State of a activities listed by project for 2016

2016 Activity Review

Yuichi Watanabe – Director, Psychiatric Social Worker
Planning Division, Stem Center, MDMHCC

1. Introduction

Over the course of around six years, since the establishment of the Stem Center in December 2011 and the establishment of the Kesennuma Regional Center and Ishinomaki Regional Center in April 2012, the Miyagi Disaster Mental Health Center (hereinafter, "the Center") has developed its support projects for areas struck by the earthquake through their division into six items. Moreover, since 2016, we have taken charge of the "Regional Projects for Children's Mental Health Care" (*kodomo no kokoro no kea chiiki kyoten jigyou*) and developed activities aiming to "seamless mental health support from child to adult," following the fundamental plan of action set in "A vision for the future of Miyagi: Implementation plan for post-earthquake reconstruction" (*Miyagi no shourai bijon: shinsai fukkou jisshikeisaku kihonhoushin*).

Likewise, in Miyagi, where the disorder had been extreme at first, little by little over the course of six years of activities since the earthquake, we have been able to regain some stability. However, different issues present themselves in each region each year, and we must carry out the support activities that are appropriate at each phase.

Below we reflect on the Center's activities each year based on aggregate results of our operations and focus on current issues in areas struck by the disaster. Moreover, in our reflections on the trends over the past years, we attempt to capture issues for the future and how support is carried out in the mid to long term.

2. Achievements this year: From all figures

Table 1 shows the number of achievements at this Center in 2016. The number of times local residents were provided support has increased each year since the Center was established, but in 2016 a downward trend occurred for the first time (7,373 in 2016, vs. 7,680 in 2015). Based on the breakdown, the number of cases decreased compared to previous years at the Stem Center, Ishinomaki Regional Center, and for relocated staff (for 2015, 2184 at the Stem Center, 1,742 for the Ishinomaki Regional Center, and 2,378 for relocated staff), and increased at the Kisennuma Regional Center (1,030 in 2015), which demonstrates that the methods differ according to the circumstances in each region.

In other projects, although there was no great change in our achievements from previous years, there was a large increase in the number of liaison and coordination meetings at the Kisennuma Regional Center. In previous years, the Kisennuma Regional Center took on projects emphasizing support for all kinds of activities, so this may be the effect of things like liaison and coordination that accompany an increase in close links with relevant organizations and support from local residents.

Table 1: Number of activities in each location

	Regional support department at each regional center				Planning division	Stem C management	Part-time or commissioned	Supporters, other	Total
	Kesennuma	Ishinomaki	Stem	Municipal relocated staff					
Resident Support	1,235	1,341	1,727	2,233	85	71	51	9	6,752
Support for Supporters	67	188	517	615	7	123	12	20	1,549
Raising public awareness	148	60	67	26	37	37	3	1	379
Human resource development	10	18	19	8	18	64	11	4	152
Support for various activities	5	0	1	1	1	0	0	0	8
Research	0	0	4	0	3	7	0	0	14
Meetings, liaison and coordination	633	179	395	556	320	57	4	0	2,144

3. Changes in each project

Below I reflect on the results of the six main projects for this Center.

(1) Resident support

With the goals of preventing mental illness and improving mental health in areas struck by disaster, we carried out support activities for local residents.

① Targets for support

a. Changing numbers of support cases, and comparison by support opportunity and response method

Table 2 shows the total number of cases for each support method. The largest number of consultations were annual visits, and these continued to tend to be high due to outreach. Although these increased by more than 400 incidences between 2014 and 2015, in 2016 the total number fell to 6,671 from 7,589 in 2015 (the numbers differ from those in Table 1 because consultations by letter have been excluded).

Looking at the breakdown, the number of "Home Visits" fell greatly from 4,465 in 2015 to 3,068 in 2016. Moreover, even in the course of the first support time (Table 3), the number of cases of support triggered by "the health survey and survey of all households" (*kenkou chousa, zenko chousa*) fell greatly from 1,425 in 2015 to 926 in 2016. Thus far, follow-ups after the health survey of prefecture citizens have led to requests to municipal bodies, many corresponding to specific case visits. However, since differences arise in the responses of municipal bodies, this has also led to differences in the number of incidences.

On the other hand, the number of cases accompanying medical examinations increased from 73 to 120 (Table 2). Among these, the increase at the Ishinomaki Regional Center and by relocated staff was particularly striking, and the response method and means of forming relationships varied depending on the department.

Aside from that, amid the downward trend in the number of overall responses, the proportion of requests from administrative bodies increased over previous years, from 429 in 2015 to 477 in 2016 (Table 3).

Table 2: Aggregate total number of cases for each support method (excluding written answers; *N* = 6671)

Support method	Number of cases
Home visits	3,068
Walk-in visitors	1,211
Telephone counseling	1,843
Consultation in group activities	281
Case conferences	21
Accompanying medical examinations	120
Others	127
Total	6,671

Table 3: Path at first use of the Center (multiple choice; *N* = 1494)

Consultation pathway	Number of cases
Health survey	926
From administrative body	477
From the person concerned	225
From family or relatives	96
From support center or temporary support workers	24
From medical care or welfare organization	38
Others (neighbors, workplace, unknown, others)	183

b. Gender, age, and employment status

Comparing men and women and looking at employment status in each age bracket, the number of cases of support targeting older people has grown over time, but this year the number of people in their 60s and 70s declined in the target group (Figure 1). The proportion of unemployed people also increased in the past year, but this is also characterized by a decrease in people in their 30s and 40s.

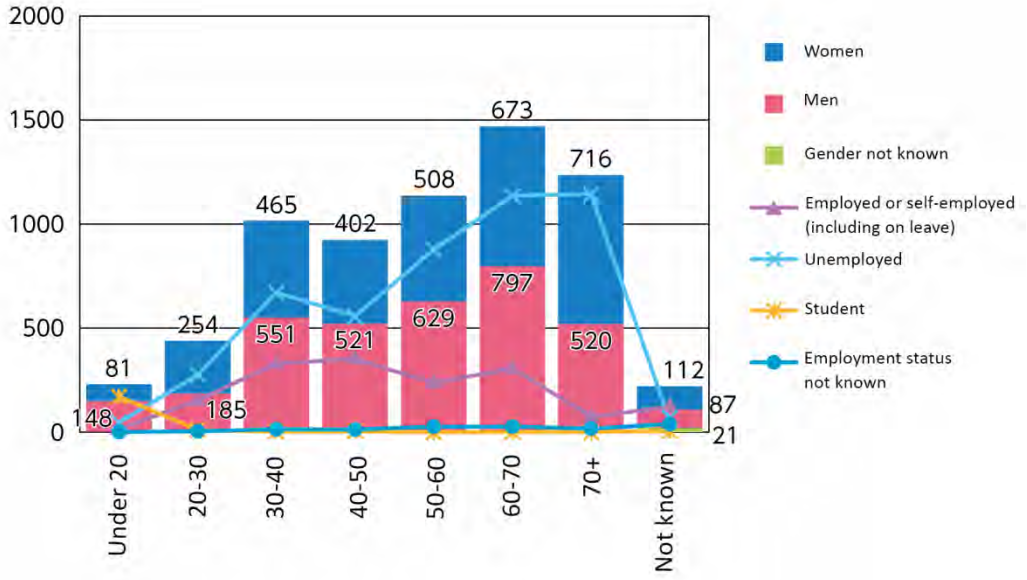

Figure 1: Number of targets for support by age and employment status (aggregated totals; N = 6671)

c. Victimization

Although the number of cases of bereavement has decreased, the percentage composition is about the same as in the previous year (Figure 2). Regarding the specifics of bereavement, although there was an increase in "spouse," "sibling," and "neighbor mentioned above," there was no characteristic change (Figure 3). The number of injuries to self or close relatives (Figure 4, Figure 5) and damages to the home (Figure 6) also declined between 2016 and last year, but there was no great change in the percentage composition.

