

4. Changes Over the Past Six Years (FY 2012–2017)

(Including Child Support)

Considering the Role of a Post-Disaster Mental Health Support Center

– An Analysis of Our Activities Using Our Business Statistics –

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1. Introduction

In Japan, whenever a large-scale natural disaster—especially an earthquake or tsunami—occurs that greatly affects a particular region or community, a “Disaster Mental Health Care Center, DMHCCC” is established in the administrative division(s) affected. These centers are not set up via legislation; they are the result of civilian organizations receiving investment funding and project consignments from national reconstruction budgets, and they often function to improve and preserve the mental health of the municipalities in which they are located. To date, six such “Disaster Mental Health Care Centers” have been established, each with its own unique activities (Figure 1) ¹⁾. The following Disaster Mental Health Care Centers were established after large disasters: the “Hyogo Disaster Mental Health Care Center” ²⁾ after the Hanshin-Awaji Earthquake in 1995, the “Niigata Mental Health Welfare Council Disaster Mental Health Care Center” ³⁾ after the 2004 Niigata Prefecture Chuetsu Earthquake, the “Iwate Prefecture Disaster Mental Health Care Center,” “Miyagi Disaster Mental Health Care Center,” and “Fukushima Disaster Mental Health Care Center” after the 2011 Great East Japan Earthquake, and the “Kumamoto Disaster Mental Health Care Center” after the 2016 Kumamoto Earthquake. Management guidelines are left to the discretion of the administrative divisions in which these centers are located, and because the organizations that take up these public consignment projects vary greatly, so too do the guidelines by which they are governed.

The Miyagi Disaster Mental Health Care Center (hereafter MDMHCC) opened in December 2011, and as of the end of FY 2017, has been involved for seven years in support activities in the field of mental health for disaster survivors.⁴ In addition to doctors, our staff includes psychiatric social workers, public health nurses, psychologists, nurses, and occupational therapists, among others, all of whom work together in teams of diverse composition. The special characteristics of our Center are the following: (1) we place emphasis on outreach support rather than walk-in, and (2) we commit ourselves, as a rule, to the guidelines and policies of the Mental Health Department of the local municipality and carry out our support in line with them. A long time has passed since our Center was founded, and as the reconstruction situation of each region changes, the things these municipalities and the organizations affiliated with them ask of us also change. In this article, we will provide an overview of the activities of our Center until now, consider the large-scale nature of our post-disaster mental health-related activities by longitudinally analyzing the content of our activities, and thereby prepare ourselves for future post-disaster reconstruction and support.



Figure 1: “Disaster Mental Health Care Centers” in Japan

2. Methods

At our Center, we have developed an in-house business statistical system based on the Disaster Mental Health Information Support System (DMHISS) to collect data on our activities. At our founding, our management structure was still unfinalized, and we were unable to collect detailed data on our activities in FY 2012. From FY 2013 onwards, quantified information on our projects has been collected as data. In this article, we have used activity report data from FY 2012 and business statistical system data over the five years from FY 2013 to FY 2017 to analyze four of the six project categories of our Center—community resident support, support for supporters, raising public awareness, and human resource development—in an effort to examine our achievements.

3. Results

(1) Community Resident Support

① Support Methods

Changes in support methods can be seen in Figure 2. We totaled methods of support used in community resident support using the following categories: at-home visitation, walk-in counseling, telephone counseling, and other. We dealt with a total of 6,000–7,000 cases each year; the yearly total increased until FY 2015 and then began to decline. Since FY 2012, at-home visitation has remained the most common form of support, with a total of 4,400 cases seen in FY 2015. The number of counseling support cases involving individuals coming to one of the various community support branches of our Center hovered around 1,000, while the figure for telephone counseling hovered around 1,500. Additionally, between FYs 2012–2014, we did not provide patients with distinguishing ID numbers. Thus, if we provided the same individual with support multiple times, each of these support cases was counted as a new case. In FY 2015, we began to issue patients ID numbers to better enable us to understand the true nature and progress of our support activities, and we began to record the total number of support cases handled and the number of new subjects separately. As a result, the continuous case counts shown in Figure 2 reflect totals across these five years.

