Introduction

Toward the revitalization of community mental health activities

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On March 11, 2011, there was a massive magnitude 9.0 earthquake and a huge accompanying tsunami, which, combined with the meltdown at the Fukushima Daiichi Nuclear Power Station, caused extensive damage, mainly to coastal areas. It has been ten years since that day. Since the disaster, there have been full-fledged reconstruction projects working toward regional revitalization; tangible developments have been made, and the construction of disaster public housing has been completed. However, new problems have arisen in attempts to rebuild the victims' lives, such as decreased regional and familial power given the depopulation and aging that has taken place in disaster-stricken areas and the concomitant increased need for mental health care.

According to resident support data from the Center in FY2019, the number of consultations has decreased somewhat since FY2018 but 5,964 cases remain. When broken down by response, home visits have gradually decreased, while walk-in and telephone consultations have increased, with each category comprising approximately one third of the total. When broken down by consultation background, it can be seen that family/domestic problems, mental disorders, health problems, and addiction-related problems (including alcohol abuse) are still the top-ranked issues. Focusing on illnesses with a post-disaster onset, mood disorders, neurotic disorders, and mental and behavioral disorders due to psychoactive substance use are the top-ranking illnesses.

Higashimatsushima has continuously conducted citizen surveys on mental health since 2012. The percentage of those with a K6 over 15 points has long remained at approximately 8% until 2018, but this decreased to 6.1% in 2019. When looking at CAGE(CAGE is derived from the four questions of the tool;Cut down,Annoyed,Guilty,and Eye-opener) for drinking problems, those with two or more categories account for 3.2%, indicating the need for focused and continued support.

Regarding the progress of resident support provided by the Center during this time, the number of consultations has tended to remain high, and no large changes in consultation content and backgrounds have been seen over time. Among counselees' accounts of events, a common story recalls the disaster experience on that day in isolated public housing, mentally disturbed by feelings of anxiety and sadness, and complaining of physical and mental disorders. Furthermore, after the earthquake disaster, there were many serious and complex situations of truancy and psychologically unstable children in an unstable domestic environment, indicating that continued mental care is needed.

In addition to supporting disaster victims, the affected municipalities have also carried out a wide range of regular health services with many challenges that need to be addressed as they move toward maintaining and improving local residents' mental health. However, there is never a sufficient number of public health nurses in municipalities; thus, there is an urgent need for development of human resources who will be responsible for community mental health activities. We must combine approaches to the high-risk population in order to develop community mental health activities to achieve public health from multiple angles. In order to do so, health centers, municipalities, and mental care centers should work closely together to share an awareness of the various regions' current situation and problems and formulate a community mental health plan that is geared toward resolution. Moreover, we should improve our own skills and develop health activities involving various related organizations and residents in the region.