Department Initiatives

② Ishinomaki Regional Center, Community Support Division

Ishinomaki Regional Center: A Year's Worth of Initiatives

Ishinomaki Regional Center, Community Support Division

1. Introduction

On March 11, 2011, a magnitude 9.0 earthquake caused a massive tsunami to hit the Pacific coast of Japan. The three prefectures of Miyagi, Fukushima, and Iwate sustained horrific damage.

Many of the individuals affected by this disaster experienced irreplaceable losses, including family members, homes, jobs, and communities, and continue even now to live in pain. The Ishinomaki Regional Center of the MDMHCC was established on April 1, 2012 in an effort to engage in support activities for these affected individuals.

Pursuant to this goal of disaster survivor support, the Ishinomaki Regional Center has, in an effort to better understand the status of various disaster-affected regions, made use of a variety of events, including conferences, training workshops, and case study meetings, to build a transparent relationship with administrative agencies, SWCs, Comprehensive Community Support Centers, NPOs, and other bodies active in the Ishinomaki area. Further, it has developed and implemented support programming to assist disaster survivors in recovering from the damage done that day. Here, we report on the results of these activities over the past year.

2. Developing Support

As we became more involved with affiliated organizations, we conducted interviews for temporary housing resident support staff and administrative personnel, continued providing support for alcohol-related problems, and provided places for private chartered housing tenants to meet and socialize, among other initiatives.

(1) Support for Supporters

At the requests of administrative agencies and SWCs, we held "listening lectures" and group work sessions for temporary housing visitation support staff and Comprehensive Community Support Center staff, who frequently met directly with disaster survivors.

Further, at the request of administrative agencies, we conducted training workshops for and individual interviews with health promotion staff and administrative personnel. Part-time physicians from the MDMHCC served as lecturers. For individual interviews, we received assistance from registered members of the MDMHCC Supporters' Club. The details of our events are as follows.

Targets	Details	Number of events	Partici-pants
Onagawa Town SWC Temporary Housing Support Staff Training Workshop	Lecture: "Listening" Group work	2	28
Ishinomaki City SWC Temporary Housing Support Staff Training Workshop	Lecture: "Listening" Group work	9	138
Ishinomaki Jurisdiction Comprehensive Support Center Staff Training Workshop	Lecture: "Self-Care" Group work	1	68
Ishinomaki Jurisdiction Health Promotion Staff Training	Lecture: "Self-Care"	12	54
Higashimatsushima Nursing Facility Staff Training	Lecture: "Self-Care"	1	42
Ishinomaki Jurisdiction Nursing Staff Training	Lecture: "Self-Care"	1	10
Miyagi Prefecture Disaster Survi-vors' Support Members Training	Lecture: "Self-Care"	3	168

Ishinomaki Public Health Nurses Training	Lecture: “Self-Care”	1	18
Toubu Health and Welfare Office Jurisdiction Training	Lecture: “Self-Care”	1	115
*Ishinomaki Area Public Health Nurse/Nurse Comprehensive Support Center Staff Training	Lecture: “About Dementia” Tokyo Metropolitan Geriatric Medical Center Physician	1	60

*Hosted by the MDMHCC.

[Supporter Interviews]

Targets and Support Content		Target Count
Onagawa Town SWC staff and temporary support staff	Interview	37
Onagawa Town administrative personnel	Interview	65
Ishinomaki City SWC temporary housing support staff	Interviews	121
Ishinomaki city-wide area administrative personnel	Interviews	3
Higashimatsushima jurisdiction nursing welfare staff	Interviews	68

(2) Community Resident Support

We received a request from the city of Ishinomaki to provide visitation/telephone counseling to high-risk private chartered housing and emergency temporary housing tenants as identified by K6 scores collected via a health survey, and worked to reduce their emotional and mental burden. Individuals receiving counseling were served via both repeated home visitations and walk-ins. When the need arose, these individuals were referred to the Comprehensive Community Support Center, or were accompanied on their visits by nursing-related staff, public health nurses, or nurses.

Further, we attended temporary housing district meetings and health counseling/case study conferences, and also visited cases on an ad hoc basis after referrals from the Ishinomaki Jurisdiction General Branch Office, Nursing Association, and Comprehensive Community Support Center.

The table below lists the number of visitations we were contracted for by the city of Ishinomaki in FY 2012.

Targets	Number of visitations
Private chartered housing visitation targets	222
Emergency temporary housing visitation targets	96

*We received assistance from the MDMHCC Supporters’ Club for private chartered housing visitations.

(3) Community Resident Support Projects

(A space for art exhibitions and socializing for private chartered housing tenants, and the Koko Farm Project, a survivor social initiative.)

We were often told by private chartered housing tenants that “temporary housing areas have art exhibitions and places to socialize, but private chartered housing areas do not.” As several private chartered housing tenants pursued art as a hobby, we established an artwork exhibition area, provided them with a place to socialize, and hosted an “art exhibition and social” in an effort to help them regain their mental and physical health.