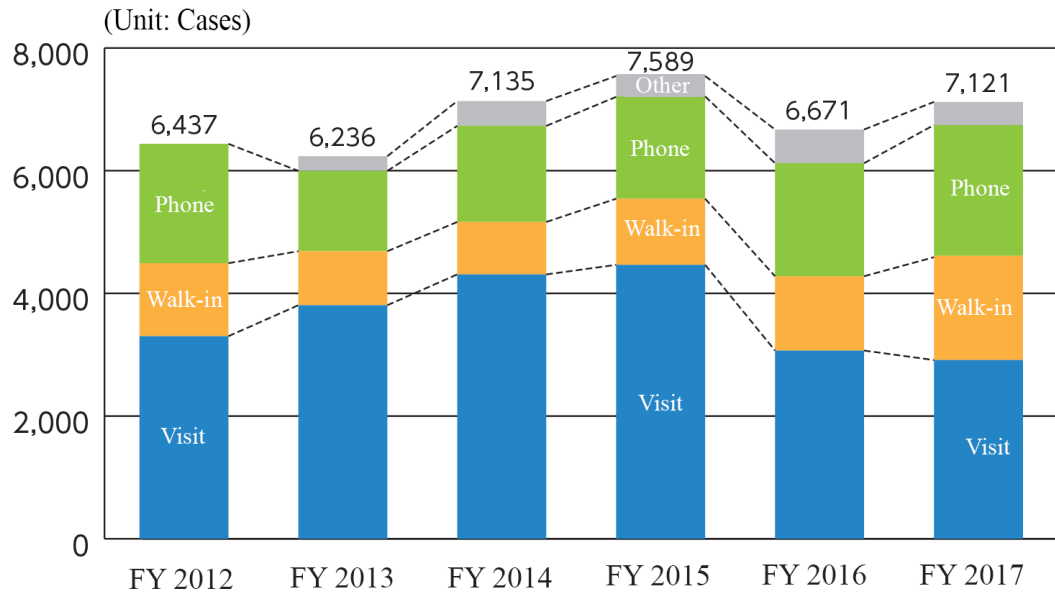


Figure 2: Changes in Support Methods (Total Support Cases Seen)

② Paths to Counseling

We have categorized the various ways in which individuals come to receive counseling in Figure 3. Immediately following the disaster, Miyagi Prefecture and other municipal authorities worked to provide survivors with health surveys and check-ups. Much of our support in that period was for individuals deemed high-risk by these surveys. Additionally, “requests from governmental agencies” (including municipalities) and “requests from patients themselves” both increased over the years.

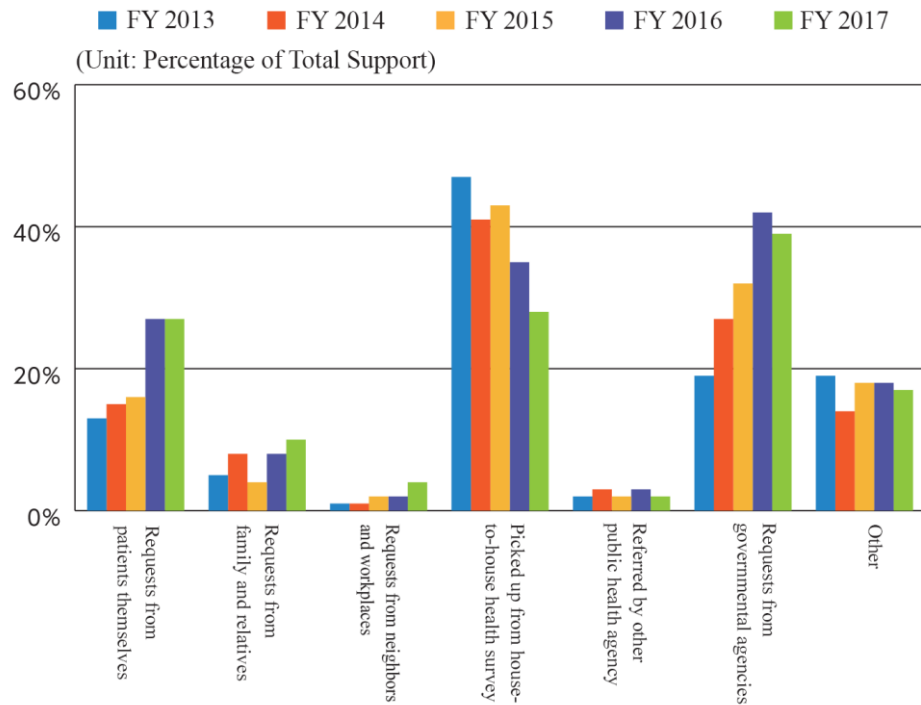


Figure 3: Changes in Paths to Counseling

③ Reasons for Counseling

We have depicted the various background reasons that led our subjects to seek counseling in Figure 4. From FY 2013 onwards, “family/household problems,” “mental disturbances,” and “health-related problems” have comprised the bulk of the cases we have seen. “Changes in living environment” and “financial difficulties related to reconstruction” peaked in FY 2013 and have declined since then. “Family/household problems” and “mental disturbances” have increased over the years.