Figure 2: Bereavement status
(aggregate totals; N = 6671)

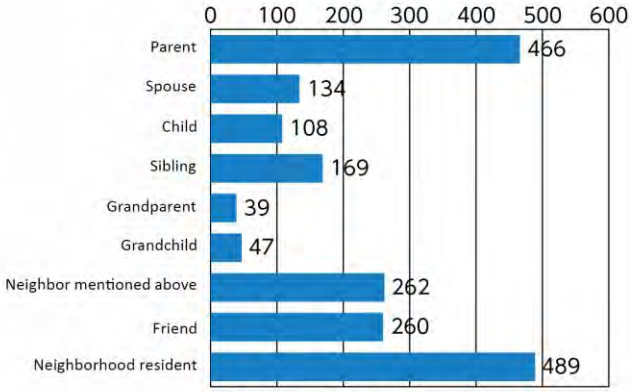

Figure 3: Details of damage to home
(aggregate totals; N = 1212)

Figure 4: Status of injury to self or close person (aggregate total; N = 6671)

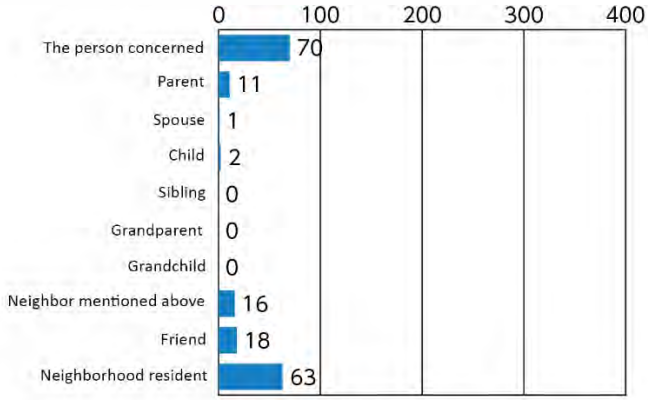

Figure 5: Details of injured person
(aggregate totals, multiple choice; N = 158)

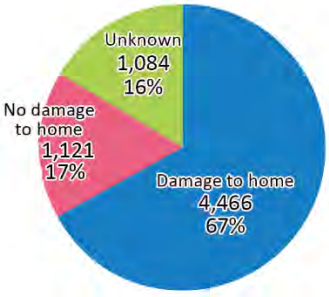

Figure 6: Status of damage to home
(aggregate total; N = 6671)

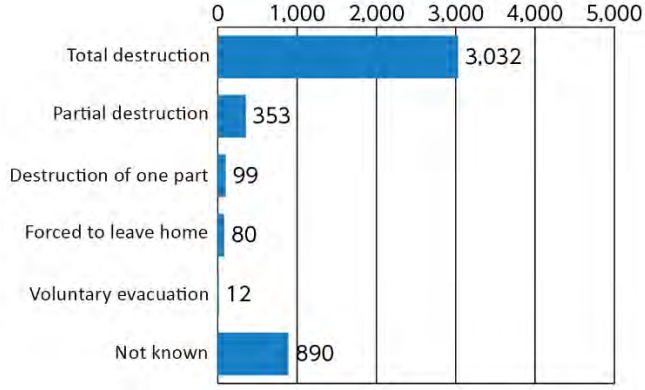

Figure 7: Detail of damage to home
(aggregate totals: N = 4466)

d. Living conditions

The number of cases responding to "living environment during support" continued from the previous year; the number of cases responding to temporary housing or private housing decreased, and the number of cases in public housing increased favorably (Table 4). Above all, the number in temporary housing fell to less than half that of the previous year, from 1,898 in 2015 to 908 in 2016, but the number of cases responding to private housing was about the same as the previous year.

There was also an increase of private housing in the proportional composition of each regional center, and in the proportion of family structures that had unmarried people, and a similar downward trend in private housing and temporary housing, but aside from these there was no great difference in composition (Figure 8, Figure 9).

Table 4: Current living environment (aggregate totals; *N* = 6671)

Living environment	Number of cases
Own home	3,054
Container-type temporary housing	908
Apartment-type temporary housing	626
Public housing	1,858
Others / unknown	225

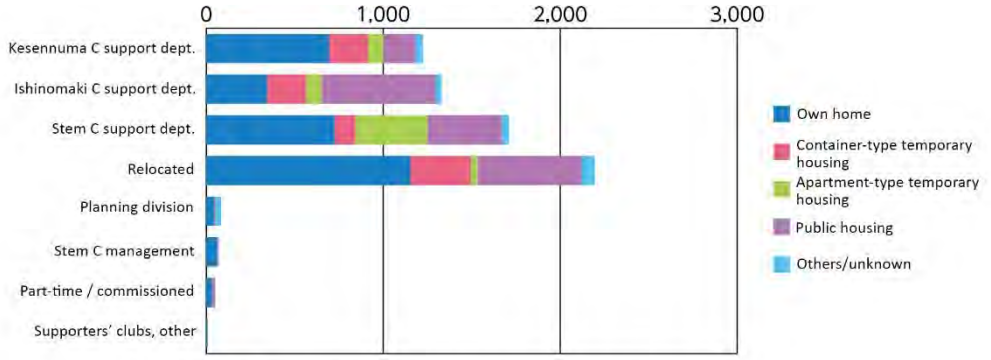

Figure 8: Current living environment by department responsible (aggregate totals; N = 6671)

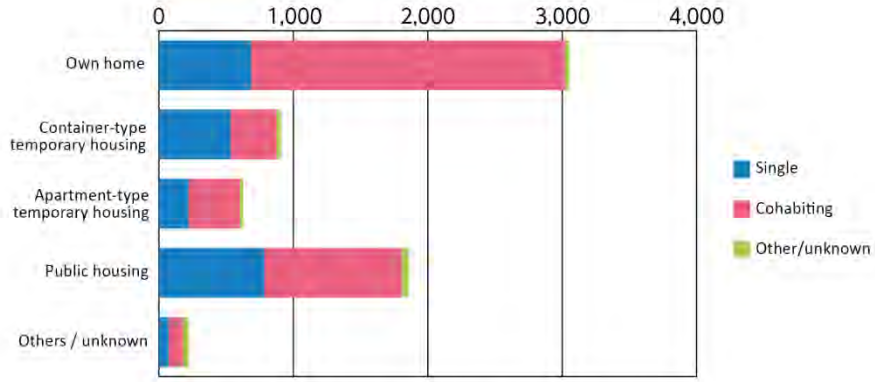

Figure 9: Living environment and household status (aggregate totals; N = 6671)

e. Background of consultations

Although in 2014 the most common factor behind the consultations was "psychological changes," in 2015 a higher proportion cited "health problems." However, in 2016 the order reversed again, with "psychological changes" once again being the reason most commonly given (Figure 10).

"Psychological changes" and "health problems" have been consistently high in recent years, but over time the proportion of respondents citing "problems with family or home" has increased (fifth place in 2014 with 17.2%, third place in 2015 with 24.1%, and third place in 2016 with 27.0%).

In addition to this, there was also an increase in the proportion of responses citing "unemployment or work" (8.8%, up from 5.3% in 2014 and 6.9% in 2015) and "education, childcare, or changing schools" (4.6%, up from 2.8% in 2014 and 3.6% in 2015). Over the years there has been a reduction in the number of responses citing "changes to living environment" (13.5%, down from 20.7% in 2014 and 18.9% in 2015), which may be linked to the steady progress in home construction.

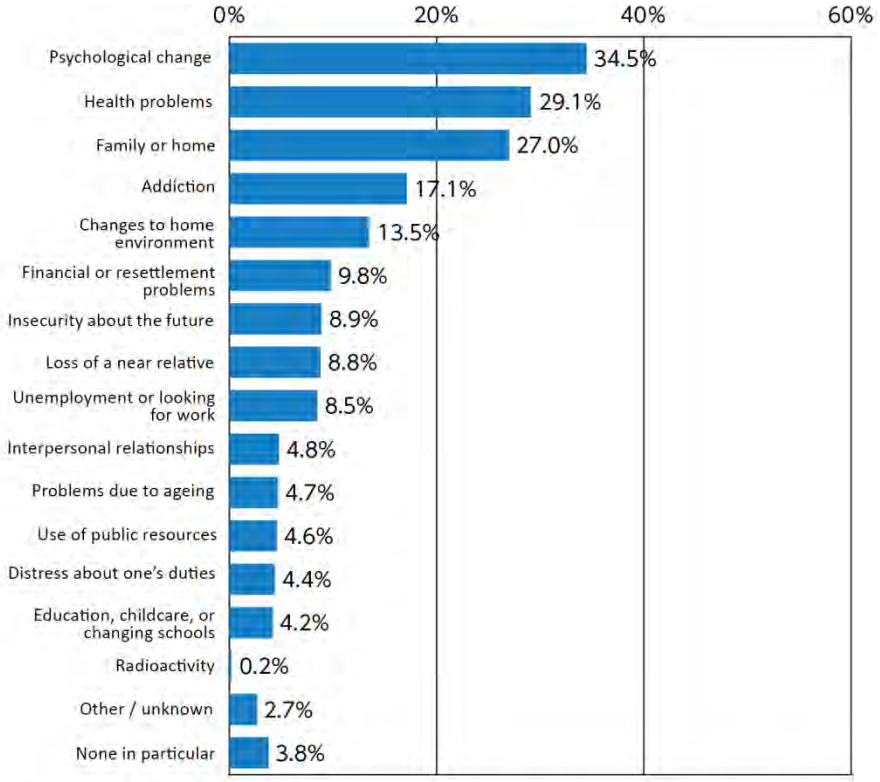

Figure 10: Proportion of valid response numbers for consultation background (aggregate totals, multiple choice; N = 6671)

f. Psychological changes

Reflecting on the items citing psychological changes in the last three years (Figure 11), there have been no significant changes in 2016 other than anxiety disorder changing places with somatic symptoms.

