The Founding of the Miyagi Disaster Mental Health Care Center

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<The Great East Japan Earthquake>

On March 11, 2011, a triple catastrophe of unprecedented proportions took place: an earthquake of magnitude 9.0—said to be the largest in recorded Japanese history—occurred, causing a massive tsunami to strike the eastern coast of Japan, from Tohoku to Kanto, resulting in the Tokyo Electric Power Company Fukushima Daiichi Nuclear Power Station undergoing a meltdown, releasing a large amount of radioactive contaminants into the air. As of February 10, 2012—11 months later—there are 15,848 dead and 3,305 missing (Police Department Data). The characteristics of this disaster include the fact that it affected most areas in which depopulation and societal aging are rampant; the extreme magnitude of both the numbers of dead and missing persons and destroyed/partially destroyed houses because of the tsunami; the complete uprooting of individual livelihoods and societal cornerstones; and the nearly fatal blows dealt to the industrial sector, especially to the farming and fishing industries, all of which together have pushed the communities of many disaster survivors to the brink of complete collapse.

This magazine compiled an urgent special issue entitled “Great East Japan Earthquake and Mental Care” in October of last year; this article is primarily a report on the issues that have arisen since then.

<The Beginning of Mental Health Care>

Immediately after the earthquake, it was extremely difficult to understand what was going on in each area affected by the disaster, owing primarily to the disruption of traffic and communication lifelines; the malfunction of government agencies and food and gasoline shortages only added fuel to this catastrophic fire.

Support from outside the prefecture, through university courses, from psychiatric hospitals and clinic groups, and from voluntary private groups, began. Through patrols in evacuation camps and in municipal Public Health Centers, mental health care began to be provided. According to summary statistics released by Miyagi Prefecture, during the five months from March to August 2011, 31 teams and 3,959 mental health personnel were involved in support activities, 7,713 evacuees received counseling, and 1,183 survivors were visited at home. Two hundred and thirty-nine victims requested walk-in counseling, and 857 disaster survivors were provided with other support.

Early on, activities consisted of securing medical services for individuals with mental disabilities living in disaster-affected areas and providing care to survivors in evacuation camps. The health of many individuals declined as they did not have access to required medications, and during the night, JSDF vehicles would travel from evacuation camps to far-off hospitals to transport back vital supplies. In combination with the poor conditions of these camps, many survivors experienced physical and mental deterioration, and in addition to insomnia, anxiety, irritability, depression, grief, and self-condemnation, physical illness became common. Thus, arrangements were made for counseling and for the procurement of necessary medications.

Approximately three months after the disaster, amidst seemingly endless stays in evacuation camps and a completely inscrutable tomorrow, between towering mountains of rubble that had yet to be cleared away, the cold, bleak face of reality grew too large to look away from. Feelings of loss and emptiness grew deeper with each passing day, and when coupled with the complicated grief most survivors experienced, disaster-related posttraumatic mental illness became an inescapable eventuality. Unending days of high-strung stress twisted life into unrecognizable shapes; chronic illnesses worsened, and many found opportunities to embrace the bitter balm of alcohol. Below, I detail a few such cases.

Case 1. After the earthquake, Dad said he was going to check out our house, so he went down to the coast. Soon enough, we were told that a tsunami was coming. I was worried about Dad, and I tried to head to my house, but my neighbors stopped me and we evacuated together. We managed to make it to high ground, but the tsunami was not far behind us. We started living in the evacuation camps, but we weren’t able to get in touch with Dad. A week later, they found his body. Every day, multiple times, images of the tsunami just pop into my head. It even chases me in my dreams at night, and I

wake up screaming. Why didn't I reach out to him sooner? Why didn't I stop Dad? I get so angry at myself.

Case 2. After the earthquake came the aftershocks, and I felt a strong sense of dread and terror. At the time of the earthquake, I was in the tearoom of the house, and the violent shaking knocked over the dish cabinets and a doll case that was sitting on top. Fragments of glass and porcelain flew everywhere. I was this close to getting badly, badly hurt. I'm in an evacuation camp now, and I'm too scared to return home and clean it up. I don't want to go back. When I think about the fact that there might be another earthquake tomorrow, I can't stop trembling. I get scared at night.

Case 3. Recently, I got placed in temporary housing, but when I think about my hometown, the tears just start coming. Yesterday, I left the evacuation camp to go back to my house, and when I saw the ocean, I just started crying. Is there something wrong with me? I guess I can sleep at night. But I dream about the people who died. My husband is away on work in Kanto, and my fourth grader wants to go to school near the evacuation area. People who didn't get selected for housing say mean things to me, and the city is telling me that I need to decide soon. I don't know what I should do.

After six months had passed, prefectures and municipalities began to conduct health surveys of disaster victims and staff with the support of related organizations. Overviews of surveys conducted by Ishinomaki City and Miyagi Prefacter are given below.