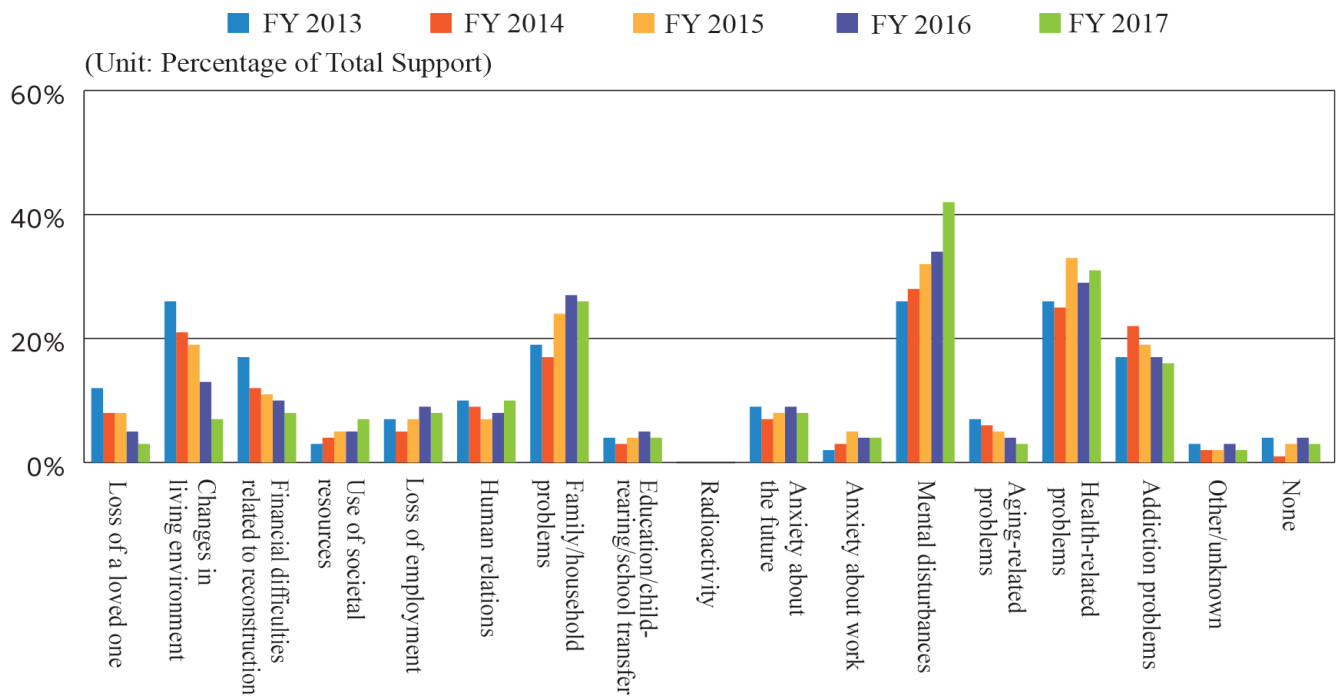


Figure 4: Reasons for Counseling

④ Sex/Age of Counselees (Figure 5)

No significant difference in counselee (individual receiving counseling) sex was seen for any specific year or across all years. Approximately 50% of all subjects were either in their 60s or older. Among women, older age ranges tended to have more subjects. For men, subjects in their 40s increased in 2014, but declined slowly afterwards. Many of these men were unemployed.