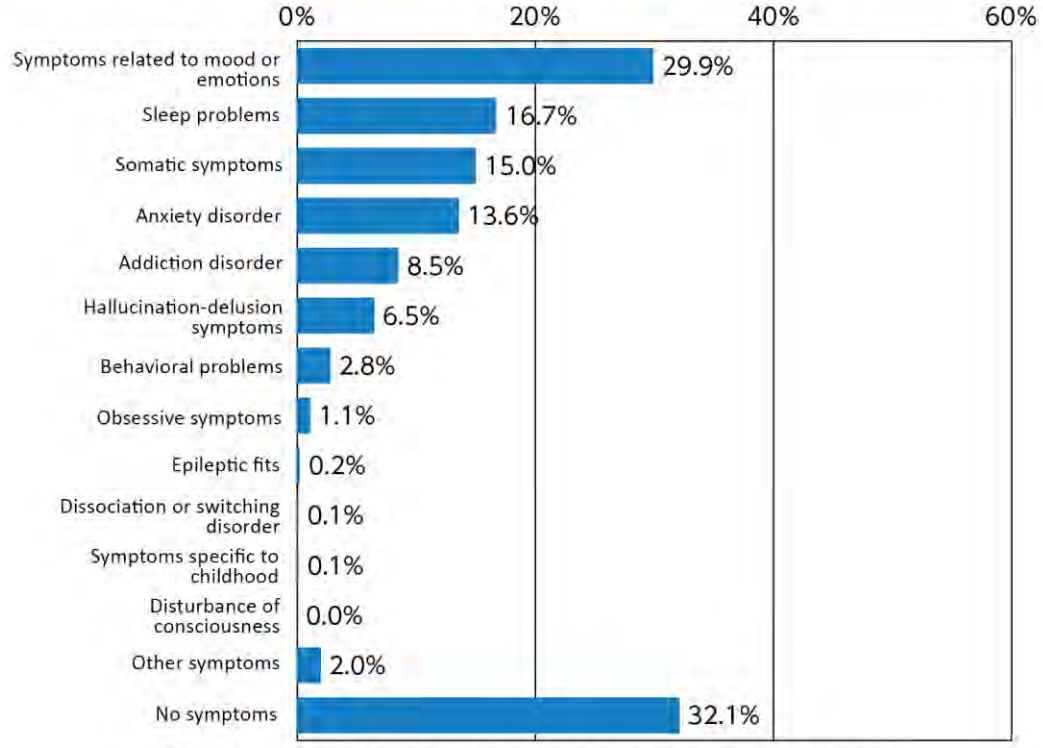

Figure 11: Proportion of valid response numbers for classification of psychological change (aggregate totals, multiple choice; N = 6671)

g. Presence or absence of a history of receiving psychiatric care related to disease name, time of onset, and medical history

The number of reported cases receiving care and cases with current illnesses fell from 7,589 in 2015 to 6,671 in 2016. In 2015 35.8% "received care" (2,716 in total), and while this was about the same as it had been in 2014, in 2016 it increased to 44.1% (2,948 total) (Table 5).

The number of cases having "received care" increased each year, from 2,653 in 2014 to 2,716 in 2015 and 2,948 in 2016. Looking at these by classification, aside from an increase under "F3: mood (affective) disorders" for both "onset before the disaster" and "onset after the disaster," it is also noticeable that "onset after the disaster" was at work in "F4: neurotic, stress-related, and somatoform disorders," and "onset before the disaster" in "F7: mental retardation" (Figure 12).

Table 5: Medical history and current medical condition (aggregated totals; *N* = 6671)

History of psychiatric care		Number of cases
Received care	(Treatment ongoing)	2114
	(Treatment ended)	210
	(Treatment stopped)	575
	(Untreated)	4
	(Treatment condition unknown)	45
Had not received care		2795
Not known		928

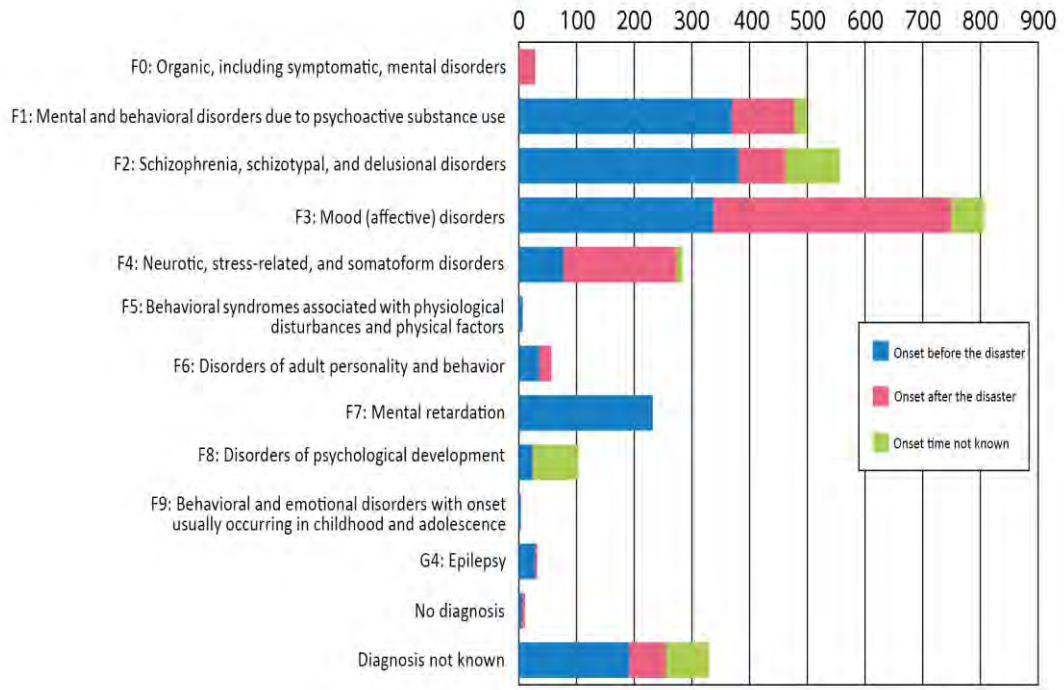

Figure 12: Number of cases of each classification for people with a medical condition or diagnosis (aggregate number of cases; N = 2948)

② Topics of support

a. Number of cases of each support method for each relevant department

Classifying by regional support department, with the exception of increases in the number of cases at the Kesennuma Regional Center, the number of cases decreased across the board, and the decrease in each department's "number of cases of consultation due to visits" was particularly clear. Also notable was the high number of cases of "telephone consultation" by relocated staff, and the fact that the proportion of consultations by people visiting the office increased (Figure 13).

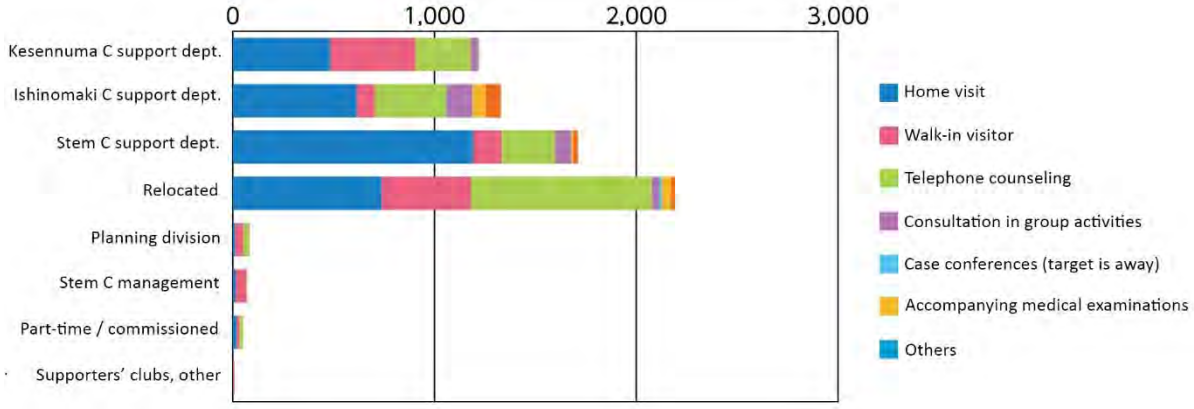

Figure 13: Number of cases for each method of support by department responsible (aggregate totals; N = 6671)

b. Classification of people receiving consultations

83.8% of all cases of consultation were for the persons themselves, and in a typical year this is followed by the next highest proportion of "family or a relative" at 10.4%. In 2016 the number of cases for "another supporter" increased somewhat, but other than that there was no major change (Figure 14).