Works were exhibited in the Ishinomaki Joint Government Building Annex hall for two days: 1–3 PM on Thursday, March 7, 2013 and 10 AM–3 PM on Friday, March 8. A great variety of works were on display, including chigiri-e (torn paper collage), ceramics, wickerwork, knitwork, and Japanese papercrafts. In order to allow attendees to socialize, we had a café corner, hand massage, and various do-it-yourself craft stations.

A total of 105 attendees visited on both days of the exhibition, and several asked the artists about the creation of their works; socialization was in full swing. Attendees told us that they were “glad that they got to talk to people who had lived here before the disaster” and that they “would like [us]

to host the session once more" and to "host it in other areas." We believe that this exhibition and social event contributed to the mental and physical health of private chartered housing tenants. We hope to provide more such opportunities in the future.

With the cooperation of Higashimatsushima farm managers, we planned the Koko Farm Project, which would allow survivors to experience farming and fieldwork, and in FY 2012, we prepared for this project by requesting affiliated organizations for their cooperation.

In FY 2013, we plan to implement the Koko Farm Project at full scale between April and October (half the year); we plan for the project to involve two hours of fieldwork and opportunities to socialize twice a month in the mornings.

In the Infant Health Survey, we were requested by the city to provide "mother-child mental health care." Our achievements in that respect in FY 2012 include holding related programming in the Kahoku and Oshika areas of Ishinomaki 12 and six times in the last year, respectively. We plan to continue to provide this support in FY 2013 as well.

(4) Public Awareness and Support for Supporters Projects

Hosting the FY 2012 "Earthquake Mental Health Exchange Meeting in Ishinomaki" event

In an effort to foster collaboration between organizations active in the mental health care space and to leverage these connections into effective disaster survivor support, we hosted the Earthquake Mental Health Exchange Meeting, Miyagi in Ishinomaki" event. This social event was co-hosted by the Disaster Mental Health Care Network Miyagi: Karakoro Station Foundation.

The event was based on the theme of "Current State of Survivor Support," and at each of the subcommittee meetings on the topics of "the elderly," "people with disabilities," and "children," there were lively discussions regarding current tasks and future problems. During the general social portion of the event, all attendees gathered in one room and were able to build face-to-face relationships via the exchange of business cards and so on. We believe that this event was meaningful to those who participated.

Date and Time	Details	Participants
March 1, 2013 (Fri). 3–7:30 PM Ishinomaki Grand Hotel	1) Subcommittee Meetings: a. Speak about the Current State of Elderly Support b. Speak about the Current State of Disabled Support c. Speak about the Current State of Child Support 2) Lecture: "Survivor Support from Here" – Hiroko Honma, Niigata Disaster Mental Health Care Center 3) General Social	104

We plan to continue to host such meetings to foster collaboration between affiliated organizations and to work toward the improvement of mental health and welfare in the region and beyond.

3. Ishinomaki Center: All-Hands Training Workshop

We of the Ishinomaki Regional Center hosted an all-hands conference and training session for all affiliated staff, including transfer personnel, where we considered the status of support and our duties in the area, and discussed issues and future directions. In particular, because we expect alcohol-related problems to increase in the coming years, we conducted a four-part training workshop. The details of these meetings are listed below.

	Details
Part 1	Lecture: “About Alcoholism (by a Physician),” group work
Part 2	Case study, group work
Part 3	Lecture: “Alcohol Problems as seen by the Ishinomaki Police Department,” group work
Part 4	Case study, group work
Supplementary Training	Alcohol-related issues training report and group work

At the request of administrative agencies, the Nursing Association, and the Comprehensive Community Support Center, we carried out support for alcohol-related cases.

Here, we would like to introduce an alcohol-related case that we worked with affiliated organizations to provide support for. We have received consent from this individual to publish the case details here, but modifications have been made to remove any identifying information.

(1) Client: Mr. A, male, 60s, lives alone in temporary housing, single
Alcoholism, care level 1 (uses day service/helper)

(2) Case Progress

Following a request from the care manager of the Comprehensive Community Support Center in November 20XX, we had been providing support for Mr. A at the MDMHCC.

After the disaster, Mr. A had been living alone with the aid of a nursing service. He would often begin drinking in the morning, subsequently becoming sleepy and lying down. This was his daily routine. His eating was irregular, he had lost nearly all his energy, and his right arm and lower limbs showed signs of edema. At times, in his drunkenness, he shouted obscenities at the temporary support staff and helpers who came to visit him.

City public health nurses, welfare staff, Comprehensive Community Support Center staff, care managers, helpers, day service staff, civilian welfare officers, and many other service personnel were involved in Mr. A’s case. Unfortunately, these individuals’ work was not coordinated, and no one had any specific ideas on what to do for Mr. A. Exhaustion among his supporters was also becoming a salient issue.

In February 20XX+1, an “alcohol-related problems study session,” organized by the Comprehensive Community Support Center with Hospital B alcohol specialist staff (part-time MDMHCC workers) as advisors was held. At this event, involved persons came together, achieving a greater understanding of Mr. A’s case. The care manager, who had the longest and best relationship with Mr. A, was determined to be the point of contact moving forward, It was decided on that meeting/that the care manager would be the contact point for support for Mr.A and coordinate among the organizations involved in the support.

