В 1995 г. в законодательство был внесен ряд изменений, которые подчеркнули важность амбулаторной психиатрической помощи. Однако, несмотря на попытки развития системы амбулаторной психиатрической помощи, уровень стационарного лечения остается высоким, а переход от больничного лечения к амбулаторному так и не осуществился в полной мере.

ЦЕЛЬ: Целью данного исследования является обзор доступной литературы, посвященной развитию амбулаторной психиатрической помощи в Японии в период с 2010 по 2020 гг.

МЕТОДЫ: Мы провели стандартизированный литературный поиск в электронной базе данных Igaku Chuo Zasshi с целью найти оригинальные исследования об амбулаторной психиатрической помощи в Японии, опубликованные в период с 2010 по 2020 гг. Результаты выбранных исследований были классифицированы как опросы эффективности, отчеты пользователей услуг, отчеты поставщиков услуг и образовательные мероприятия. В настоящем обзоре использован описательно-аналитический метод.

РЕЗУЛЬТАТЫ: Всего включено 25 исследований. В шести исследованиях сообщалось об опросах, оценивающих эффективность амбулаторной психиатрической помощи в проведении ассертивной амбулаторной терапии, принудительного лечения, сестринского ухода на дому, соматических осложнений и социально-медицинском сотрудничестве на отдаленных островах. В четырех исследованиях изучали представления потребителей услуг или их семей о сестринском уходе на дому, социализацию, общественные программы и изменения в законодательстве. Десять исследований были посвящены социальному отчуждению, представлениям поставщиков услуг о потребностях населения, навыкам обслуживания, программам ухода и профессиональному росту психиатрических социальных работников. Пять исследований были посвящены подходам к обучению будущих медицинских работников и мерам по повышению грамотности подростков в вопросах психического здоровья.

ЗАКЛЮЧЕНИЕ: В данной статье представлен первый всеобъемлющий обзор амбулаторной психиатрической помощи в Японии. В период с 2010 по 2020 гг. в Японии наблюдалось развитие амбулаторной психиатрической помощи во многих областях благодаря растущему пониманию необходимости удовлетворения существующей потребности. Наиболее изученными и разработанными видами помощи можно считать сестринский уход на дому и ассертивную амбулаторную терапию (ААТ). Исследования, в которых используется строгая методология, такая как рандомизированные контролируемые испытания, необходимы, если целью является получение надежных выводов.

Keywords: *community-based mental health; assertive community treatment; compulsory treatment; home-visit nursing care; physical complication*

Ключевые слова: *амбулаторная психиатрическая помощь; ассертивная амбулаторная терапия; недобровольное лечение; сестринский уход на дому; соматическое осложнение*

INTRODUCTION

The effectiveness of community-based mental health is being increasingly recognized worldwide [1, 2]. The approach encourages not just a deinstitutionalized and decentralized treatment view, but it also advocates interacting with persons with mental illnesses in a community setting [3, 4]. The foundational principles of community-based mental health care are the following: 1) consider every person experiencing a mental illness as a multifaceted individual and avoid any stigma-heavy attitude such as perceiving the person as a mere 'patient' [5, 6]; 2) focus not only on the person's deficit and disability (an illness perspective), but more so on the person's strength, capacity, and aspiration (a recovery-emphasizing

perspective) [7]; 3) plan a person-centered care execution based on the needs of the user, their values, and preferences [8]; 4) find and identify the needs of every local population [7]; 5) implement a care approach that is accessible and acceptable to those with mental illnesses [7], and 6) advance the coordination of care by promoting wide networks of support and service across different mental health and other health structures [9].

Japan's legislative origin of its hospital-centered system can be traced to the 1950s, when home confinement was prohibited, and involuntary admission was enacted. In 1957, a discriminatory law for psychiatric wards was passed, setting the physician/patient and nurse/patient ratio three times and one-and-a-half times higher, respectively. Since psychiatric hospitals did not need to hire many physicians and nurses, the number of psychiatric hospitals considerably increased in the 1960s and 1970s. This increase caused untoward growth in inpatient admissions, deterioration in the quality of inpatient treatment, and prolonged hospitalization in Japan. General characteristics of the mental health care system in Japan are illustrated in Table 1.