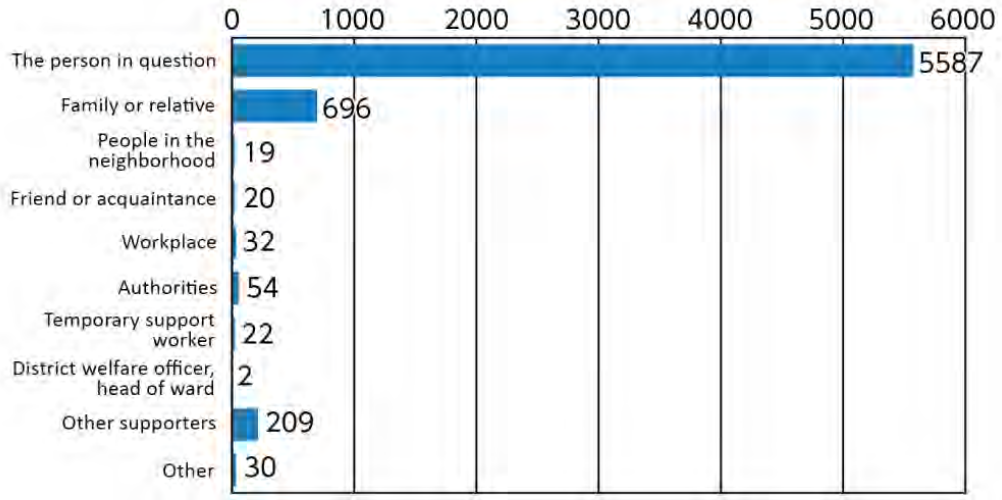

Figure 14: Total number of cases for each consultee (aggregate totals; N = 6671)

c. Collocated organizations

The proportion of "people from support centers or temporary support workers" was 27.3% in 2014 and 26.4% in 2015, but in 2016 this decreased drastically to 6.4% (Figure 15). In particular, although the proportion had remained relatively high for the main support department, this decreased drastically in 2016.

Regarding this, in 2014 the proportion of collocated municipal staff was 45.6%, and this has been increasing year by year to 52.8% in 2015 and 65.87% in 2016, and a large gap has emerged between medical institutions and health care centers or social welfare (Figure 16). According to the local government, there has been a reduction in the activities of support centers and temporary support workers who had been active after the disaster, and tendencies have emerged in response to problems with the original structure of local government, and these kinds of changes may have had an effect on the data.

Aside from this, it was also notable that the proportion relating to welfare was high for relocated staff, and the proportion collocated with a health care center differed depending on the Center.

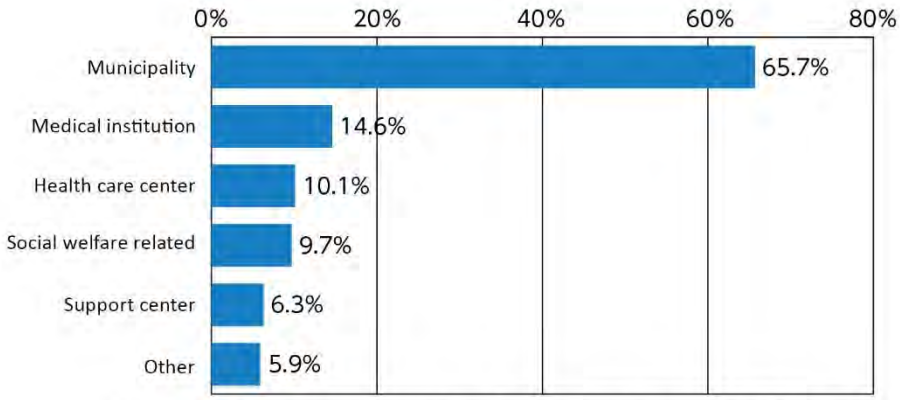

Figure 15: Proportion of number of valid responses relating to collocated organizations (aggregated totals, multiple choice; N = 1498)

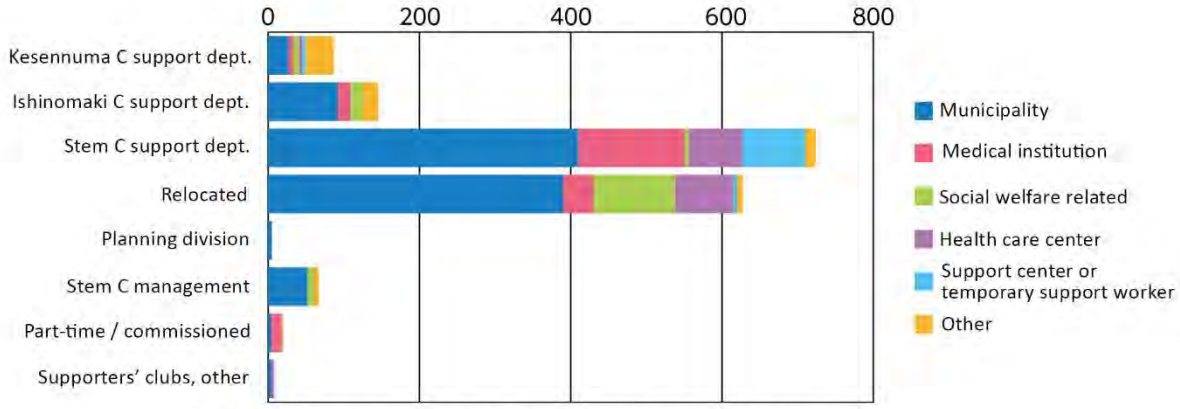

Figure 16: Classification related to other collocated organizations for each department (N = 1498)

③ Condition at the end of support

Although there was a gap between the number of cases in 2015 at 7,589 and the number of cases in 2016 at 6,671, no changes worthy of specific mention can be seen (Table 6). Although the high proportion of those whose condition improved, the high proportion of local government referring other organizations, and the proportion composition were similar to previous years, the proportion of referrals by medical institutions has increased every year, from 13.2% in 2014, 19.7% in 2015, and 27% in 2016 (Figure 17).

Table 6: Outcomes (*N* = 6671)

Condition being responded to		Number of cases
Continuing (aggregate)	Regular interviews	3,014
	Consulting when needed	2,239
	Other	1
Ended (real number)	Condition improved	1,259
	Referral to another organization	111
	Refusal of support	43
Other		4

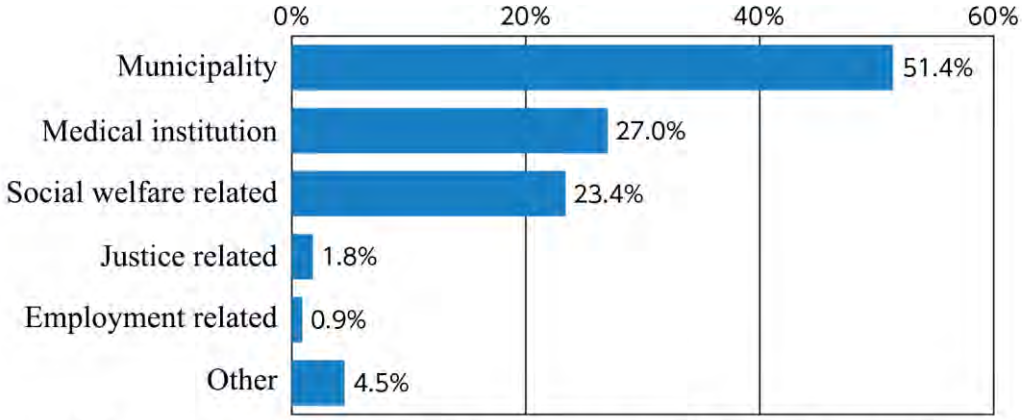

Figure 17: Proportion of number of valid responses classified by other organization support (N = 111)

④ Conclusion

Regarding resident support outside of the data above, as well as having implemented a children's camp project in Matsushima-cho, we also established various kinds of projects to suit the particulars of each region, such as "Koko Farm" (Ishinomaki Regional Center), a place for interactions through activities such as growing vegetables in a field; "Utsukushima Salon" (Stem Center Regional Support Department), for people who had moved from Fukushima; and "Salon for Mental and Physical Health," a place for interaction and activities that are good for health, such as balanced food.

The total number of cases of resident support decreased within the year, and at first glance it may seem that the volume of projects was lower. However, the activity time for each project was comparable to previous years, and we also suspect that it was necessary to relate carefully to people whose issues are more difficult to resolve, rather than decreasing activity time along with the reduction in the number of cases.

Six years after becoming victims of a disaster, people are moving to public housing and making progress reorganizing their communities, and a shift is proceeding toward a reduction in activities by support workers and the pre-existing municipality responding to the disaster. Amid this, areas struck by disaster must not be left behind, and their needs must be responded to sensitively. From now on, resident support must be positioned within our core activities.

(2) Support for supporters

With the aim of supporting supporters in areas struck by the disaster, we held workshops and consultations and deployed professionals to municipalities.

① Topics of support

The total number of supporters who we supported was 1,549 in 2016, having fallen year by year from 1,915 in 2014 and 1,606 in 2015 (Table 7), but there were slight increases in "reports after visits or interviews," "guidance and advice from professional positions," "case conferences," and "setting up mental health consulting services."

In "guidance and advice from professional positions" (Table 8) in particular, aside from the fact that proportion of cases responding to alcohol problems remained high at 90 total cases (120 in 2014 and 107 in 2015), in 2016 the number of cases responding to abuse increased greatly to 119, from 36 in 2014 and 56 in 2015. There has been an upward trend since we took charge of children's mental health care, so continuous attention may be necessary.