Mr. A had complained of high blood pressure, and after being recommended to see an internal medicine specialist, consented. The care manager arranged for this, and in mid-March 20XX+1, an MDMHCC staff member accompanied Mr. A as he visited an internal medicine clinic. We had already explained to this internal medicine physician that Mr. A had alcohol-related problems. The internal medicine specialist did as we asked and referred Mr. A for a psychiatric examination. At this point, Mr. A himself had reached some level of understanding regarding his condition, and he asked the internal medicine specialist to write him a referral letter. In late March 20XX+1, Mr. A visited an outpatient psychiatric clinic. The psychiatrist explained that based on descriptions of his alcohol habits and his test results, hospitalization was necessary. The care manager made arrangements with Mr. A’s family, and in early April 20XX+1, Mr. A’s family admitted him to a psychiatric hospital.

Two weeks after being admitted to the facility, Mr. A was able to walk with the aid of a cane or other mobility assistance device and his gait had become much steadier. The edema in his right arm and lower limbs had disappeared, the color had returned to his face, and his expressions had brightened. He had slowly recovered his physical energy and was now even able to use the toilet on his own. Mr. A himself, his family, and his care manager collectively decided that they would consider admitting him to a long-term facility in the future.

(3) Case Wrap-Up

While a variety of support organizations were involved in Mr. A's case, the supporters from these agencies did not share information with one another, and the point of contact was not clear. Mr. A's supporters were involved in his case in a disorganized manner and were growing exhausted. Thus, we worked with the prefecture and other public health nurses to emphasize the following two points in our collaborative support with other organizations.

①. In order to further their mutual understanding of Mr. A's case, the supporters involved in his care would implement a case study session or an alcohol-related problems study session.

②. The care manager, whom Mr. A trusted, would become a point of contact for Mr. A's case and mediate the involvement of other organizations.

In this case, information exchange and proper collaboration between involved persons was finally achieved following the study session. Further, the care manager, trusted by Mr. A, became the one who would deal with affiliated organizations, and interactions with his family became quite smooth.

This case reminded us of the importance of collaboration and information sharing between supporters.

4. Looking Back on One Year of Activity

We have developed our activities over the past year in collaboration with affiliated organizations throughout the region. Our collaborative relationships with these organizations have allowed us to provide advice enabling more effective support of counselees by deepening our mutual understanding of the roles and characteristics of each organization. Further, through case study sessions and conferences, we have aimed to deepen understanding between supporters, confirm the content of our support, and move toward more effective support.

Further, we believe that continued collaboration between affiliated organizations will contribute greatly to the improvement of mental health and welfare throughout the region.

In the future, as we continue to develop our work, we hope to take the aforementioned lessons to heart, and in our correspondence with disaster survivors and support organization personnel, keep in mind the following creed: "Listen closely to people's stories, empathize with, and respect their feelings, and think alongside them." We hope to work as closely as possible with those affected by the disaster to continuously improve the quality and scope of our support endeavors.

Insomnia Among Tenants of Temporary Housing and its Causes

Ishinomaki Regional Center, Ishinomaki City Transfer
Occupational Therapist – Miyoko Kubota

1. Introduction

Two years and two months have passed since the Great East Japan earthquake, which occurred on March 11, 2011. Ishinomaki suffered enormous damage in the disaster, and over 10,000 people still live in emergency temporary housing. At the Ishinomaki City Health Promotion Division, where I was transferred, we have developed a variety of projects aimed at maintaining the physical and mental health of emergency temporary housing tenants (hereafter "temporary housing tenants"), but at our counseling sessions and so on, there seems to be an endless supply of tenants complaining of insomnia. In this manuscript, as part of the Disuse Syndrome Prevention Project (the "Yuikko Project"), we will survey the daily activity levels of tenants, explore possible causes of insomnia, and report our results.

2. Subjects

Our subjects were 102 (26.4%) of the 387 tenants who complained of insomnia, surveyed between March and July 2012 as part of the Yuikko Project. Twenty-one of these individuals were men and 81 were women, with a mean age of around 69.4±8.3 years. All subjects exhibited symptoms of insomnia: 56 (54.9%) had difficulty falling asleep, 22 (21.6%) experienced nighttime awakening, two (2.0%) experienced early morning awakening, and 22 (21.6%) had difficulty achieving deep sleep. Thirty-eight (37.3%) individuals were using hypnotics.

3. Results

(1) Daily Activity Levels

While the most common response among tenants was that they "frequently worked outside" (40.2%), responses indicating low activity levels, including "sedentary" (26.5%), "frequently work at home" (24.5%), and "sometimes lie down" (5.9%), made up more than half of all answers, indicating that tenants complaining of insomnia have reduced activity levels (Fig. 1).