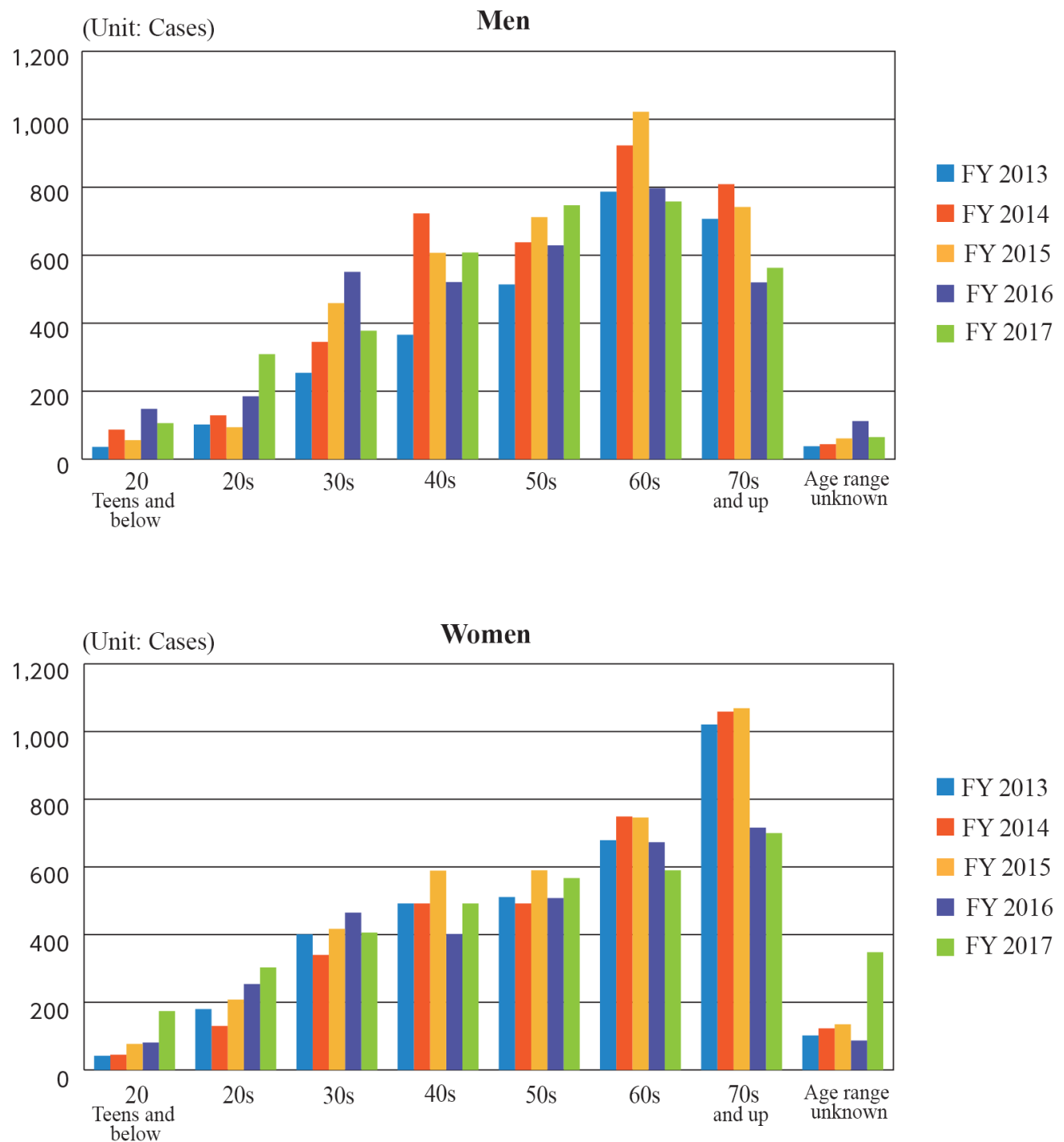


Figure 5: Changes in Counselees by Gender and Age Range

⑤ Subjects by Illness Classification and Occurrence Time (Figure 6)

From FY 2013 onward, approximately 30–40% of our subjects had been seen by a psychiatrist. “F1: Mental and Behavioral Disorders due to Psychoactive Substance Use,” “F2: Schizophrenia, Schizotypal, and Delusional Disorders,” and “F3: Mood (Affective) Disorders” described more than half of these. In FY 2014, F1 and F2 diagnoses increased, and cases that had begun before the disaster were more numerous. F3 and “F4: Neurotic, Stress-Related, and Somatoform Disorders” increased from year to year, and cases that occurred after the disaster were particularly numerous. Finally, while their total percentage was quite small, and we have not included them in Figure 6, an increasing trend was observed in “F7: Cognitive Impairment (Mental Retardation)” and “F8: Disorders of Psychological Development.”

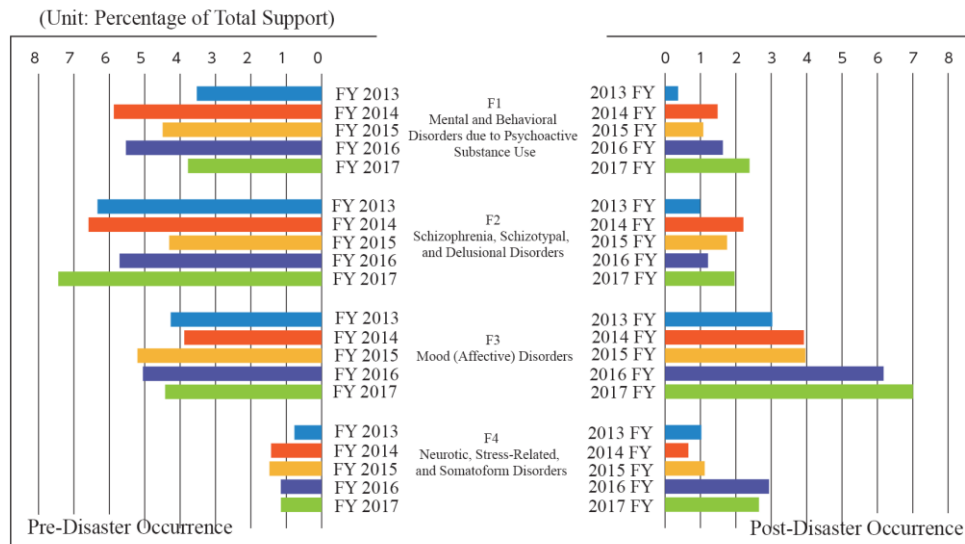


Figure 6: Subject Percentages by Disease Classification and Occurrence Time (F1–F4, top 4 classifications shown)