1. Ishinomaki City Survey

According to a door-to-door survey of 6,341 people conducted in temporary housing developments in Ishinomaki—which suffered severe damage in the disaster—359 individuals (5.7% of those surveyed), required some form of follow-up. As of November, mental health care teams have attended to a total of 4,873 cases, with the greatest increases seen in cases whose chief complaints include anxiety/terror, depression, and irritability; meanwhile, insomnia and alcohol-related issues, which rose initially, have decreased, and stayed the same, respectively. While relocations into temporary housing have afforded survivors increased privacy, worries about the future and the difficulty of living in unfamiliar areas has caused loneliness and shut-ins to become more common. Slightly less common but nevertheless significant are feelings of loss, self-blame, and grief, and trouble related to domestic violence, abuse, and discord with neighbors is increasing.

2. Survey of Prefectural Personnel

In addition, according to a health survey of prefectural personnel conducted seven months after the earthquake, 67.2% felt some kind of stress, and 60.5% felt strongly affected by the earthquake. Further, 17.0% answered that they had difficulty sleeping, 13.7% stated that they were drinking more, 32.3% exhibited some degree of psychological effects based on indices of stress levels, and 4.2% required institutional care. These findings suggest that we are transitioning from the early stages of mental health care into a new phase of care needs.

<About the MDMHCC>

On March 15, four days after the earthquake, officials from across the prefecture gathered to exchange information. At that event, the establishment of a support system for the entire prefecture, including Sendai, was approved, and on March 18, the Prefectural Disability Welfare Division convened and established the "Mental Health Care Measures Conference." The prefecture, Sendai, prefectural and city-level Mental Health and Welfare Centers, the Tohoku University Department of Psychiatry, and organizations involved in mental health welfare throughout the prefecture participated in this conference; the development status of and issues associated with mental health care in each disaster area, as well as required support programming, were discussed. Further, to facilitate rapid responses, the prefecture, Sendai, prefectural and city-level Mental Health and Welfare Centers , the University, the Miyagi Mental Health and Welfare Association, and the Miyagi Psychiatric Clinic Association, among others, were assembled into a board of governors. Afterward, in the four months until July, countermeasure conferences were periodically held.

Three months after the disaster, in May, opinions about the necessity of medium- to long-term support were exchanged, and given that external teams involved in support were slowly withdrawing from the prefecture, the need for an organization around which mental health care within the prefecture could be centered and advanced was pointed out. It was noted that Disaster Mental Health Care Centers had been set up after the Great Hanshin-Awaji and Niigata Chuetsu-Chuetsu-Oki earthquakes, and discussion continued with these agencies as reference points. At the same time, the Miyagi Mental Health and Welfare Association received during its May meeting a report from the city regarding the establishment of a Disaster Mental Health Care Center, and the decision was made

to move proactively toward establishment. In July, we observed the operation of the Niigata and Hyogo Disaster Mental Health Care Centers. The Disaster Mental Health Care Center Project was approved at a special prefectural assembly held in August, and afterward, the prefecture and the Miyagi Mental Health and Welfare Association met to discuss the organization and management of the MDMHCC. In September, the Association was formally entrusted with the project to manage the Center. In October, the Tohoku University Graduate School of Medicine, Endowed Department of Preventive Psychiatry was established in response to a request from the prefecture with the directive to act as a counterpart to the Center. With the constant support of the Endowed Department, the MDMHCC Operations Room was established on November 1, and the MDMHCC itself on December 1, both in the city of Sendai.

<The Needs of Disaster-Affected Areas>

In November, the MDMHCC Operations Room was set up, and although the number of staff has remained low, we have been energetically holding meetings with the people involved in the disaster area and considering future activities. The main requests made of the Center from disaster areas during this period are as follows: how should depression screening for disaster survivors be set up; how should mental health-related questions be added to medical questionnaires; we would like to add items that enable disaster survivors to conduct self-checks; will it be possible to obtain the assistance of the Center for the creation of a system to follow up on survey results; how should we deal with individuals who develop depression or alcohol problems after becoming anxious about the future or lose hope in the present, and as a result, shut themselves in their temporary housing units or fall out with their families, among whom there are some who are faced with the splitting of their family; and finally, how do we get individuals who are experiencing complex grief responses owing to increases in the number of dead or missing persons to go to grief care.

We heard the following from supporters and Support Center staff: even when working with them on visitations with supporters and staff, disaster survivors won’t meet with me; it’s not uncommon for me to get treated like some kind of punching bag for survivors’ dissatisfaction against the government; even though we’re both survivors, the people I meet with balk at what I tell them just because I’m a “supporter”; I’ve had cases that were so difficult that I lost faith in my ability to even do this work, and I would appreciate it if you provided some training or case study sessions for supporters; supporters in temporary housing development receive survivors’ requests and directly put them in touch with public health nurses; and finally, we’d like to ask for your cooperation in continuing to hold the monthly study sessions you have been organizing for supporters.