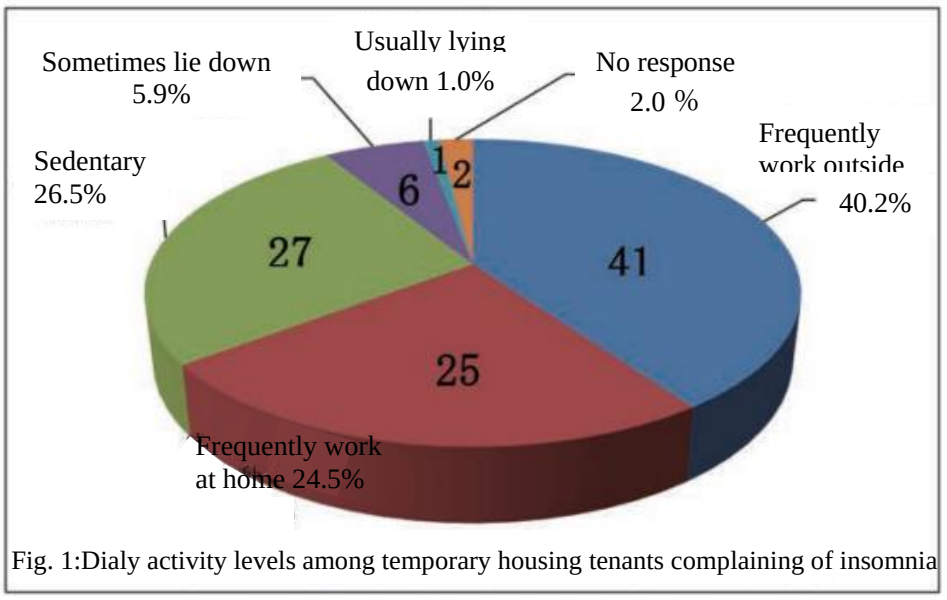

Fig. 1:Dialy activity levels among temporary housing tenants complaining of insomnia

(2) Frequency of Going Out (for 30 Minutes or More)

While those who went out "nearly every day" (48.0%) and "more than three times per week" (23.5%) accounted for more than 70% of all responses, the results indicate that nearly 30% of tenants complaining of insomnia showed a tendency toward shut-in habits, stating they went out "around once per week" (20.6%), "around once per month" (3.9%), and "almost never" (2.9%) (Fig. 2).

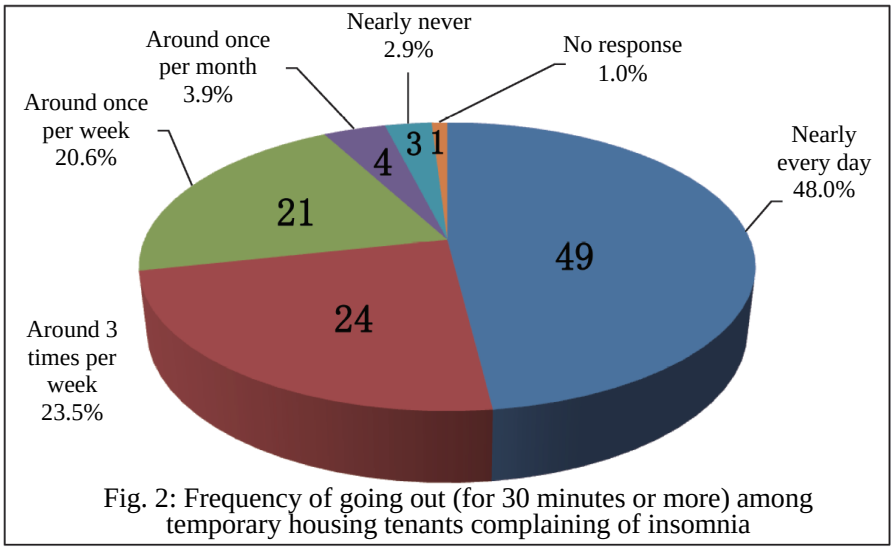

Fig. 2: Frequency of going out (for 30 minutes or more) among temporary housing tenants complaining of insomnia

(3) Causes of Insomnia

Causes of insomnia that tenants were subjectively aware of included physical factors, such as "frequent use of the toilet at night" (8.8%) and "joint and/or muscle pain" (2.9%), psychological factors, such as "anticipatory anxiety or other anxiety symptoms" (5.9%) and "mental illness" (2.9%), and environmental factors, such as "being woken by noises and/or snoring" (2.9%) (Fig. 3). However, 73 individuals (71.6%) did not provide answers identifying any specific causes of insomnia.

