ORIGINAL ARTICLE

MENTAL HEALTH CARE IN JAPAN: BALANCING CARE IN HOSPITALS AND IN THE COMMUNITY

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ABSTRACT

In Japan, the number of people with mental illness, especially depression and dementia, is growing. Although mental health care in Japan is in its transition phase from traditional hospital-based care to community-based in the recent decades, it has been characterized by orientation to large psychiatric institutions. This paper aims to provide recommendations for achieving well-balanced mental health care both in hospital and the community in Japan by reviewing facilitators and barriers of current mental health care system. A narrative literature review was conducted to identify facilitators and barriers to implementing community-based mental health care in Japan. The databases PsycInfo, Medline, Pubmed, CiNii and Google Scholar were searched in English and Japanese. 46 studies published from 1980 to 2016 were included in the review. The review identified six categories of mental health care services provided in the Japanese community: Outpatient clinics, Outreach services, Rehabilitation and Living support, Case management and public health centers, Community-based residential care, and Work and Occupation. The crosscutting themes of facilitators and barriers to implement these services in the community were funding, staff management, and collaboration among community resources. To further promote the transition to community mental health care in Japan, this paper recommends the following actions: to shift funding and human resources from inpatient to community care services, to strengthen a capacity building system and supportive environment for service providers in the community, and to set a clear policy and strategic framework integrating medical and social welfare services in the community.

***Keywords**: Mental health services, mental health care system, community mental health care, Mental disorders, Japan*

INTRODUCTION

As World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community", mental health is the foundation for effective functioning for an individual and for a community[1]. However, mental illness, which affects mental health, is a leading cause of disease burden worldwide. The cost of mental health issues is estimated to be USD 6 trillion by 2030 or 25% of the global GDP[2]. Japan is no exception. 19% of the Disability-Adjusted Life Years (DALYs) or "healthy" years lost in Japan was attributable to mental illness and higher than cancer and cardiovascular disease[3]. More than 3.92 million patients were diagnosed with mental illness in 2014 with 723,000 cases increased since 2011[4]. Mood disorders (158,000 increase) and Alzheimer's dementia (60,000 increase) were the most increased from 2011 to 2014. Depression is one of the critical issues as it is associated with high suicide incidents in Japan which was 21,897 in 2016[5]. However, only 30% of those who experience symptoms of mental illness sought help due to a lack of awareness in mental health issues[6]. In 2008, cost of major mental illness including schizophrenia, major depressive disorders, and anxiety disorders of ICD-10 classifications was JPY 8.2 trillion (USD 79.2 billion at annual average rate of 2008 (1USD=JPY103.46))[7]. This amount comprised direct (provision of medical treatment and social services) and indirect (morbidity and mortality by mental illness) costs. Regardless of a rapid growth in needs of accessible mental health care services in the community, its system has traditionally been concentrated in large psychiatric institutions. The number of psychiatric beds has been exceeded 340,000 since 1990, and the average length of psychiatric hospital stay was 291 days in 2012, both of which are by far the largest number compared to other industrialized countries[8].

The Japanese government has been promoting deinstitutionalization advocated by domestic and international communities who are concerned about human rights of patients in psychiatric hospitals[9]. In 2004, the Ministry of Health, Labour and Welfare announced, "Mental Health Care and Social Welfare Reform Vision" to promote the system transition from hospital-based to community-based[10]. This paper aims to provide recommendations for achieving well-balanced mental health care in hospital and the community in Japan through the review of facilitators and barriers of current mental health care system [11].

Mental health care in Japan

This section summarizes the history of policy and legislation, and current mental health care system in Japan.