A set of legislative revisions were made in 1995, emphasizing the importance of community-based mental health care. Consequently, the number of psychiatric outpatient clinics rapidly increased and "home-visit nursing stations" have become available. Also, the provision of administrative home-visit services was transferred from the larger administrative entity of the prefecture to the smaller one of the municipality, making the service more accessible. Currently, community-based mental health care includes the following: home-visit nursing care, administered by medical institutions, outpatient clinics, nursing stations, and administrative home-visit services arranged by municipalities and Public Health Centers (PHCs). The Mental Health and Welfare Centers (MHWCs), operated by prefectures and designated cities, are central to community-based mental health care.

Table 1. General characteristics of the mental health care system in Japan

Mental health care facility	**Number**
Psychiatric hospital [49]	1,054 (2019)
General hospital with a psychiatric department [49]	1,760 (2019)
Psychiatric outpatient clinic [50]	6,864 (2017)
Home-visit nursing station[a] [51]	11,580 (2019)
ACT team [10]	26 (2021)
Public Health Center [52]	470 (2021)
In-hospital psychiatric treatment [49]	**Number/Length**
Psychiatric bed	326,666 (2019)
Inpatients in a day (mean)	
Psychiatric hospital	213,237 (2019)
Psychiatric ward of general hospital	68,089 (2019)
Inpatient treatment (days, mean)	265.8 (2019)
Home-visit psychiatric nursing service [50]	**Number**
Hospital	838 (2017)
Visit in a month per hospital (mean)	135.9 (2017)
Psychiatric clinic	457 (2017)
Visit in a month per clinic (mean)	54.0 (2017)
Medical expenditure [b] [53]	**Expenditure (billion JPY)**
For persons with mental and behavioral disorders	1,921 (2018)
In-hospital treatment	1,362 (2018)
Other than in-hospital treatment	559 (2018)

Note: Abbreviations — JPY, Japanese Yen; [a] — Home-visit nursing stations' include all nursing stations providing medical home-visit nursing care, not restricted to stations providing psychiatric nursing care; [b] — medical expenditure' does not include expenditure for home-visit nursing care.

The Assertive Community Treatment (ACT) program was commenced as a research project in 2001 [10]. Furthermore, the Japanese government launched the second five-year period of the "Vision for the Reform of Mental Health and Medical Welfare" program in 2009. Following this program, the Ministry of Health, Labor, and Welfare's Department of Health and Welfare established the "Study Team for the Establishment of a New Regional Mental Health Care System" in 2010.

Despite the attempts to develop community-based mental health care, the rate of inpatient-based treatment remains high. Hospital-centered care transformation has not yet been completed [11], and an in-depth analysis of the situation is required [3]. This study aims to review the available literature on the development of community-based mental health care in Japan.

METHODS

Search strategy

A standardized literature search was conducted in the electronic database called Igaku Chuo Zasshi (Ichushi), issued by the Japan Medical Abstracts Society in January 2021, using a "community-based mental health services" keyword for titles, abstracts, and keywords. Ichushi is a bibliographic database established in 1903, containing bibliographic citations and abstracts from more than 2,500 biomedical journals and other serial studies published in Japan.

Selection criteria

Studies were eligible if they met the following conditions: (a) they were original research articles of any design reporting findings on the development of community-based mental health care in Japan, and (b) were published between 2010 and 2020. This timeframe was chosen, because the development of community-based mental health care supported by the government started in 2010. Meeting reports, perspectives, reviews, opinions, and commentaries were not eligible for inclusion.

Identification and data extraction

A review author (YT) screened all abstracts to find studies that met the inclusion criteria and retrieved all full-text copies that might be relevant. Two review authors (JI and TA) independently assessed full-text articles for eligibility. Any disagreements about the selection process were resolved by discussion. Primary findings were extracted into a spreadsheet as reported by the authors of the included studies, avoiding re-interpretation [13]. The final extraction form included the following categories: study design, aim, population, data collection methods, number of enrolled participants (response rate), and data analysis method.

Data analysis

A descriptive-analytical method was employed for the current review. The findings of the included studies were categorized as performance surveys, service user reports, service provider reports, and educational activities.