(2) Support for Supporters

The total number of support-for-supporters cases peaked in FY 2014 and declined afterwards (Figure 7). As for the breakdown of supporters receiving support, governmental officials made up the largest part. A great deal of the support we offered involved offering guidance and advice on difficult cases, including alcohol-related problems and abuse (Figure 8). Finally, we were requested to analyze data related to survivor support as well as assist in various aspects of psychiatric social work, and these activities made up, as they have in the past, a significant portion of our work.

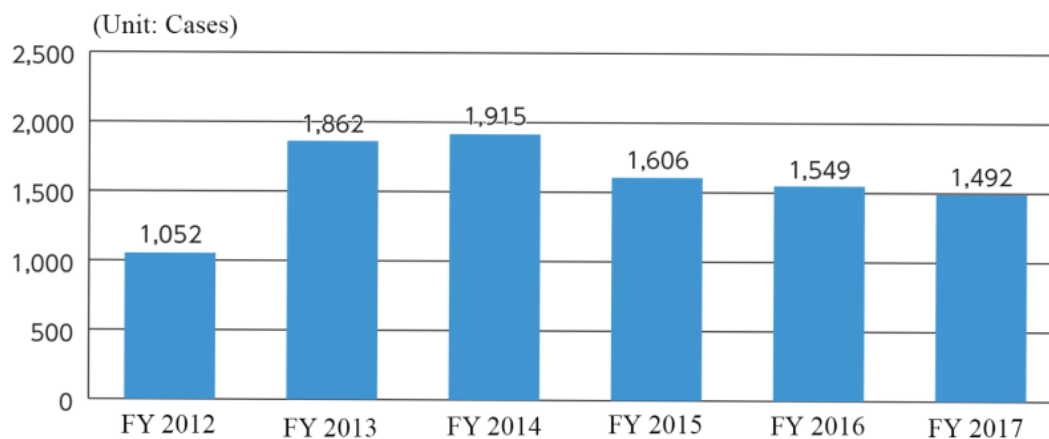


Figure 7: Support for Supporters (Change in Total Cases)

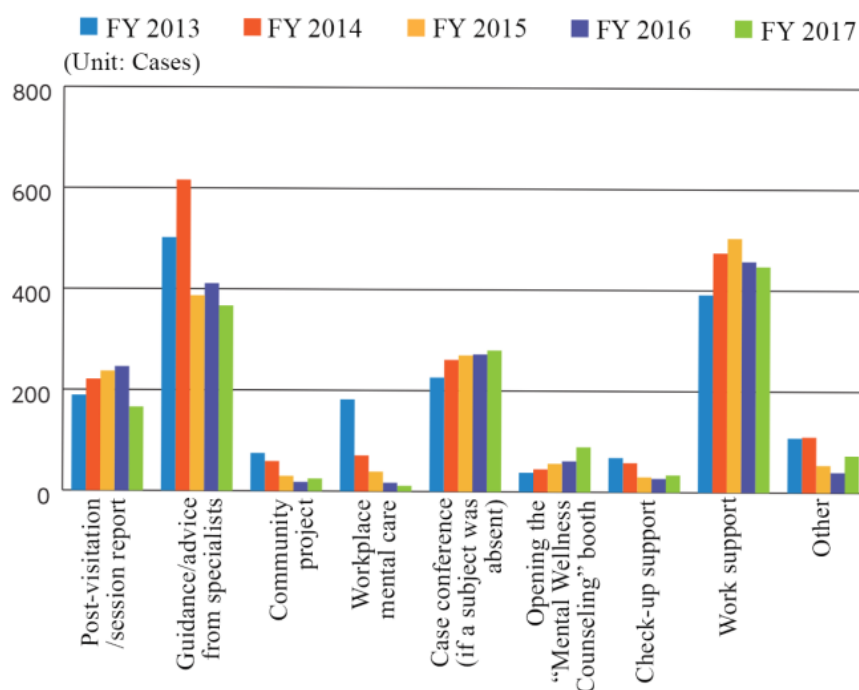


Figure 8: Support for Supporters (Changes by Project)

(3) Raising Public Awareness

The number of activities undertaken to raise public awareness increased until FY 2014; it fluctuated around approximately 400 per year thereafter (Figure 9). As can be seen in their breakdown, “raising public awareness training” and “salon activities” comprised the bulk of these efforts (Figure 10). “Raising public awareness training” involved general lectures on health or training for alcohol-related problems, and the number of participants increased over time. “Salon activities” are gatherings designed to strengthen connections between the residents of a particular area, and their objectives primarily centered around moderation in alcohol, dementia education, preventing loneliness, and related endeavors.