There have been three phases in the direction of mental health care legislation in Japan: private custody care, institutionalization, and community-based care. In 1900, private custody was promoted nationwide with the Law for Mentally Ill Patient Custody to deal with the severe shortage of psychiatric beds (2,000 beds for 43 million populations). Mental Hospital Law was established in 1919 advocated by a psychiatrist researcher to reduce inhumane treatment of patients including locking-up and chaining. However, private custody care continued to be mainstreamed[9]. After the end of World War II, the enactment of the Mental Hygiene Law in 1950 triggered the trend towards institutionalization. The number of psychiatric beds grew from 1.4 beds per 1,000 population in 1963 to 2.5 beds in the 1970s[13]. Due to severe lack of psychiatric beds (0.3 psychiatric beds per 1,000 populations), the government encouraged opening of mental hospitals by offering several governmental supports such as subsidization for hospital establishment and operations[12-13], investment scheme for private mental hospitals, and special arrangement of staff requirements applied only for mental hospitals[12]. Although there was a positive movement for including social rehabilitation component to the law, one scandal of a young man with schizophrenic history attacked the U.S. ambassador in 1964 raised public opinions for prioritizing public safety through institutionalization, which resulted in the law amendment to further promote hospitalization. In 1984, a series of scandals of abusing patients in mental hospitals revealed malpractices in Japanese mental hospitals such as unnecessary involuntary admissions and a severe shortage of staff. The International League for Human Rights accused Japanese mental hospitals of violating human rights, leading to the enactment of the Mental Health Law in 1987. This law introduced the principle of social rehabilitation, voluntary admission scheme, and monitoring system which The Mental Health Care Committee checks necessity of hospital admission and care provided in the hospitals. In 1995, taking the social welfare element into consideration, the law was amended to the Mental Health and Welfare Law.

Currently, care for patients with mental illness is provided by the two different systems: psychiatric medical system and social welfare system. Firstly, psychiatric medical system provides medical services such as inpatient and outpatient care, day/night/short care, and outreach services under the Mental Health and Welfare Law. It is strength that Japan applies Universal Health Insurance Coverage through public health insurance, and psychiatric care is free to access and available at low co-payment. On the other hand, it is weakness that priority of mental health care is low in general health care system, leading to the overburdened hospital staffs, deteriorated quality of care, and delay in deinstitutionalization[13]. In 2014, the total expenditure on ICD-10 mental and behavioral disorders was JPY 1.9 billion (USD 17.9 million at annual average rate of 2014 (1USD=JPY105.85)), which was 6.5 % of the total health expenditures[4]. Psychiatric hospitals face a shortage of human resources, having more than 29 inpatients per a psychiatrist, 148 per a psychologist, and 41 per an occupational therapist and a social worker[15]. In 2004, the Mental Health Care and Social Welfare Reform Vision was announced to promote the shift from hospital-based to community-based care[10], resulting in the gradual decrease in the number of psychiatric hospitals and beds and increase in the community services. In 2015, there were 1,064 mental hospitals with 0.3% decrease from 2014, and 336,282 psychiatric beds with 0.6% decrease[14]. The average length of stay in psychiatric hospitals is also decreasing with 274.7 days in 2015[14]. In community, private psychiatric clinics are rapidly expanding from 400 clinics in 1985 to 3,622 clinics in 2010[16]. On the other hand, social welfare system provides the following social and welfare services under the Act in Support for Persons with Disabilities (the Disability Act): service consultation, home-based care, rehabilitation, residential, vocational and living support. By registering disability status at municipal government, a person with mental illness can benefit from social welfare services and financial aid such as pension, discount for public services, and tax deductions.

METHOD

A narrative literature review was conducted to identify facilitators and barriers of implementing community mental health care for adults and the elderly in Japan, referring to Guidance on the Conduct of Narrative Synthesis in Systematic Reviews from the ESRC Methods Program[17]. The objectives of this review were to identify: (i) existing models of community mental health care programs and services for adults and the elderly in Japan, and (ii) facilitators and barriers for implementing community mental health care for adults and the elderly. PsycInfo, Medline, Pubmed were searched in English, CiNii (a Japanese academic database) and Google Scholar in Japanese. The three key concepts for search terms *Japan*, *Mental illness*, and *Community mental health care* were searched in the five databases, whereas facilitators and barriers were identified from reading the contents of the selected studies. First review was conducted in the United Kingdom during August 2014, and second review in Japan from July to August 2017 to update the results of the first review.