RESULTS

The original search identified 243 potentially relevant studies. Among them, 212 were meeting reports, perspectives, reviews, opinions, and commentaries, which were excluded during the abstract screening stage. The full texts of 31 articles were assessed. Six studies were excluded, since they concerned mental health care outside of Japan. As a result, 25 studies were included (Figure 1). The overall characteristics of the included studies are presented in Table 2.

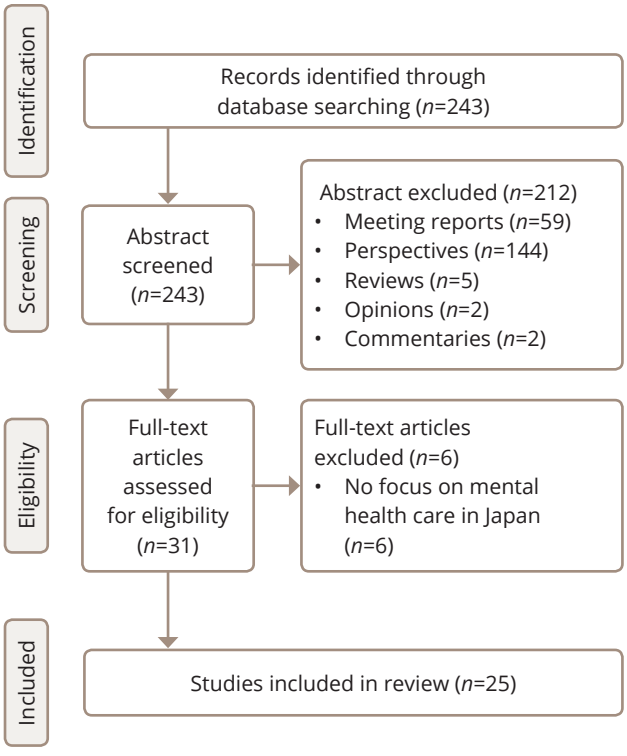

Figure 1. Flow diagram of the study search and inclusion process.

Table 2. Overall characteristics of the included studies

Study	Design	Focus	Population	Data collection methods	No of enrolled participants (response rate)	Analysis method
Performance surveys						
Yoshida et al. 2011 [14]	Cross-sectional study	ACT	Service users of ACT and usual home-visit nursing service	Questionnaire for supporter	42 ACT users from 6 teams 124 home-visit nursing users from 21 stations	*t*-test
Yoshida et al. 2013 [15]	Prospective double-cohort study	ACT	Participants of the previous study [13]	Questionnaire for supporter	32 ACT users from 5 teams (follow-up rate: 76.2%) 96 home-visit nursing users form 21 stations (follow-up rate 77.4%)	Repeated measures two-way ANOVA
Nagata et al. 2016 [16]	Retrospective cohort study	Compulsory treatment	Recipients ordered in-hospital treatment	Questionnaire for rehabilitation coordinator	402 users from 25 designated medical institutions	Survival time analysis
Tsujimoto et al. 2017a [17]	Cross-sectional study	Compulsory treatment	PHCs and MHWCs	Questionnaire for public nurse or psychiatric social worker	329 PHCs (response rate: 66.6%) and 69 MHWCs (response rate: 100%)	Descriptive statistics
Tsujimoto et al. 2017b [17]	Serial cross-sectional study	Compulsory treatment	Recipients ordered treatment	Questionnaire for public nurse or psychiatric social worker	785 users (2012, response rate 72.1%); 1,124 users (2013, response rate 65.0%); 1,202 users (2014, response rate 66.6%)	Descriptive statistics
Noguchi 2014 [18]	Case study	Home-visit treatment and care	Service users with physical complications	Existing record	3 users	-
Hanashiro et al. 2016 [19]	Practice report	Home-visit welfare service	Welfare Institutions	Existing record	3 institutions	-
Service user reports						
Narita et al. 2014 [21]	Cross-sectional study	Home-visit nursing care by public nurse	Service users	Semi-structured interview	5 users	Qualitative analysis
Inoue et al. 2011 [22]	Cross-sectional study	Social participation	Service user participants in volunteer activities	Focus group interview	6 users	Qualitative analysis
Komatsu 2020 [23]	Cross-sectional study	Community program (stigma eradication)	Participants in a program	Questionnaire	10 respondents among 16 participants (response rate 62.5%)	Qualitative analysis
Matsushita 2018 [24]	Cross-sectional study	Legislative Revision	Members of Family Associations	Questionnaire	219 among 270 members from 4 associations (response rate 81.8%)	χ-square test
Service provider reports						
Tsujimoto et al. 2017 [25]	Cross-sectional study	Social withdrawal	PHCs	Questionnaire	353 among 485 PHCs (response rate 72.8%)	Descriptive statistics
Hirokawa et al. 2013 [26]	Cross-sectional study	Public assistance recipient	Municipalities	Semi-structured interview	5 municipalities	Qualitative analysis
Yoshioka-Maeda et al. 2017 [27]	Cross-sectional study	Clinical supervision	Service users supported by a municipality	Existing records	309 of 372 users, 5 supervisors	Qualitative analysis
Okada 2017 [28]	Cross-sectional study	Technical support	Psychiatric social workers in prefectures	Semi-structured interview	7 psychiatric social workers among 20 candidates	Qualitative analysis