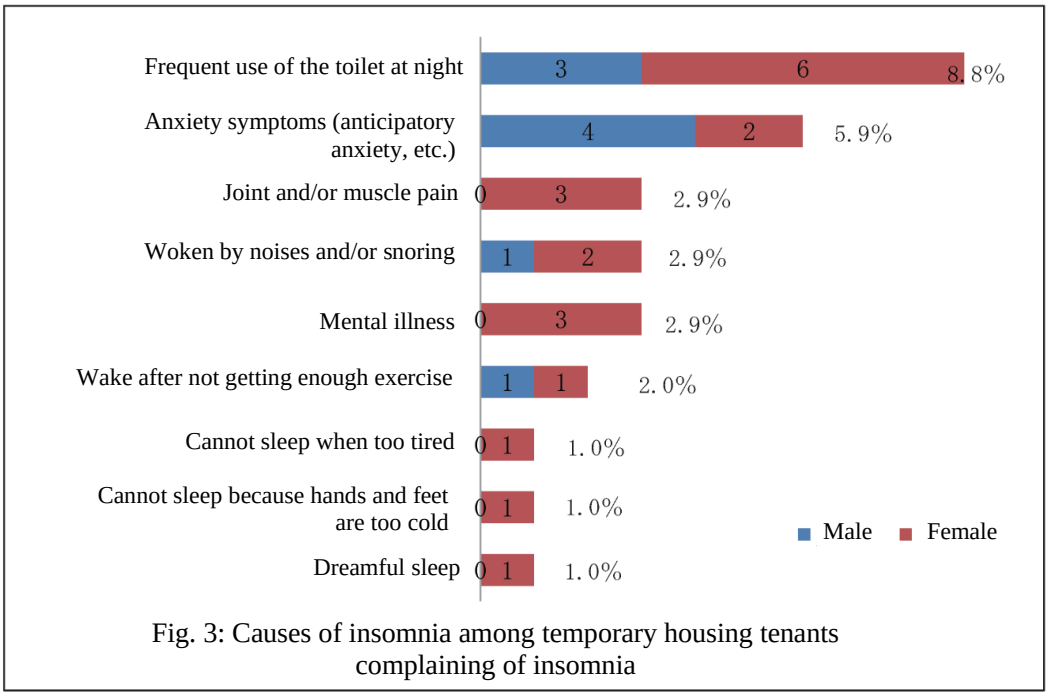

Fig. 3: Causes of insomnia among temporary housing tenants complaining of insomnia

4. Discussion

Our results suggest that reduced daily activity levels and low frequency of going out were affecting the sleep habits of temporary housing tenants. Epidemiological surveys in Japan have identified three independent factors related to insomnia: stress, lack of exercise, and unemployment [1]. Further, in the wake of the 2004 Niigata Chuetsu earthquake, the role of disuse syndrome and the importance of treating attendant losses of functionality in activities of daily living were emphasized [2]. In addition to evaluating the daily life functions of individuals complaining of insomnia, it is important that we increase their opportunities to participate in exercise and physical activity and heighten their daily activity levels.

The causes of insomnia among tenants complaining of insomnia were divided into three categories: physical, mental, and environmental factors. In the case of physical/bodily factors, we recommend that individuals be referred to a specialist and that they receive treatment for the underlying causes. However, in this study, in more than 70% of the tenants who complained of insomnia, the cause could not be identified. One important outstanding issue is the building of a diagnosis and treatment system that allows individuals immediate access to care after insomnia onset [3]. We must identify the effects of insomnia causes and insomnia itself on the body via counseling sessions and so on, and quickly move to collaborate with medical organizations.

5. Conclusion

We determined that reduced daily activity levels were one cause of insomnia. In an effort to ensure that countermeasures against disuse syndrome among temporary housing tenants lead to improvements in sleeping habits, we plan to continue to support projects that seek to maintain their physical and mental health.

References

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Higashimatsushima Activity Report

Ishinomaki Regional Center, Higashimatsushima Transfer
Psychiatric Social Worker – Yuko Arai, Shizuka Oguchi

I was transferred to the city of Higashimatsushima after it was decided by the JAPSW that with their assistance, there would be one or two psychiatric social workers rotating through on a daily basis beginning in January, after which in April, Shizuka Oguchi and myself would be permanently stationed in Higashimatsushima. I was placed in the Welfare Division of City Hall and put to work on post-disaster mental health care with two public health nurses from the Disability Welfare team.

Our primary work is to provide individual support via telephone/visitation to high-risk individuals as identified from the results of health surveys conducted by the prefecture or city, or as listed in Support Center or Comprehensive Community Support Center data. Insomnia, depressive affect, and binge drinking are common among these individuals, and background factors include loss of a loved one, family issues, loss of employment, anxiety regarding the post-disaster rebuilding of their lives, and bottled-up emotions following the disaster. By listening to them speak, we help put them at ease, and can, if needed, refer them to other societal resources. When doing so, our paramount concern is to "respect the needs and pace of the individual."

In addition, regarding individuals targeted via health surveys, we provide counseling to direct walk-ins. While there are times when the counseling an individual is seeking appears to have no relation to the disaster, we often uncover surprising, distant relationships between the two. We also continue to provide this service as a way of supporting local supporters.

Nearly all local supporters in this area were affected by the disaster. They continue to work without time to rest their minds and bodies, and with their own myriad emotions and circumstances set aside. As we think of the feelings and circumstances that drove them to such lengths, we reaffirm the unforgettability of their sacrifices, and resolve to continue to work alongside them.

The foundation of our activities has been, since the beginning and till date, the ideal of local public health nurses: "We do not want to lose even one more person." Post-disaster mental health care is a long-term undertaking, and our transfer appointment is a short-term posting. Thus, one of our goals is to build relationships between community residents and City Hall. We hope to be able to spread seeds of awareness among residents, such that they will think to turn to the city if they need counseling or realize that it is okay for them to approach the city with questions regarding alcohol-related problems. (Written by Yuko Arai.)

I was dispatched as a transfer employee to the Higashimatsushima City Department of Health and Welfare, Welfare Division, Disability Welfare Team alongside Yuko Arai in April 2012.