As can be seen in the results of the prefectural personnel survey described above, the municipal staff, firefighters, police officers, childcare workers, and medical professionals who had been working without rest since the disaster began to develop mental health issues; we responded to requests to provide care to these individuals as well.

<Organization and Management Policies of the MDMHCC>

In the process of establishing the MDMHCC, we determined that because of the extent and severity of the damage, it would be best to divide the prefecture into three blocks and establish Regional Centers. In consideration of transportation infrastructure, we decided to place the Stem Center in Sendai and have it be responsible for the Shiogama and Iwanuma areas as well; the Kesennuma and Ishinomaki areas would each get their own Regional Center. At present, our personnel are allocated thus: 17 full-time and 16 part-time staff in the Stem Center; six staff, including one part-time staff, at the Ishinomaki Regional Center; and seven staff, including one part-timer, at the Kesennuma Regional Center. Our staff includes psychiatrists, public health nurses, nurses, psychiatric social workers, and psychologists. In addition, we have formed a supporters’ club within the prefecture and solicit help from a variety of prefectural mental health professionals.

Further, the disaster has caused a shortage in the number of public health nurses and other mental health personnel at the municipal level; thus, at the request of four cities and towns, we have directly dispatched psychiatric social workers, occupational therapists, psychologists, and other professionals to assume semi-permanent posts there.

Even before the disaster, there was a shortage throughout the prefecture of mental health and medical staff and specialists; it was, therefore, rather difficult to fill a staff roster of over 30 people through prefectural hires alone, and we have made use of a national transfer/dispatch system through the Ministry of Health, Labour, and Welfare.

By the way, according to our project plan, the Project Mission Statement of the Care Center is as follows: “We consider all residents of Miyagi Prefecture psychologically affected by the Great East Japan Earthquake that occurred on March 11, 2011 to be targets for mental health care initiatives, and in order to enable these people to lead meaningful, purposeful lives in stable communities as soon as possible, we resolve to collaborate with affiliated organizations and remain cognizant of regional circumstances as we work to address the needs of survivors, municipalities, and support organizations. With the regional mental health care activities that Public Health Centers and prefectural municipalities have carried out till date as our foundation, and through close collaborative relationships with psychiatric institutions throughout the prefecture, we are currently developing a long-term activity plan. In terms of our relationship with our staff, our operations began in earnest in April of this year; an outline of our projects for FY 2012 is given below.

① Raising Public Awareness

We will engage in projects aimed at disseminating information on mental health, encouraging mental health awareness among disaster survivors and prefectural residents, and communicating the roles of this Center. Specifically, we will create and distribute PR pamphlets that focus on issues expected to worsen in the coming years: disaster-related depression, alcoholism, PTSD, and dementia. We will also plan and hold forums and resident lecture sessions.

② Community Resident Support

We will work alongside affiliated organizations on counseling support projects that seek to maintain and promote mental health and prevent mental illness and on group relief projects for disaster survivors who have experienced the loss of loved ones.

③ Human Resource Development

We will plan and host on an as-needed basis training workshops, case study sessions, and so on aimed at disseminating knowledge and technical skills for individuals in the mental health field in order to better equip them to prevent and treat disaster-related illness and disease.

④ Support for Supporters

In order to preserve and promote mental health and prevent mental illness among those engaged in support for supporters, we will dispatch specialists to affiliated municipalities and carry out mental health-related training workshops and counseling sessions for occupations that have been subject to severe stress since the occurrence of the disaster, through which we aim to deepen supporter knowledge of self-care.

⑤ Research

We will organize our thoughts regarding the myriad changes that disaster-affected areas and persons go through, and carry out practical research aimed at identifying and ultimately solving major problems.

⑥ Support for Various Activities

We will work with various support organizations, survivor groups, and other bodies active throughout the prefecture to establish spaces for information publication and promulgation, strengthen our social and cooperative bonds, and build a large network, thereby raising a foundation for a regional mental health welfare system.

<Toward the Future>

One year has passed in what feels like the blink of an eye. While this was but the first year of reconstruction, even if we disregard media reports, the glacial inertia of the current situation carries within it the sinister possibility that the anger of those living here may soon give way to depression. Many voices caution that an anniversary reaction might well occur. Now, the reconstruction of survivor homes and lives and the rebuilding of disaster-stricken communities has become a significant issue, and we cannot deny the possibility that that journey may stretch for several years, if not longer. We believe that while building mutually beneficial relationships with the various organizations dedicated to reconstruction efforts and as we draw closer to survivors and their needs, share in their truths, and build supportive ties, we must find new paths to mental health care. The MDMHCC is yet in its infancy, and we are in need of many more intelligent, creative people. With the idea of embarking on this journey together as our goal, we hope to channel the tangible and intangible passion and emotion offered by readers like you into continued support in the years to come.

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