Table 2. Overall characteristics of the included studies (continued)

Study	Design	Focus	Population	Data collection methods	No of enrolled participants (response rate)	Analysis method
Suzuki et al. 2010 [29]	Cross-sectional study	Disaster mental health service	Public nurse participants in training workshops	Questionnaire	523 respondents among 1,031 participants (response rate 51.3%)	Descriptive statistics
Fujisawa et al. 2019 [30]	Cross-sectional study	Disaster mental health service	Member of clinical psychologist society in a disaster site	Questionnaire	81 among 220 members (collection rate 36.8%)	Multiple logistic regression analysis
Taneda et al. 2016 [31]	Cross-sectional study	Disaster mental health service	On-site supporters in Great East-Japan Earthquake site	Focus group interview	55 supporters from 7 sites	Qualitative analysis
Yamamoto et al. 2010 [32]	Case study	Child-adolescent mental health service	Service user of Child Welfare Center	Existing record	1 user	-
Yoshino et al. 2018 [33]	Case study	Home-visit nursing care program	Service user participants in Meriden Family Programme	Existing records	2 users	-
Shiomitsu 2012 [34]	Cross-sectional study	Service provider's growing process	Psychiatric social workers in leadership position	Semi-structured interview	7 psychiatric social workers	Qualitative analysis
Educational activities						
Hisai 2010 [35]	Cross-sectional study	Learning in Community	Nursing students and training officers of work-support institutions	Existing records for students; Questionnaire for training officers	11 students and 2 training officers	Qualitative analysis
Higashi et al. 2012 [36]	Cross-sectional study	Learning in Community	Nursing students	Questionnaire	54 students	χ-square test
Arai 2011 [37]	Cross-sectional study	Learning in Community	Welfare institutions receiving nursing student' practical learning	Questionnaire	52 users and 12 staff from 4 institutions (response rate 100%)	Qualitative analysis
Omori et al. 2011 [38]	Cross-sectional study	Social participation	Nursing student participants in community activities	Focus group interview	7 students	Qualitative analysis
Uematsu et al. 2017 [39]	Practice report	Community program (mental health literacy)	Public schools	Existing record	8 junior high schools and 1 high school	-

Note: Abbreviations — ACT, Assertive Community Treatment; PHCs, Public Health Centers; MHWCs, Mental Health and Welfare Centers.

Performance surveys

Six studies reported on surveys assessing the performance of community-based mental health care on the ACT, compulsory treatment, home-visit nursing care, physical complications, and a welfare medicine collaboration on a remote island [14–19]. One article reported on two sets of results obtained using two different research designs [17].

In the study by Yoshida et al. (2011), two types of home-visit services, the ACT program and usual home-visit psychiatric nursing care, were compared in terms of service quality for persons with severe mental illnesses. According to the results, the ACT provided substantial support in managing psychiatric symptoms and daily living. In contrast, usual nursing care included more assessments on drug side effects and coping with physical

symptoms. In contrast, standard home-visit nursing care was shorter and less frequent for users with higher Global Assessment of Functioning (GAF) Scale scores (p=0.001, respectively) [14].