Table 7: Status of implementation of support for supporters (aggregate totals; *N* = 1549)

Topic of support	Number of cases	Number of targets
Report after home visit or interview	246	458
Professional guidance and suggestions	411	1,530
Problem area	18	81
Workplace mental health care	17	62
Case conferences	272	1,265
Establishing mental health consulting service	61	88
Support with health checkups	27	93
Support with clerical work	457	966
Others	40	225
Total	1,549	4,768

Table 8: Details of professional guidance and advice (aggregate totals, multiple choice; *N* = 411)

Details of professional guidance and advice	Number of cases
Alcohol problems	90
Gambling problems	1
Drug problems	0
Depression	36
Complex grief	4
PTSD	13
Abuse	119
Others	255

Classifying support for supporters by state of achievement, although no great increase or decrease could be observed in the total number, the number of cases at the Kesennuma Regional Center and the Stem Center Department for Regional Support decreased, and the number of cases with relocated staff and the Ishinomaki Center increased remarkably (Figure 18).

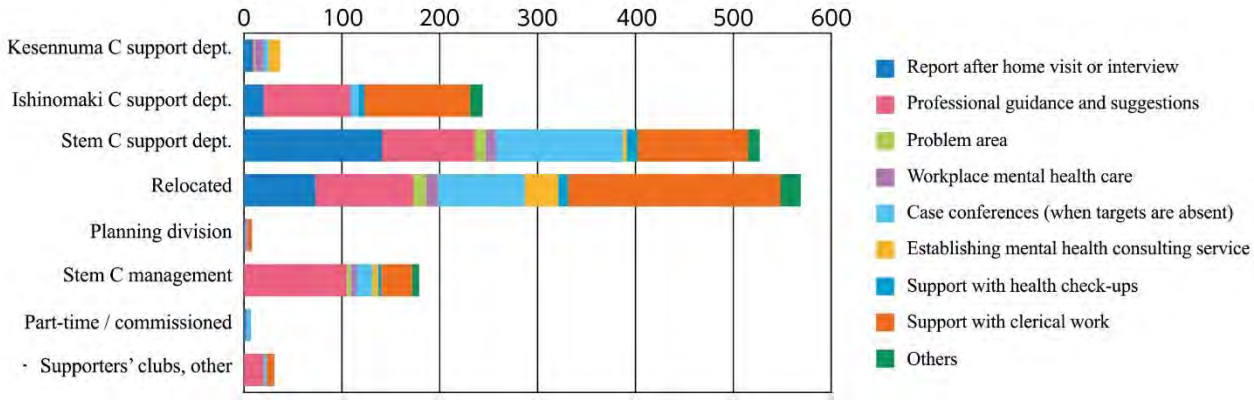

Figure 18: Status of implementation of support for supporters in each department (aggregate totals, multiple choice; N = 1549)

Classifying these shows that the proportion at the Stem Center Support Department that were collocated for case conferences was higher than at the Kesennuma Regional Center and the Ishinomaki Regional Center. The proportion of collocated case conferences for relocated staff temporarily fell a great deal in 2015, but in 2016 the number of such cases was similar to that in 2014. It is also striking that there was a lot of clerical work support for the Stem Support Department and for relocated staff. The local situation and municipal objectives may have had a strong influence on the number of cases. "Advice and guidance from a professional position," aside from a high proportion of cases responding to alcohol problems, specifically had a high rate of cases responding to abuse problems in 2016 in management at the Stem Center (Figure 19).

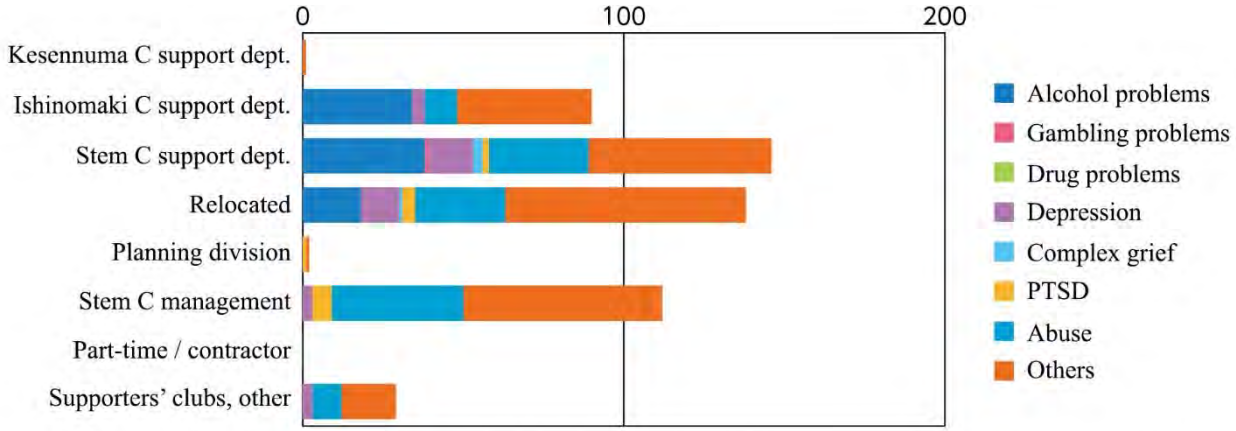

Figure 19: Details of professional guidance and advice by department (aggregate totals, multiple choice; N = 411)

② Targets for support

As with other years, the proportion of people involved with municipalities stood out from the rest, and support may have continued to gather pace with municipalities. However, "temporary support workers," who had constantly constituted a large group, decreased greatly in the last year. The number of responses citing "support centers" also decreased compared to previous years, and this may be due to a reduction in duties connected to the earthquake and progress transitioning back to preexisting municipal functions (Figure 20).

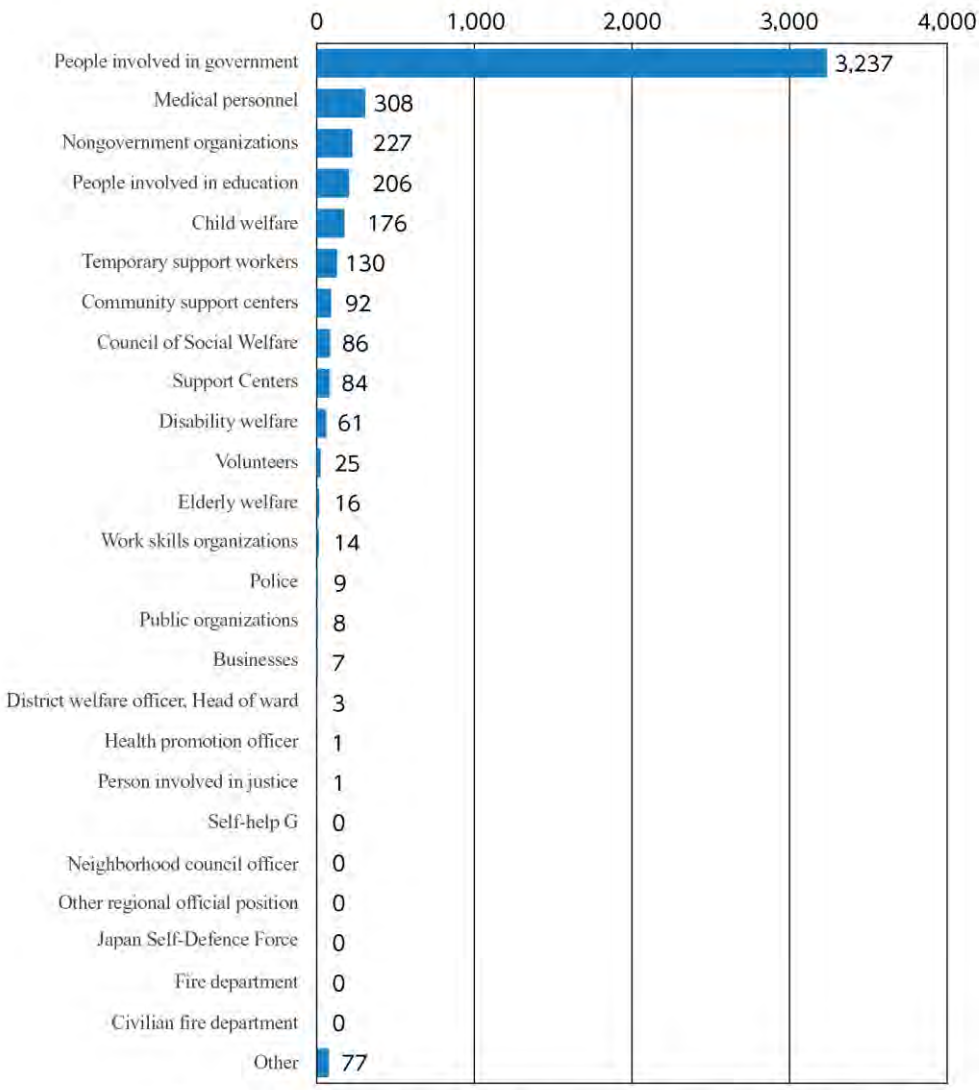

Figure 20: Details of targets for support (aggregate totals; N = 4768)

Due to requests from municipal bodies, in 2016 eight relocated staff were deployed to seven municipal bodies. Regarding their occupation, many were psychiatric social workers, while there was also one occupational therapist and one clinical psychotherapist (Figure 21).