The first thing we were told by the public health nurses we worked with was the following passionate statement: "I don't want anyone else to lose their lives to this disaster. These people have survived; I want them to keep on living." Through these words, I realized just how important the duty that had been entrusted to us was, and I remember deciding that we had come to our posts to realize this dream.

As I began to wonder what exactly I could do in my new position, I thought about living up to the expectations of the public nurses we worked with, and decided to make "putting a smile on the nurses' faces" my goal."

These public health nurses are very busy and do not even have time to eat lunch in peace. I resolved not to get in their way, to adjust myself to the local atmosphere, and to keep calm and smiling at all times.

As I started becoming involved in actual work, I was surprised at how easy it was to get along with everyone. This was because the workplace environment was wonderful. I cared for my colleagues and for myself, thought of the residents as my family, and was truly moved at how wonderful a place Higashimatsushima was. I also feel that we were given a job that plays to our strengths, enabling us to build a mutually beneficial relationship and function as part of a team.

Thanks to this fortunate environment, I feel I was able to put my all into working for the benefit of the residents of the city. In this past year, I have met and talked over the phone with so many

different people. All the residents of this city are our targets, and I have realized quite deeply that their pain is unrelated to the degree to which they were affected by the disaster, and that very few individuals will, of their own volition, say that they are in pain. At the same time, I have remained aware of the need to build a good relationship between these individuals and the city itself, so that they can rely on it as necessary.

Would a city resident, if asked, say “I’m glad she came to Higashimatsushima”? Have I really managed to put a smile on the public health nurses’ faces? As I ask myself these questions, I look forward to my second year of work in this position. (Written by Shizuka Oguchi.)

Looking Back on FY 2012 Mental Health Care Activities in Onagawa

Ishinomaki Regional Center, Onagawa Transfer
Psychiatric Social Worker – Tomoko Arashi

All governmental buildings in Onagawa were damaged during the disaster, and a large amount of data stored inside the government office was lost. Furthermore, all administrative personnel were affected by the disaster. Staff members who had lost a wife, child, or parent to the tsunami were not uncommon. At the same time, if we look at the designated temporary housing and individual cases outside of welfare households (and I believe this is something that could probably be said for other regions as well), a great many cases of alcohol-related problems can be observed. Onagawa has always had a very lively fishing industry, and many cases involve individuals who worked on fishing boats in their youth. It was not rare for these fishermen to be in on-board environments where alcohol use was a given. For this reason, individuals who were forced to give up fishing owing to the disaster (or perhaps prior to it) found it rather difficult to escape from years of training oneself to wake up early in the morning and go to sleep early at night, and ultimately found themselves with very little to do during the day. For this reason, many turned to drinking. Further, while many individuals who had retired prior to the disaster led similar lives, at that time, such habits were explainable as those of one who merely "enjoys his drink." However, after being placed in temporary housing, in close proximity to other residents, trouble was far closer at hand, and these individuals began to be viewed as "troublesome drunkards."

In light of these circumstances, we of course provided individual follow-ups to town residents, and also directed our efforts toward support for the Town Hall staff. Specifically, we disseminated information on staff mental health, established a staff counseling counter, and provided counseling via email as necessary. We named our information exchange letter the "Heart Tsushin," and collected a variety of facts on mental and physical health, enabled individuals to read the letter from their borrowed computers, and are currently adding new issues every other week. The counseling counter for the staff was named the "Heart Salon," and is currently being held in a room inside the government building every second and fourth Wednesday. Initially, we held the salon from 1:30 to 4 PM, but despite the fact that the Director of the General Affairs Division had given employees leave to participate in the salon during business hours, most staff did not feel comfortable leaving their desks in the middle of work. Thus, we consulted with the Town Hall, and from FY 2013 onwards, changed the time slot to 4 to 6 PM, allowing personnel the chance to make use of the service after work. As we plan to change the timing of the salon in April, which is very soon, there are still only a few individuals making use of the service, but after the change, we plan to implement a variety of measures to increase participation. Further, in terms of my duties as an MDMHCC employee, one unique responsibility I have relative to staff in other regions is that I am also in charge of providing back-to-work support to administrative personnel. As mentioned earlier, these individuals were all affected by the disaster and had also been functioning as supporters for quite some time; thus, in the case of many of these individuals, their mental and physical health was destroyed, and they were forced to take leave of absence. I conducted multiple one-on-one interviews with these individuals, worked with their attending physicians at Health Care Centers as needed, and helped them move toward recovery. At present, the individuals whom I have had the pleasure of working with have returned to work and are contributing meaningfully to their departments. I plan to continue to watch over their progress in their early days of re-employment.

In terms of resident support, I began first with private visitations to tenants of private chartered housing who were determined, via a health survey, to need follow-up. At the same time, I took over the cases that public health nurses had been supporting through visitations and the like, and continue to be in charge of them. Finally, in December 2012, I moved my desk from the Public Health Center to the Welfare Section of the Health and Welfare Division at City Hall and became involved in the support of welfare households that also have issues with mental illness.

As I think of individuals who will continue to live in temporary and reconstructed housing, I feel my next goal should be to set up a Danshukai in Onagawa. In any case, I hope to continue to provide long-lasting support to the people of this town.