Yoshida et al. (2013) analyzed the characteristics of ACT and home-visit nursing care. They reported that ACT extended intensive care to users with low scores based on the (GAF) scale. ACT users could actively utilize three service items: assistance with shopping, building relationships with staff, and aid in relations with other health and social care staff. However, home-visit nursing care shifted from direct to indirect nature after one year of service [15].

Recipients of compulsory treatment because they had committed serious crimes were considered as another population group. Compulsory treatment was legalized by the Medical Treatment and Supervision Act in 2005. In the nine-year follow-up study of 402 patients, Nagata et al. (2016) reported that five persons committed seven severe re-offenses, 14 persons attempted 18 suicides, six suicides were completed, and 157 re-admissions were registered to designated institutions under the Medical Treatment and Supervision Act and psychiatric wards under the Mental Health and Welfare Act. The standardized mortality ratio was 3.84 (95% CI 0.1–7.6) (P-value was not provided) [16].

In the study by Tsujimoto et al. (2017), the effectiveness of the treatment order in the context of changes in recipients' living arrangements was examined from the viewpoint of PHCs and MHWCs. Overall, 266 out of 329 PHCs (80.9%) and 51 out of 69 MHWCs (73.9%) supported recipients under compulsory treatment. The number of recipients supported by PHCs increased from 785 to 1,202 in three years. In the same three years, the number of persons who underwent treatment under the Mental Health and Welfare Act increased from 51 to 87. However, the employment rate in the third year of follow-up was only 9.3% (10 out of 107 persons) for regular work and 5.6% (6 out of 107 persons) for welfare employment [17].

Co-occurring physical complications for persons with a mental illness represent another set of challenges for community-based mental healthcare. A case report by Noguchi (2014) proposed a team-based home-visit service involving psychiatric treatment to address these challenges. It was suggested that regular home visits, visits to the physical department in a hospital, psychiatrist-physician cooperation, and management of care would help persons with a severe mental illness to recognize symptoms properly and receive the necessary treatment [18].

A welfare-medicine collaboration on a remote island without psychiatric facilities was reported by Hanashiro et al. (2016). Among home visits provided by a Core Consultation Support Center, 85 out of 268 (31.7%) were accompanied by home-visit treatment or nursing care. Furthermore, 122 visits (45.5%) were provided in partnership with another welfare institution called Place of Business for Consultation Support [19].

Service user reports

Four studies investigated the perspectives of service users or their families regarding home-visit nursing care, social participation, community program, and legislative revision [20–23].

In the study by Narita et al. (2014), persons with schizophrenia evaluated home-visit nursing care by public health nurses. Positive feedback regarding home-visit nursing care was received concerning "advice regarding living arrangements", "listening and watching" with concerns, and "support by forming familiar relationships" [20]. According to Inoue et al. (2011), persons with mental disabilities who helped persons with intellectual disabilities as volunteers reported that they (persons with mental disabilities) had not only "acquired skills of living in the community" and "broadened the area of daily living", but also "felt fulfillment and satisfaction" and "experienced a sense of being a member of society". Volunteer service users were encouraged by self-help groups and intimate supporters in a comfortable environment [21].

Komatsu (2020) investigated the effectiveness of community programs and reported that, after a two-hour community group work program aimed at doing away with stigma, nine out of ten participants reported being "highly satisfied/satisfied" with the program. Although stigma often puts limits on relationships and mutual understanding, peer support was gained as participants shared their experiences from their perspectives [22].

Although the Mental Health and Welfare Act (2013 revision) abolished the requirement that family members perform as guardians of persons with mental illness, the compulsory hospitalization system was not

dismantled. In the study by Matsushita (2018), only 57 out of 219 (26.0%) family members said they "strongly agree or agree" with the revision of the law that maintained compulsory hospitalization. At the same time, 186 out of 219 (84.9%) of the respondents wanted change in the current system, such as employment support, disability pensions, support in admission and discharge from the hospital, support centers for community activities, general support for independence, and decreasing cost of services. Members of the Family Associations considered the revision with ambivalence [23].

Service provider reports

Ten studies focused on social withdrawal, the service providers' perspectives on local population needs, supporting skills, care programs, and the professional growth of psychiatric social workers [24–33].