Although so far there have been cases of one municipal body having more than one relocated staff member deployed to them, in many of them these had the same occupation. However, in 2016, we deployed relocated staff of different occupations to one municipal authority (three days a week and two days a week), and both relocated staff responded jointly to problems according to their own occupations.

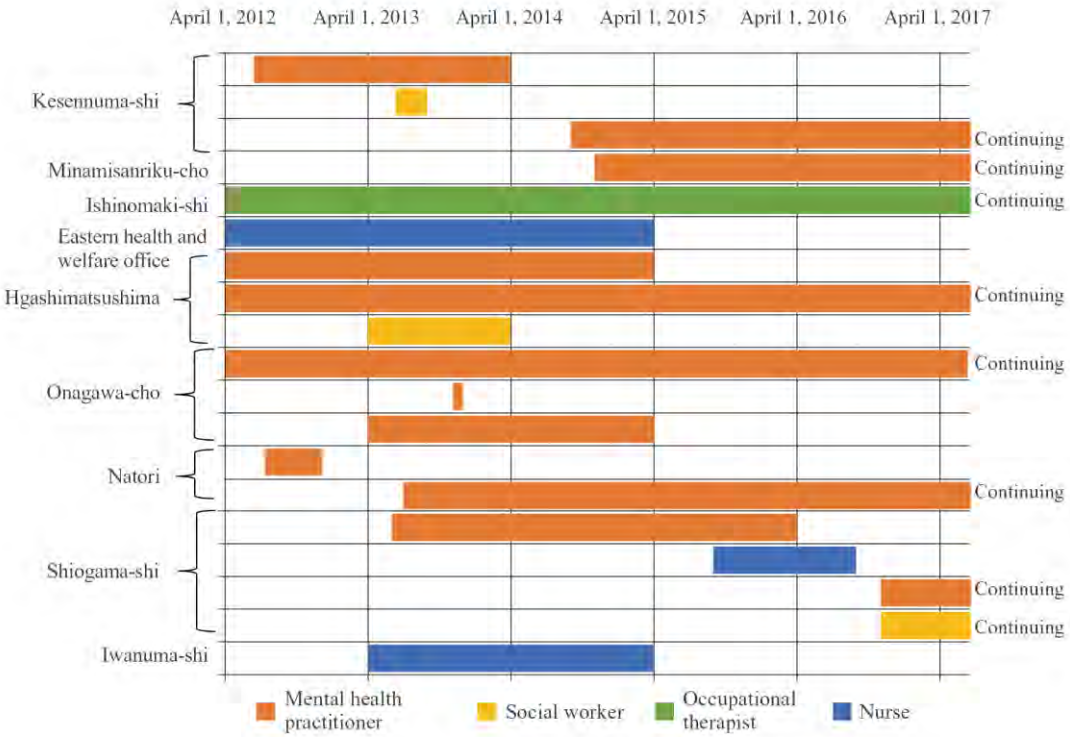

Figure 21: Relocated staff deployment status

③ Conclusion

In 2015 we were concerned that due to a large reduction in external supporters, the burden on remaining supporters would increase. In 2016, the numerical value of our support for supporters may seem to have decreased in terms of the people from earthquake-related occupations such as temporary support workers. Although one could say that the reduction in people in earthquake-related occupations is a marker of progress toward reconstruction, on the other hand it may also be linked to a cost increase for the municipal staff responsible. We must bear in mind the changes in each region when thinking about how to support supporters in future.

Supporters' concerns about alcohol problems remain high. Moreover, initiatives aiming to start alcohol abstinence meetings and study groups are ongoing in every area. From now on, one of our aims will be to cooperate with relevant organizations and bodies, including this Center, in order to train supporters who will engage in core activities that are rooted in each region and maintain systems that can continue to support relevant people in the region.

In 2016, institutional reorganizations were carried out by municipal bodies, and this also changed the affiliation of relocated staff from our Centers. The many major changes to the numerical value of relocated staff in support for supporters may be an effect of this.

(3) Raising public awareness

① Status of implementation of raising public awareness

We aim to disseminate information in many ways, such as by distributing public awareness materials and corresponding with news media and by carrying out public awareness training and salon activities for the region, and to deepen understanding of post-disaster mental health (Table 9, Table 10). In 2015 we increased our number of acceptance inspections from nine to fifteen. This may be affected by the fact that in the previous year we have had observation reports on the April 2014 sinking of MV *Sewol* in South Korea and the April 2016 Kumamoto Earthquake.

In 2016, we reprinted our Center pamphlets, as well as the two PR brochures that we published in March and October that presented the initiatives of the Centers and the conditions in each area.

Table 9: Status of PR brochure publication

Issue no.	Publication month	Number of copies
15	October	2,400
16	March	2,400

Table 10: Status of pamphlet creation

Distribution region	Title / contents	Original / reprint	Number of copies
All regions in the prefecture	Miyagi Disaster Mental Health Center pamphlet	Reprint	3500

② Public awareness training

We maintained about the same number of "Addiction (alcohol problems etc.)" events as the preceding year, and the need for this seems to remain high. Moreover, as well as seeing an upward trend in the number of "Stress and mental health self-care" events from 21 in 2014 to 41 in 2015 and 75 in 2016, there was a similar increase for "Workplace mental health" (Table 10). This achievement may be linked to our tackling workplace mental health in the previous year jointly with the Kyokai Kenpo (Japan Health Insurance Association).

The salon activities targeted at local residents also showed an upward trend year by year, from 67 in 2014 to 97 in 2015 and 127 in 2016. From this year onwards the Center has also planned to take over some of the salon activities carried out by other organizations. These circumstances may have led to Stem Support Department's "reducing collaboration with other organizations' salons" and increasing the "organization and co-organization of salons" (Table 11).

Table 11: Salon activities (*N* = 153)

	Regional support department at each center				Other	Total
	Kesennuma	Ishinomaki	Stem	Relocated		
Organized / co-organized salons	38	40	43	3	3	127
Collaboration with other organizations' salons	5	0	4	11	6	26

The contents of public awareness projects have changed greatly compared to when the Centers were first established. Although there has been a reduction in the number of new pamphlets and the like, the number of salon activities held in each region has increased. As well as the Kesennuma Center carrying out "mental health social" (Koko café) using kamishibai and musical performances as in previous years, the Ishinomaki Regional Center also plans to announce other performances. In the Kesennuma Center Regional Support Department there have also been initiatives tackling the actual circumstances of the region, such as establishing consulting services at places where residents receive medical examination, and materials such as the pamphlets previously produced are used within these plans. The increase in the number of various salons in 2016 occurred in the context of supporters' major problems with how to prevent isolation as residents relocate to public housing from temporary housing and build new communities, and they may have been a useful way of responding to this issue.

(4) Human resource development

Targeting supporters in areas struck by the disaster, we held all kinds of workshops aiming to raise awareness, and activities such as socials aiming to build networks (Table 12).

Although there has so far been an increase in the number of events for "addiction-related problems" and "support skills training," this year this shifted to a decrease. However, there was a two-fold increase in "workplace mental health training" and "suicide prevention issues training."

"Earthquake Disaster Mental Health Care Social Miyagi" was carried out at the Kesennuma Regional Center, the Ishinomaki Regional Center, and the Stem Center, and different initiatives were carried out at each Center. At the Ishinomaki Center, this took the form of an executive committee,

taking the opportunity to link to a number of organizations through their own planning processes. Various organizations in the region spend time on planning, and they hold discussions with them many times before the appointed date.

The three prefectural disaster mental health care center meetings that have been carried out so far have not been run as human resource development, so that we can plan an academic conference this year. However, cooperation between all of the disaster mental health care centers is important for human resource development and should continue. In 2016 the Kumamoto Earthquake led to the creation of disaster mental health care centers in Kumamoto Prefecture. Just as our Centers benefitted from a great deal of information and know-how from the disaster mental health care centers in Hyogo and Niigata Prefectures, we hope to create beneficial links with them and share as much of our own experiences as we can.

Table 12: Status of implementation of human resource development (*N* = 159)

Contents	Number of times	Number of participants
Earthquake social	3	157
Media conference	0	0
Addiction-related problems	20	370-
(alcohol)	(20)	(370)
(other addictions)	(0)	(0)
Support skills training	45	1,641
(close listening)	(5)	(136)
(stress and mental health care, self-care)	(7)	(194)
(other)	(33)	(1,311)
Supporter mental health training	3	56
Workplace mental health training	18	360
Children's mental health training	20	1,194
Elderly mental health training	2	157
Suicide prevention issues training	18	42
Mental disorder and disability training	7	551
Circumstances in areas struck by disaster and Center activities	8	553
Case discussion	7	197
Other	1	28
Total	152	5,286

(5) Other

① Research

Six years have passed since the earthquake, and we are entering a phase in which we will have to wrap up the Center's activities so far, so regarding our research projects, as well as once again organizing research groups, we have started to prepare and manage a research ethics committee and strengthen our systems going forward.