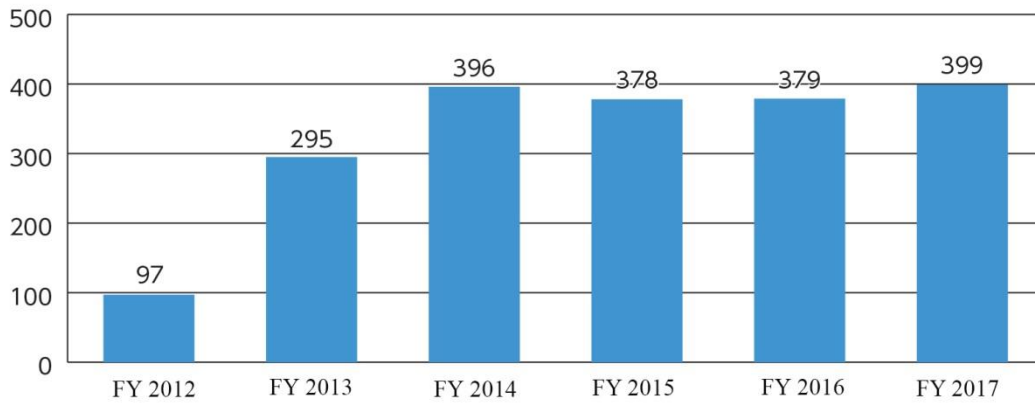


Figure 9:Raising Public Awareness (Changes in Total Activity Count)

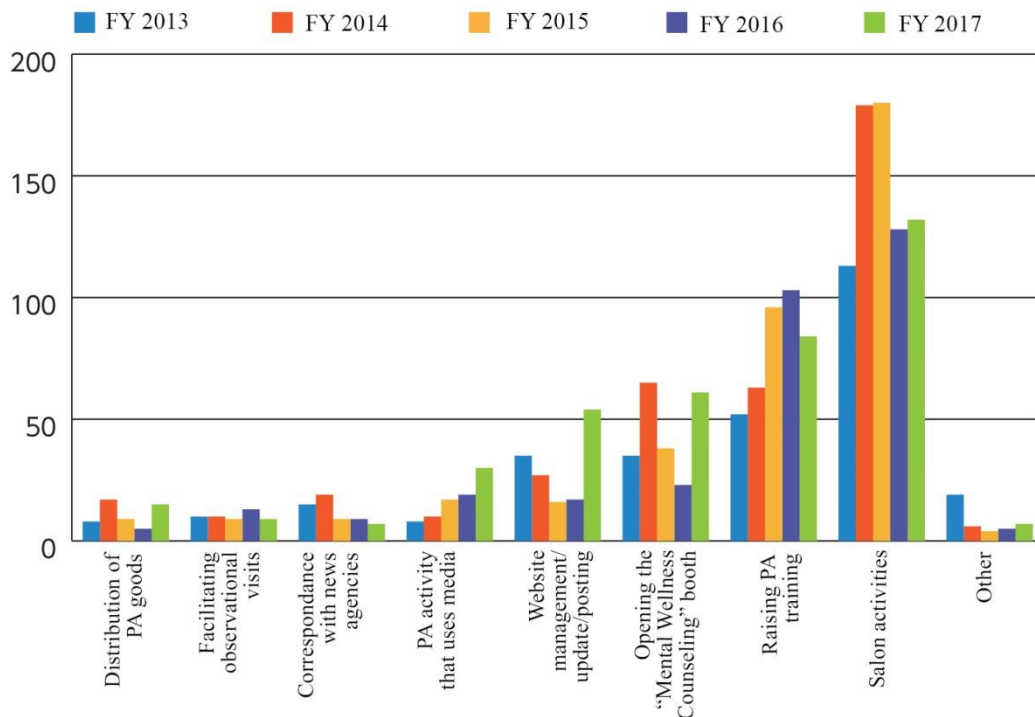


Figure 10: Raising Public Awareness (Changes by Project)

(4) Human Resource Development

No longitudinal change in the total number of human resource development undertakings was observed after FY 2013 (Figure 11). While we mainly catered to governmental officials, participants came from a variety of different fields, including education officials and welfare commissioners. As can be seen in the breakdown, “addiction-related problems” training and “support skill training” comprised the bulk of these efforts (Figure 12).