Tsujimoto et al. (2017) investigated the current state of and challenges to support activities for social withdrawal and reported that out of 334 PHCs 265 (94.6%) were involved in programs for persons with severe social withdrawal, and 188 (53.3%) were provided continuous service. More than 40% of service providers indicated that they "often feel" worried about patients' withdrawal due to the following factors: 1) dissolution of professional relationships with the person who is withdrawing, 2) concerns about patients' future life and household finances, 3) concerns about patients' independent living after the death of a parent, 4) the person has nowhere else to go, and 5) possibility of violence toward family members/trouble with neighbors [24].

Hirokawa et al. (2013) investigated the difficulties in establishing supportive relationships between welfare recipients and municipality staff. The supportive measures included regular or repeated home visits via which relationships through daily conversations were built and all family members were assessed. The municipality staff highlighted that providing support to welfare recipients was challenging due to various issues, including household issues, withdrawing family members, isolation of the family from society, trouble with neighbors, and refusal to accept support [25].

A study by Yoshioka-Maeda et al. (2017) analyzed the assessment strategies used by supervisors of municipality mental healthcare providers (psychiatrists, psychiatric social workers, and public health nurses) working in community mental health care. It was reported that supervisors identified who was in need, assessed the relationships and problem-solving skills within the family, anticipated potentially challenging situations, and encouraged collaboration among healthcare providers. In this study, two themes were extracted from municipality mental health care providers' records: "clarification of the present and future health issues of a person with mental illness and his/her family members" and "preparation of a support plan" [26].

Okada (2017) investigated the technical support provided to municipal staff by prefectural psychiatric social workers (PSWs), and they reported that while assisting municipality staff, PSWs "created complementary relationships", "made decisions based on a wide range of information", "put in place support policies", "collaborated to support", and "evaluated the support rendered by PSWs to the municipality staff". The skills taught by PSWs included problem-solving, person-centered care, and understanding of the needs of residents [27].

Suzuki et al. (2010) investigated the preparedness of public health nurses for disasters and reported that nurses lacked in experience in extending support to disaster victims. Among public health nurses, 183 out of 509 (36.0%) had experience supporting disaster victims, 308 out of 514 (59.9%) nurses had experience helping those affected by the death of a family member, and 253 out of 512 (49.4%) nurses had experience in how to assist victims of child abuse. In addition, 331 out of 508 (65.2%) were unsure about how to respond to a mental health crisis, indicating that nurses were unprepared to cushion the mental health crisis of disaster victims [28].

Fujisawa et al. (2019) surveyed clinical psychologists in the affected areas to explore the experiences they consider essential when providing community mental health services. Clinical psychologists in the affected regions suggested that "collaboration among supporters," "experience of participating in care teams in affected areas", and "experience in welfare provision and educational facilities" were essential factors in developing a community-based mental health services framework [29].

Taneda et al. (2016) explored the role external actors can play following a disaster. They noted that actors in areas affected by a disaster often hesitate to collaborate with their "outside" homologues. The burden on these

actors in the affected areas is likely to be made lighter through a collaboration with and supervision by "outside actors" [30].

As an example of "participation in care teams," Yamamoto et al. (2010) explored the essential role of a child-adolescent psychiatrist in diagnosing and supervising a child welfare center team. The issues of an accurate diagnosis as the basis for appropriate assistance and the importance of transitioning from child psychiatry to general psychiatry beyond the age of 18 were discussed [31].

In the study by Yoshino et al. (2018), the implementation of the Meriden Family Program was assessed. The Meriden Family Program is a type of care that puts the highest value on both the service user and the family. Through 18–20 home sessions, service users and their families were given opportunities to learn about each other's experiences and perspectives [32].

Shiomitsu (2012) analyzed the professional development of PSWs working in local welfare facilities. The author identified different issues, depending on a practitioner's stage of professional development: Newcomers tend to focus on searching for the correct answer, while the mid-career staff are committed to trying their professional knowledge in practice, and experienced staff aim to build relationships with service users [33].

Educational activities

Five studies focused on the future of healthcare professionals' education and efforts to improve mental health literacy among adolescents [34–38].