FY 2012 Activities in Review

Ishinomaki Regional Center, Tobu Health and Welfare Office Transfer
Certified Expert Psychiatric Nurse – Tomoko Uchida

The Tobu Health and Welfare Office predicted that in the wake of the disaster, counseling cases related to mental health issues, including alcohol-related problems, would increase. Thus, in an effort to support work with individuals with alcohol-related problems or mental illness, I began providing professional support as part of the Mother-Child Disorders team in April 2012. As I had been working for private medical institutions for so long, when initially faced with the difficulty of mental health and welfare tasks in the region, I found it problematic to situate myself, and floundered for some time. However, the leader of the Mother-Child Disorders team and my fellow public health nurses gave me invaluable advice, and I was able to work through this past year. My main duties during this time are summarized below.

①. Support for Individual Cases
(1) Visitation/interview support for individuals with alcohol-related problems or their families.
(2) Individualized support for individuals/families with mental illness who are experiencing worsening symptoms or need help arranging medical services.
(3) Counseling support for individuals who need mental health care because of the disaster.
(4) Lifestyle and care support via outreach to enable individuals to continue to lead stable lives after retirement.

②. Public Health Center Professional Support
(1) Management and case support for alcohol-related special counseling, and creation of materials and management support for alcohol-related problem family seminars (Document 1).
(2) Planning and management support for training workshops on alcohol-related problems.
(3) Management of specialist counseling and case support for adolescent shut-ins.
(4) Management support for developmental counseling (specialist counseling by pediatricians for children with delayed motor development and for their parents).
(5) Professional support for checkup support provided by the Public Health Center for municipal infant checkups.

After being involved in these duties for one year, I have realized one thing above all: the sheer number of individuals throughout the region who had been living in horrible conditions even before the disaster, who were exposed to a variety of significant stressors afterward, and who continue to go about their daily lives with alcohol-related problems or various mental issues. I have also realized the sheer necessity of the activities of public health nurses and medical professionals, who work daily to ensure that these individuals' lives are at least somewhat supported. In order to construct a community that will enable individuals with some sort of mental illness to live out their lives, I believe that further and farther outreach activities are necessary. As medical workers, to ensure that our activities in the community can be conducted as smoothly as possible, close collaboration with Public Health Centers (and other administrative agencies) that carry out mental health activities in the region are vital, and further network building between medical, community, and administrative entities is essential.

As a nurse who has moved her arena of practice from the clinical domain to the community, I plan to continue to share information and collaborate with affiliated organizations, make full use of my specialist knowledge and communication skills in psychiatry, and attend to my duties, all in an effort to build a community in which individuals with mental issues can more easily live out their daily lives.

Alcohol Seminar

Ishinomaki Public Health Center

Rules for participation in this seminar

Please do not repeat details shared by another participant anywhere else.

Please only listen to what other participants have to say. Do not offer critiques or criticisms.

What Alcohol Does

- Cheers you up
- Relieves anxiety
- Lifts your mood
- Can lift depression
- Removes your inhibitions
- Can help you sleep (But drinking too much has the opposite effect)

What happens to alcohol inside my body?

Gets broken down in your liver

Eventually even reaches your brain

Gets absorbed in your gut and small intestine

Travels throughout your body via blood

Problems caused by excessive drinking

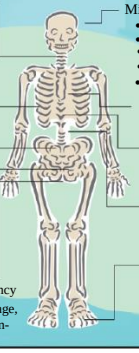
~ Health prob-

- Malnutrition (loss of nutrients/dehydration)
- Liver disease (fatty liver/cirrhosis)
- Pancreatitis, high blood pressure, cancer, dementia, depression

~ Domestic & social problems ~

- Drinking and driving, accidents
- Strife at home, violence, divorce
- Unemployment and other financial troubles

The effects of drinking on the body



Esophagus
• Esophagitis, • esophageal cancer, • esophageal varices

Liver
• Fatty liver • liver fibrosis
• alcoholic • hepatitis
• cirrhosis

• Diarrhea, colonic cancer

Small intestine
• Digestive malabsorption

Gonads/genitals
• Men: testicular atrophy, • impotency
• Women: • Amenorrhea, miscarriage, premature delivery, fetal alcohol syndrome

Mind, brain, and nerves
• Acute alcohol poisoning
• loss of memory
• hypobulia dementia (cerebral atrophy)
• neuritis • TPO disorders
• autonomic dysfunction

Cardiovascular system
• Cardiac hypertrophy, • arrhythmia, • hyperemia

Stomach/duodenum
• Acute gastritis, • gastric ulcers
• erosive hemorrhagic gastric ulcers
• Pancreas

Pancreas
• Acute/chronic pancreatitis, • cholelithiasis
• diabetes

Peripheral nerves, bones, blood
• Peripheral neuritis, anemia, gout
• osteoporosis, • femoral head necrosis

How much should you drink in a day?