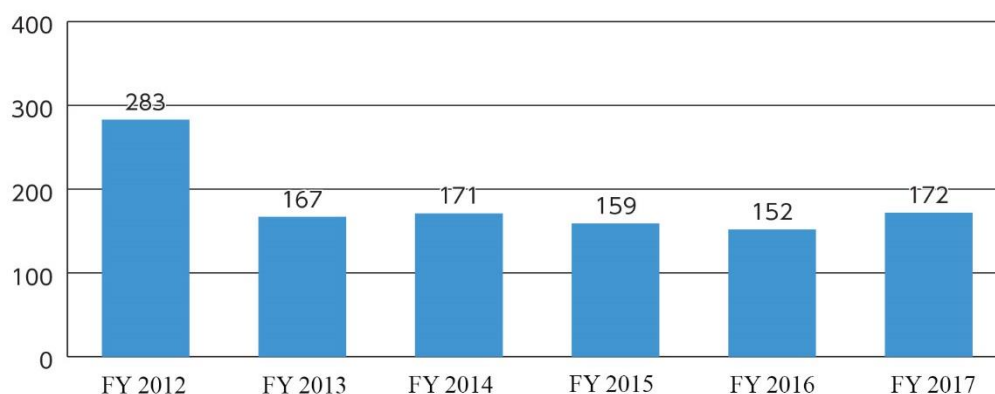


Figure 11: Human Resource Development (Changes in Total Events)

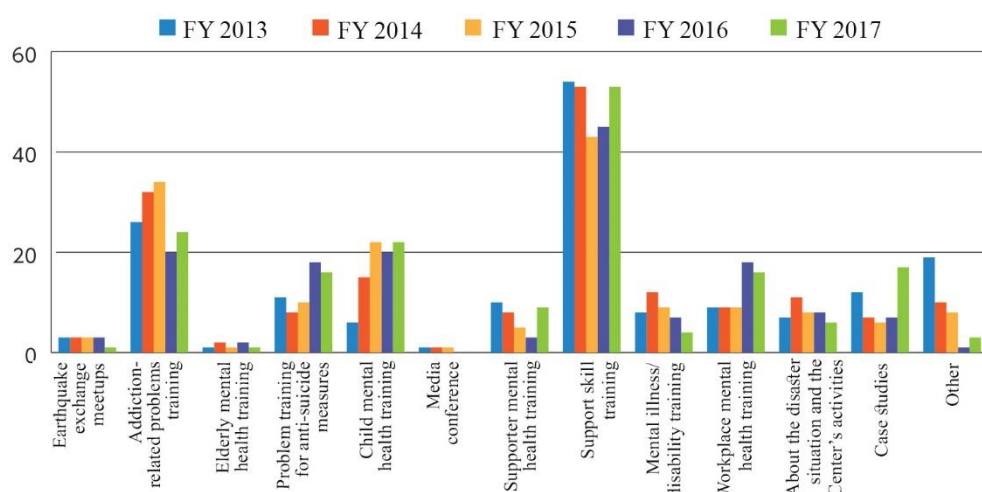


Figure 12: Human Resource Development (Changes by Project)

4. Discussion

The founding principles of this Center are as follows: ① to create an organization that places an emphasis on outreach, and ② to unequivocally ensure that our primary clients are cities, towns, villages, and other municipalities. We conduct our work with these principles in mind. Immediately after the disaster, we went to work in each municipality, conducting health surveys and home-to-home visitations to confirm the safety of people determined to be at high risk; these efforts comprised the bulk of our business at the time. So soon after the disaster, the limited municipal personnel available—such as public health nurses—were unable to deal with these issues, and many of them requested our Center for help. Our Center was newly formed after the disaster, and at first we were at a bit of a loss as to how best to form collaborative and cooperative relationships with organizations in the area. The opportunity to assist in home visitations for safety checkups became a foundation on which much cooperative work would later be built. For the employees of this Center, this project was an invaluable opportunity to take to heart the techniques of outreach work. Little by little, we built relationships of trust with each municipality, and eventually the support requests we received from governmental agencies began to increase. As per the analysis of our early activities contained in this article, our proactive, dedicated work on the difficult, exhausting work of home visitations built a relationship of trust with community organizations and served as the foundation for a great deal of future collaboration.