Hisai (2010) explored the training of nursing students practicing in local welfare facilities. Practicum at the welfare facility was seen as helping nursing students to identify the "healthy aspects of persons with a mental illness", "insufficient understanding in the society", the "need to take the family into consideration", "the important role of community facilities", the "need for continued involvement", and the "awareness of one's own emotional changes" [34].

The study by Higashi et al. (2012) investigated how visits to people with mental disabilities at their homes and welfare facilities influence nursing students' understanding of community mental health. Nursing students who completed the practicum rated visits to welfare facilities (23 out of 30, 76.6%) and patients' home visits (9 out of 11, 81.8%) as the most valuable information-yielding experiences about the mental healthcare community [35].

Arai (2011) analyzed the evaluation of nursing students' training at a community welfare facility through the eyes of its users and staff. Overall, 42 out of 52 (80.1%) users and 9 out of 12 (75.0%) staff members said they considered practice training of nursing students as "very good/good". Service users enjoyed conversations with nursing students, felt that their stories were valued, and received good stimulation [36].

In a study by Omori et al. (2011), nursing students participated in horticultural activities with persons with mental illnesses for four years. The students reported having "pleasure of the activity", "preoccupation with the situation of involvement", "establishment of role awareness", building "natural relationships without walls", and being "part of the community-based mental health activity". The confusion after knowing the person as a "patient" was overcome through the rebuilding of human relationships [37].

Since no official school program in Japan is dedicated to mental health, Uematsu et al. (2017) reported on efforts to improve mental health literacy. The importance of starting a mental health education program in at least one school per region was discussed. Launching such a program requires recognition by the affiliated organizations, families, and students [38].

DISCUSSION

This review shows that the study of community mental health care in Japan covers diverse themes. It was determined that home-visit nursing care and ACT can be considered the most thoroughly investigated and highly developed. While ACT provides an effective service, home-visit nursing care seems to be more widely accepted because of its non-invasive and caring nature. Apart from the ACT and home-visit nursing care, physical complications, welfare medicine collaboration on a remote island, social participation, stigma eradication as a community program, and legislative remedies were also widely explored. Studies on social withdrawal, service providers' perspectives on local population needs, supporting skills, care programs, and the professional growth of psychiatric social workers are still in their infancy. Also, studies focused on how to better educate future healthcare professionals and improve mental health literacy remain scarce.

Comparison with the existing literature

Regarding community-based mental health in Japan, there have been two reviews [40, 41]. Aikawa (2018) pointed out the importance of ACT and discussed the issues, such as ethical dilemmas, informed consent, over-treatment, protection of privacy, and resource allocation in mental health care [40]. Aikawa's review aligns with the findings of this review, indicating that community mental health care needs to meet a wide range of needs. Noguchi (2018) reported on the importance of the various roles played by public health nurses, including home-visit nursing care [41]. However, the scope of these two reviews was limited to the ACT and the roles of public health nurses.

Strengths and limitations of the study

To our knowledge, this is the first comprehensive review of community-based mental health care in Japan. Another strength of this review is that it applied a robust methodology, leading to comprehensive results and discussions. However, the methodological quality of the obtained evidence was not high enough. No randomized controlled trials (RCTs) were found, and causal relationships, such as treatment/care effectiveness, were not confirmed. Also, since the field of community-based mental health care in Japan is in evolution, the themes in the studies proved highly atomized, making it difficult to categorize the study findings and draw readily actionable conclusions.

Implications for future research and practice

Although community mental health care in Japan was developed with good awareness of what should be entailed, there is still room for improvement. For practical purposes, an international exchange should be helpful. Also, the role of service users should be emphasized and improved. Users should be more actively drawn into the decision-making process and given the chance to better voice their perspectives regarding the design, delivery, and evaluation of care. For research, it is indispensable to develop reliable assessment tools and conduct RCTs, ascertaining the effectiveness of the care.

CONCLUSION

Between 2010 and 2020, community mental health care in Japan developed in many directions with the awareness that various needs have to be met. Home-visit nursing care and ACT are the most thoroughly investigated and seriously developed. Research using more rigorous methodologies, such as randomized controlled trials, is required if we want to arrive at conclusions that can be trusted with a high degree of certainty.

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