Aside from organizing the Japanese Council of Social Welfare health survey projects that we have carried out over the years in collaboration with the Tohoku University Graduate School of Medicine Department of Preventive Psychiatry, we are moving forward on multiple fronts with research based on support activities such as resident support, cooperation between supporters, and salon activities. Moreover, we are carrying out "longitudinal support research with children born after the Great East Japan Earthquake and their families" as a collaborative research project with the Iwate Prefecture Children's Center. In 2016 we published our sixth research report and our third symposium (referenced elsewhere).

② Support for various activities

We aim to strengthen cooperation while supporting initiatives for support activities in the region, and cooperate in building the region in the future. In 2016 we jointly hosted three and supported two

general plans.

4. Regional projects for children's mental health care

At Miyagi Disaster Mental Health Care Center, since April 2016 we have taken charge of the Miyagi Prefecture-commissioned project "Regional Projects for Children's Mental Health Care" (*kodomo no kokoro no kea chiiki kyoten jigyou*).

Following the Great East Japan Earthquake, children's mental health care was handled immediately afterwards at the Department for Health and Welfare, focusing on the General Children's Center and the Children's Welfare Center. Furthermore, at the request of the Ministry of Health, Labour and Welfare, in October 2011 the "Great East Japan Earthquake Central Children's Support Center" (*Higashi Nihon Daishinsai Chuuou Kodomo Shien Sentaa*) was established at the Social Welfare Service Corporation, Imperial Gift Foundation Boshi-Aiiku-Kai's Japan Child and Family Research Institute, and in February 2012 the "Miyagi Prefecture Office of the Great East Japan Earthquake Central Children's Support Center." This was closed in March 2014, and from April 2014 it was renamed the "Great East Japan Earthquake Miyagi Children's Support Center" (hereinafter, the "Children's Support Center") and the office moved to the Miyagi Prefecture Medical Center, where it came to carry out children's mental health care work. At the same time, within the General Children's Center, the "mental health care steering group" was established, and it came to execute mental health care functions for children in cooperation with the Children's Support Center.

In Miyagi prefecture, a basic policy of the reconstruction plan regarding mental health care after the earthquake is to have "seamless mental health support from child to adult" (*kodomo kara otona made kiremi no nai shien*), and since April 2016, Miyagi Disaster Mental Health Center has been commissioned for "children's mental health care tasks." The Children's Support Center closed in March 2016, and the Mental Health Care Steering Group that had been established at the General Children's Center also closed in March 2017. This Center has come to shoulder the burden of "child to adult" projects specializing in mental health care after the earthquake.

Below, we represent consultations, etc., with under-20s in the "Regional Projects for Children's Mental Health Care" which we took charge of from Miyagi Prefecture in 2016, with statistical materials from this Center based on documents such as specifications.

(1) Contents and results of the commissioned projects

① Consultation projects

Through home visits, walk-in visits, and telephone counseling, etc., we respond psychologically and psychiatrically to children, guardians, supporters, etc.

The number of consultations has been an aggregate total of 230, with 89 individuals. The number of consultations for each age separated by the person seeking consultation is shown in Table 13, and the number of consultations for each age separated by address is shown in Table 14.

As a general rule, this Center has come to carry out consultations through the cities or towns with educational institutions such as kindergartens and children who have been victims of the disaster. Looking at the topics of these consultations, when consulting children under the age of 6, many have delayed development or behavioral problems, such as not taking to group activities in nursey or kindergarten, and their mothers are anxious about child-rearing. These mainly respond to the mothers' requests for consultation through a referral from a city or town public health nurse or a nursery school teacher. When consulting with 7–15-year-olds, there are many consultations about children's truancy, in the context of developmental problems or problems at home. Moreover, when consulting with 16–19-year-olds, again there are many consultations about truancy against the backdrop of problems at home, and long-term consultations with the person concerned.

Table 13: Number of consultations by age and person seeking consultation

		Under 6	7–15	16–19	Total
Aggregate number of people (separated by client)	Person concerned	2	58	92	152
	Family	27	33	16	76
	Other	1	0	1	2
	Total	30	91	109	230
Real number of people		23	38	28	89

Table 14: Number of consultations for each age, classified by address

Location			Under 6	7–15	16–19	Total
Client location	Stem Center	Sendai	0	2	1	3
		Shiogama	0	2	1	3
		Natori	3	9	8	20
		Tagajo	1	0	0	1
		Iwanuma	0	0	4	4
		Watari	4	1	0	5
		Yamamoto	4	0	3	7
		Matsushima	0	1	1	2
		Other	1	0	0	1
	Ishinomaki Regional Center	Ishinomaki	4	46	2	52
		Higashi Matsushima	5	14	1	20
	Kesennuma Regional Center	Kesennuma	1	13	52	66
		Tome	0	2	32	34
		Minamisanriku	0	0	3	3
	Anonymous		7	1	1	9
Total			30	91	109	230

② Professional deployment projects

We deployed professionals such as child psychiatrists and clinical psychologists to locations such as municipal health centers, nursery schools, kindergartens, and elementary schools, and carried out consultations with staff. In 2016, there were deployments to 236 organizations. The number of deployments for each destination organization and type of occupation is shown in Table 15, and the number of deployments for each destination organization and location is shown in Table 16.

When broken down by organization, municipalities had the most consultations. The topics were advice on difficult cases regarding health preservation in infant medical examination and advice on difficult cases regarding the regional council child protection measures. Requests from nursery schools and kindergartens were often regarding children who had developmental disorders or suspected abuse, and consultations concerned how to respond to difficult parents.

Table 15: Number of deployments for each destination organization and type of occupation

	Prefecture-related	Municipality	Nursery, kindergarten	Elementary school	Junior high school	Other	Total
Psychiatrist	2	7	22	17	3	3	54
Clinical psychologist	1	39	6	0	0	26	72
Mental health and welfare	3	23	0	3	2	1	32
Public health nurse	5	61	0	0	0	4	70
Other	0	1	4	0	0	1	6
Total	11	131	32	20	5	35	234

Table 16: Number of deployments for each destination organization and location

		Prefecture-related	Municipality	Nursery, kindergarten	Elementary school	Junior high school	Other	Total
Stem Center	Sendai	1	1	0	3	2	25	32
	Natori	0	38	5	1	1	0	45
	Tagajo	0	2	0	0	0	0	2
	Iwanuma	0	19	1	0	0	0	20
	Watari	0	8	4	0	0	1	13
	Yamamoto	0	19	1	0	0	0	20
Ishinomaki Regional Center	Ishinomaki	9	37	0	2	0	6	54
	Higashi Matsushima	0	6	21	5	0	0	32
	Onagawa	0	1	0	0	0	0	1
Kesennuma Regional Center	Kesennuma	1	0	0	7	2	2	12
	Tome	0	0	0	1	0	1	2
	Minamisanriku	0	0	0	1	0	0	1
Total		11	131	32	20	5	35	234

③ Research projects

Staff were deployed to carry out training in municipalities, nursery schools, etc. 43 workshops were carried out in 2016. The status of implementation of workshops by lecturer occupation and municipality is shown in Table 17, and the list of project implementation plans is shown in Table 18.

The venue region was most often Sendai-shi, followed in order by Natori-shi, Ishinomaki-shi, Higashimatsushima-shi, and Kesennuma-shi.

The topics of training are shown in Table 18, but two large workshops were: “Get close to children’s heart: How to bring out children’s power,” held in Ishinomaki-shi (140 participants), and “Children’s responses to abuse,” held in Osaki-shi (180 participants). The former was organized by this Center, and for the latter we deployed a lecturer. Moreover, “Training in Psychiatric First Aid (PFA) for children” (hereinafter, PFA training), which presented basic methods of psychological care after a disaster, was held five times. “Children’s PFA training” has standardized the important points concerning children who have experienced major disasters or accidents, and this Center will continue to proactively hold “Children’s PFA training” and attempt to popularize it in the prefecture’s educational institutions.