The reasons why individuals seeking counseling came to us changed over time. Individuals reporting “changes in living environment” and “financial problems related to reconstruction” decreased over time, and those with “family/household problems” and “mental disturbances” increased. As has been pointed in many analyses of disaster support, issues with mental health do not surface immediately after the occurrence of a disaster; the problems of individuals hard up for basic necessities like food, clothing, and shelter are the first major issue to be addressed. As long as physical problems like this remain, reconstruction is able to blithely progress; the psychological tension remains under the surface. As reconstruction proceeds, physical

problems are solved and, little by little, discord in the home and mental health problems become apparent. As can be seen in Figure 3, “Paths to Counseling,” requests from patients themselves increased from FY 2016 onward, and we felt this point marked a shift whereby people began to come to us for help of their own accord. From these results, we see that there is a slight time lag until survivors come to seek help for themselves, and that it is vital for supporters to situate themselves in an appropriate place and space that enables them to receive these requests at any time.

From changes in the age range and sex of those that came to us seeking support, we saw that elderly and unemployed men and women were most numerous.

A certain bias is present in this data, however. Nearly all of our activity is limited to weekdays, and that too, during the day, and the primary method we make use of is the home visitation. Inevitably, therefore, the community residents whom we come into contact with are far more likely to be those at home during the day on weekdays. However, even after considering this bias, we know from Miyagi Prefecture health surveys that many elderly individuals live alone in prefab temporary housing, and their isolation and lifestyles are major issues facing the prefecture in the future.⁵ Additionally, as can be seen in Figure 5, we receive many requests from men in their 30s–50s, the prime age for work, and many of these men have employment and other financial problems as their chief complaint. Thus, we can surmise that for this age group, the psychological burden of supporting their household or community is quite great. From these results, we therefore see that while the particulars may depend on the characteristics of a specific affected region, following a large disaster, isolation among the elderly and anxiety among middle-aged men who support their home/community are two issues to which special attention should be paid.

Most of the illness classifications of those seeking support were the following four: F1, F2, F3, and F4. The great majority of those with F1 experienced alcohol-related problems and many had had some sort of problem before the disaster. As has been pointed out in previously published research,^{6,7} new illnesses that spring into being after the occurrence of a disaster are by no means common. Instead, the amount drunk by individuals with pre-existing cases increases and becomes more of a problem. The great majority of those with F2 diagnoses with schizophrenia, and most of these had had this issue since before the disaster. Because schizophrenia is an illness that requires a close relationship with treatment providers to control its symptoms, we believe the disaster may have contributed to their worsening by cutting off patient access to healthcare, which necessitated outreach support. Post-disaster F3 and F4 diagnoses increased with time, and as mentioned previously, a slight time lag occurred before they manifested clearly. Because the period immediately after the disaster was a psychologically tense time, symptoms like depression and anxiety were unlikely to emerge. As physical and material reconstruction proceeded, peace and stability were established, and psychological symptoms began to surface.

From the case counts of support for supporters, public awareness, and human resource development activities, we can infer the needs of the community. With regard to support for supporters, “work support” in each municipality was most common. This is because the work amount for municipal employees increased dramatically following the disaster and help was needed to supplement those duties. While this sort of work might appear to have no direct connection to mental health, we believe it is behind-the-scenes work that allows municipal employees to return to their normal duties and become accessible to community residents again. Additionally, despite the fact that “guidance/advice from specialists” decreased year to year, it still comprised a great deal of our activity, and case study/supervision by experienced staff of this Center was another large role we fulfilled. As for raising public awareness, our most common activities were “raising public awareness training” and “salon activities,” and the content of these events reflected the issues of the communities in which they were held. In particular, at all of our community centers—Kesennuma, Ishinomaki, and the stem center—gatherings for alcohol-related problems (Danshukais, temperance meetings, etc.) were formed, and our Center assisted in their operation. With regard to human resource development, “addiction-related problems training,” including alcohol addiction, numbered highest, indicating that community needs in that area were high.

5. Limitations

This article has several limitations. First, the specific nature of public/community mental health care in each administrative division of Japan differs, and there is no guarantee that the changes we experienced will also occur in other communities. Next, the community with which we interacted made up only a small part of

those who needed support, and it is difficult to imagine that our totals reflect the situation of all disaster survivors as a whole. Finally, because our Center is not a medical organization, we involve ourselves, insofar as we can, primarily in connecting together pre-existing community resources. As a result, we are unable to ensure that all individuals seeking support reach recovery, and we cannot analyze the extent to which our efforts contribute to an individual's recovery.

6. Conclusion

It is clear that as post-disaster reconstruction efforts change phase, the issues of community residents who need support and the things asked by the community of support organizations also change. As an organization of supporters, we believe that it is necessary to quietly observe these changes and provide appropriate support at the correct time. Additionally, we realize that there are many support organizations like ourselves in this country and would like to highlight the fact that our figures do not represent the community in any way. The conclusions we draw from our figures are therefore but theories that require careful analysis to be taken as fact.

References

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