Middle-aged mens	Women/elderly individuals
Pure alcohol: 20g	Pure alcohol: 10g
Beer (5%): 500 ml	Beer (5%): 250 ml
Sake (15%): less than 1 bottle	Sake (15%): less than 1/2 bottle
Choshu (25%): 100 ml	Choshu (25%): 50 ml
Chu-hai (7%): ~350 ml	Chu-hai (7%): ~175 ml
Wine (12%): ~200 ml	Wine (12%): ~100 ml
Whiskey (43%): 60 ml (one double)	Whiskey (43%): 30 ml (one single)

Appropriate amount of alcohol: 20 g of pure alcohol
Women and elderly individuals are more susceptible to the effects of alcohol, and should only drink half that.

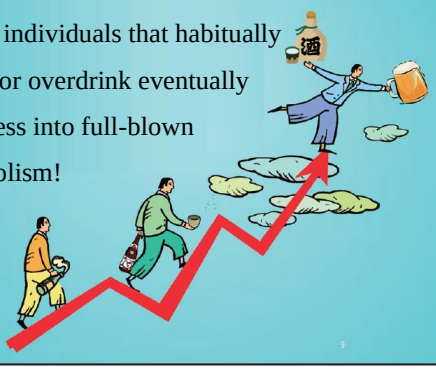
Overdrinking

Equivalent of more than 60 g of pure alcohol
Pure alcohol conversion (gram): volume drank * alcohol concentration * 0.8

Beer, 5%: 1500 ml (3 500 ml cans)
Sake, 15%: 500 ml (slightly less than 3 bottles)
Choshu, 25%: 300 ml
Chu-hai (7%): 1050 ml (3 350 ml cans)
Wine, 12%: ~625 ml (4/5 of a bottle)
Whiskey, 43%: 180 ml (3 doubles)

Individuals who overdrink regularly have the potential of becoming alcoholics.

Some individuals that habitually drink or overdrink eventually progress into full-blown alcoholism!



Let's look at how much alcohol we drink: Use the handout given to you.

Screening A

Men: 5+ points, Women: 4+ points

Screening B

Men/women: 19 or fewer points
You should try to reduce the amount you drink.

Men/women: 20 points or more

You are at a very high risk for alcoholism.
You should consider being seen by a medical professional.

Diagnostic criteria for alcoholism

①. Not at ease unless there's some alcohol at home. Ends up wanting to drink it even if it's hidden. (Strong need for alcohol, compulsion)
②. Cannot control the amount of time spent drinking or the quantity of alcohol consumed (loss of control)
③. Once the alcohol at home runs out, starts trembling or grows annoyed (withdrawal symptoms)
④. Requires more to get drunk (tolerance)
⑤. Alcohol becomes more of a priority than work or home life
⑥. Physical illness, worsening of depression, troubles at work or at home (adverse events)

*If three or more of the above apply to you, you might have alcoholism.

Characteristics of alcoholism

- It is a disease involving a lack of control in drinking.
- When an alcoholic's alcohol runs out, they exhibit withdrawal symptoms.
- It is a chronic, progressive, fatal disease.
- It causes mental, physical, and social complications.
- The only real path to recovery is to completely stop alcohol intake.
- Alcohol cannot be quit alone.
- This disease involves ignoring one's own problems.
- It has nothing to do with one's personality.

The vicious cycle at home

In an effort to do something, a family member puts their own issues aside and cleans up after the drinker.

Responsibilities become unclear

Denial/loss of emotions, begin to react reflexively to situations without any thought

Constantly overwhelmed by unending problems

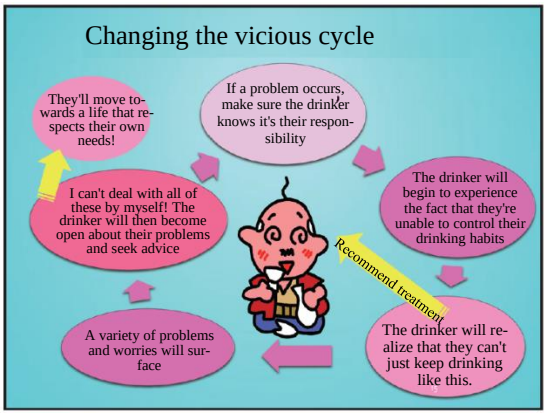
Begin to hide things and feel alone

Try to look for a reason

- They do not realize it is a problem...
- They think they are not being trusted...
- They continue to only think that things are bad deep down...

The drinking will continue.

Changing the vicious cycle



The family's attitude

- Do not concern yourself with whether or not the drinker drinks.
- Do not clean up after them, and do not solve their problems.
- Distance yourself from their violence.
- Only have important conversations with the drinker when they are sober.
- Participate in seminars and counseling sessions to give yourself a chance to have your story be heard.
- - The family should engage in fun activities together.
- - Don't try to deal with all of this alone.

If you try to quit by yourself...

- The strong need to drink, mood swings, insomnia, and other symptoms can cause you a lot of trouble.
- You might start arguing or fighting with your family and friends.

Why not try participating in a self-help group or getting seen by a professional?

A self-help group is...

A group of individuals and families that are grappling with alcoholism.

AA: Hebita Community Center, Tuesdays, 2-3:30 PM
Danshukai: Medical Association Hall, Saturdays, 7-8 PM

If you would like to be seen by a professional...

Talk to your doctor, a municipal public health nurse, or go in to your public health center.