Table 17: Number of workshops by lecturer occupation and municipality

		Psychiatrist	Clinical psychologist	Mental health and welfare worker	Other	Total
Stem Center	Sendai	7	7	0	0	14
	Natori	3	4	0	3	10
	Tagajou	0	2	0	0	2
	Iwanuma	1	0	0	0	1
	Kurihara	1	0	0	0	1
	Osaki	0	1	0	0	1
	Watari	1	0	0	0	1
Ishinomaki Regional Center	Ishinomaki	0	4	0	1	5
	Higashi Matsushima	4	0	0	0	4
Kesennuma Regional Center	Kesennuma	2	0	1	0	3
	Tome	1	0	0	0	1
Total		20	18	1	4	43

Table 18: List of research projects implemented

No.	Date	Location	Topic	Main participants	No. of participants	Lecturer profession
1	May 14, 2016	Sendai	"Understanding delinquent children and parent response"	Parents of delinquent children	20	Clinical psychologist
2	May 27, 2016	Sendai	"Children who need social care"	Non-government organization	2	Clinical psychologist
3	June 8, 2016	Natori	Training in PFA for children	People involved in research and education	130	Psychiatrist
4	June 24, 2016	Natori	"How children's minds react after a disaster"	People involved in education	30	Psychiatrist
5	June 28, 2016	Kesennuma	Course in developing mental health for high school students	High school students	100	Mental health and welfare worker
6	August 1, 2016	Iwanuma	"Workplace mental health, basics of responding to children"	Non-government organization	2	Clinical psychologist
7	August 2, 2016	Iwanuma	Child-rearing assistance home visitor training course	Child welfare	8	Clinical psychologist
8	August 4, 2016	Kesennuma	"Long-term psychological support for children and students after a disaster"	People involved in education	35	Psychiatrist
9	August 5, 2016	Kesennuma	"State of support for specific cases"	People involved in education	20	Psychiatrist
10	August 10, 2016	Tome	"Start by understanding adolescent mental health"	General	15	Psychiatrist
11	August 17, 2016	Higashi Matsushima	"Points for relating to troubled parents: A child abuse prevention perspective"	People involved in education	50	Psychiatrist
12	September 2, 2016	Iwanuma	"Understanding and responding to difficult parents"	People involved in education	35	Psychiatrist
13	September 17, 2016	Sendai	"Overcoming difficulty making a living"	Parents with delinquent	40	Clinical psychologist

				children		
14	September 26, 2016	Sendai	“About mental health for children and social nursing care”	Junior college students	110	Clinical psychologist
15	September 29, 2016	Natori	“About attachment”	Child welfare	20	Clinical psychologist
16	October 14, 2016	Ishinomaki	“Get close to children’s heart: How to bring out children’s power”	People involved in education	140	Clinical psychologist
17	October 14, 2016	Watari	“Nursery school staff mental health care”	Child welfare	20	Psychiatrist
18	October 29, 2016	Sendai	“About children’s disabilities”	People involved in justice	100	Psychiatrist
19	November 1, 2016	Ishinomaki	“Important things for supporters when children need support”	People involved in education	15	Development psychologist
20	November 2, 2016	Sendai	Training in PFA for children	Non-government organization	13	Psychiatrist
21	November 9, 2016	Kurihara	“How to raise a child peacefully: Effects of child abuse on childrearing”	People involved in education	15	Clinical developmental psychologist
22	November 11, 2016	Natori	“Troubling children”	Child welfare	15	Clinical developmental psychologist
23	November 13, 2016	Sendai	“Children’s reactions at times of emergency and how to support them”	People involved in education	30	Psychiatrist
24	November 13, 2016	Sendai	“Supporting parents to raise children with empathy”	General	30	Clinical psychologist
25	November 17, 2016	Sendai	Training guardians in PFA for children	Child welfare	10	Psychiatrist
26	November 17, 2016	Osaki	“Dealing with child abuse”	Child welfare	180	Clinical psychologist
27	November 21, 2016	Ishinomaki	“Childrearing in puberty”	Guardians of orphaned children	1	Clinical psychologist
28	November 24, 2016	Higashi Matsushima	Matsushima-shi Child Protection Measures Regional Conference Workshop: “How to consider cases 1”	People involved with authorities	45	Psychiatrist
29	December 15, 2016	Natori	Case conference, “Points on case conferences”	People involved with authorities	16	Clinical psychologist
30	December 20, 2016	Sendai	Training in PFA for children	General	80	Psychiatrist
31	December 20, 2016	Natori	“Development disorders and attachment, responding to guardians”	Child welfare	7	Clinical developmental psychology
32	December 26, 2016	Higashi Matsushima	Matsushima-shi Child Protection Measures Regional Conference Workshop: “How to consider cases 2”	People involved in education	40	Psychiatrist
33	January 6, 2017	Natori	“About mental health care: Take care of emotions and self-esteem”	Child welfare	20	Clinical psychologist
34	January 10, 2017	Sendai	“Problems with developmental disorders	Child welfare	40	Psychiatrist

			and abuse"			
35	January 16, 2017	Natori	"Diagnosis and response regarding mothers" (Part 1)	People involved with authorities	11	Clinical psychologist
36	January 19, 2017	Higashi Matsushima	Matsushima-shi Child Protection Measures Regional Conference Workshop: "How to consider cases 3"	People involved with authorities	13	Psychiatrist
37	January 21, 2017	Ishinomaki	"Childrearing in puberty"	Guardians of orphaned children	8	Clinical psychologist
38	February 9, 2017	Tagajou	Tagajo case conference, "how to examine cases, how to cooperate"	People involved with authorities	15	Clinical psychologist
39	February 27, 2017	Ishinomaki	"Attachment disorder"	People involved with education	25	Clinical psychologist
40	March 10, 2017	Natori	"How to raise children who are active in the community"	General	10	Psychiatrist
41	March 13, 2017	Natori	"Children's condition and family support"	People involved with authorities	9	Clinical developmental psychologist
42	March 23, 2017	Sendai	Training in PFA for children	Fire department	30	Psychiatrist
43	March 23, 2017	Tagajou	"Supporting families with complex problems"	People involved with authorities	25	Clinical psychologist

④ Public information projects

a. We distributed pamphlets about children's mental health care after earthquakes, such as "Understanding and responding to children's mental health," "Children's mental health care (for parents/guardians)," and "Children's mental health care (for educators)," and began to spread information and raise public awareness about children's mental health.

b. We worked to publicize mental health consultations and accepted consultations for children in the correspondence consultation corner.

c. We came to implement regional projects for children's mental health care at this Center from April 1, 2016, taking over children's mental care from the Great East Japan Earthquake Central Children's Support Center that had been carrying it out until March 2016, so we have worked to publicize this by attending meetings in the prefecture, sending information to the municipalities, nursery schools, etc., and making sure that we are well-known.

d. We implemented four projects for children's mental health outreach.

A list of our activities is shown in Table 19.

Table 19: Summary of children's mental health outreach activities

No.	Date	Location	Topic	Number of people
1	May 28, 2016	Natori	Salon project for Natori children who were victims of disaster, "Natori Genkikko"	10
2	June 17, 2016	Kesennuma	Collaboration with Kesennuma nursery school event "Creating parent-child candle holders"	41
3	July 25, 2016	Natori	Salon project for Natorii children who were victims of disaster, "Natori Genkikko"	55
4	December 10, 2016	Natori	Salon project for Natori children who were victims of disaster, "Natori Genkikko"	70

⑤ Surveys and research

a. Longitudinal support research for children born after the Great East Japan Earthquake and their parents

"2016 children's mental health regional project survey and research report: Longitudinal support research for children born after the Great East Japan: Report on baseline results in Higashi Matsushima, Miyagi-ken"

b. Children's daycamp project

"2016 children's mental health regional project survey and research report: Research at a camp project for children and parents in areas struck by disaster"

5. Conclusion

Six years have already passed since the earthquake, and changes are progressing, such as the change from temporary housing to public housing. We must respond to those residents who have still not yet settled into their change of residence, as they face many problems. However, we often hear that by moving to public housing, their connections in their temporary housing are cut off and they don't fit in with the community in public housing. As the work of rebuilding communities continues, this is a time when there may be a new risk of becoming isolated.

However, the withdrawal of outside supporters of years past is continuing, and this year there has been a downward trend in temporary supporters, so there are concerns that administrative officer costs will also increase due to the response to local residents. In local resident support "pathways during initial support at the Center" (Table 3), although there has been a reduction in referrals from health surveys, door-to-door visits, and support centers or temporary support workers, this may be an effect of this kind of situation, in the context of which referrals from administrative organizations have actually increased.

Moreover, salon activities have been proactively carried out in all regions (Table 11). Although collaboration with other organizations on these salons has reduced, the number of salons organized or co-organized by the Center has increased over previous years. Aside from salons, we have developed various interaction projects, and the need for opportunities for people who tend to be isolated to form connections and opportunities to build new communities is even greater now.

Moreover, in addition to traditional subsidized projects, from this year onwards we began regional projects for children's mental health care, and the Center took responsibility for the prefecture's basic policy for reconstruction plans, "seamless mental health support from child to adult."

Our breakdown of the aggregate total of 230 cases of consultation demonstrates how common truancy problems are in the context of developmental problems and family problems. Training and consultation also bring together a variety of needs, such as responding to developmental disorders and abuse problems, and relating to difficult parents. Aside from having pointed out that the rate of truancy was high in Miyagi Prefecture before, this may be additionally affected by environmental change due to the earthquake. We believe it will be important to respond to these continuing problems in the next year.

Moreover, the "Training in PFA for children," a method of psychological support after a great disaster, was held five times in 2016, and many relevant people participated, asking questions that really concerned them. We hope to proactively hold these in future as well, and widen the group of relevant organizations and bodies.

With the passage of months and years, the problems of each region and the problems faced by residents have changed from moment to moment, but problems identified at the start, such as alcohol-related problems, have continued. We would like to carefully and humbly respond to the continuing needs of the region, where the differences in conditions are striking.