The database search was complemented by reviewing reference lists of related papers (snowballing method) and by searching a list of government granted studies. The literature was screened first by author, title and abstract, second by duplications and availability of full-text, and third by inclusion and exclusion criteria. The inclusion criteria were: a study (i) targets adults over age 18 in Japan, (ii) published after 1965 (when the concept of community mental health care was first introduced in the law), (iii) includes mental health care intervention delivered at community level, (iv) describes a model of community mental healthcare, (v) describes/implies facilitators or barriers of implementing community mental health care. The exclusion criteria were a study targeting emergency settings or specified population (such as pre/postnatal women, children, adolescents, homeless, hikikomori, persons with mental retardation, alcohol/drug misuse, or forensic issues), so that this review can focus on adults or the elderly patients after hospital discharge. Study design was not specified in the exclusion criteria to broaden the number of search results.

RESULTS

A total of 46 papers were selected for the review after the screening process. 13 were written in English and 33 in Japanese. This review identified a variety of community mental health service models which were summarized into six categories as below (See Table1 for a summary of the results).

Outpatient clinics

One study was identified under this category which is a retrospective study of medical and outpatient records of "memory clinic" providing detection and provision of care for persons with mild cognitive impairment and dementia. This paper implied facilitators as accessibility to the memory clinic, clear role as a comprehensive dementia care facility, a system of psychosocial care provision, and linkage with primary health care.

Outreach services

Of 16 studies identified, 7 evaluates assertive community treatment (ACT). The major facilitators for ACT implementation were highly motivated staff, collaboration among multidisciplinary professionals, leadership, sufficient funding, provision of family care, and integrated case management. The major barrier was funding shortage, caused by unclear funding source for the intersectoral services of health, welfare, and employment. Studies on home-visit nursing indicated barriers such as a lack of staff supervision and training, information-sharing among nurses, and shortage of community nursing stations, home-help and case management services.

Rehabilitation and living support

7 studies identified for this category included 4 studies of day care programs, 1 study of chronic disease management program at outpatient clinics, and 2 studies of home help services. One study on day care indicated that coordination of two different services (rehabilitation and living support) is a key facilitator. The major barriers included the deficiency in linkage among community agencies for effective service provision, a lack of structure and evaluation in day care programs, and lack of knowledge and education among home helpers in psychiatric care.

Case management and public health centers

12 studies were identified for this category, including 7 studies of case management or "consultation support service" provided by public or private agencies, and 5 studies of daily operation in public health centers. The major facilitator was clear role recognized and good collaboration among service providers in local agencies under public health center's leadership. Role demarcation was also described as a barrier as it is confused after a series of legal amendments. Other barriers included linkage and information sharing system among local agencies, shortage of staff, staff knowledge of mental illness

and burnout, and service recognition in the community.

Community-based residential care

Among 5 studies identified for community-based residential care, 4 papers studies special nursing homes or group homes, and 1 paper on halfway houses. The increased number of residential units and staff, and home-like environments contributed residents' improved quality of life in nursing homes, whereas staff shortage was the major barrier in all studies. There were other barriers in relation to staff such as a lack of staff knowledge and qualification in dementia care, a lack of training/meeting/supervision, and low salaries. The study on halfway houses also points out overburdened staff as a barrier, in addition to a lack of linkage with other medical and social welfare agencies for after care.

Work and Occupation

This category consists of 6 studies regarding Individual Placement and Support programs (IPS), workshops, vocational programs, and employment support offered by public health centers. The examples of facilitators are trial employment with shorter working hours, tailored programs to patients' educational levels, redeployment of existing clinical staff for vocational support, coordination with other community agencies, and collaboration among intersectoral professionals in health, welfare, and employment. The major barriers were low wage for patients, program acceptance by employers and service users, and a shortage of vocational support staff including IPS job coaches and workshop assistants.

Table1: List of the results by six categories of community mental health care models

Categories	Type of care models	Results
1. Outpatient clinics	Memory clinic	(Kawano et al. 2007)
2. Outreach services	ACT	(Chow et al. 2011) (Horiuchi et al. 2006) (Ito et al. 2007) (Nishio et al.2009) (Nishino et al. 2012) (Sono et al. 2008) (Setoya et al. 2009) (Sono et al. 2010)
	Home-visit nursing	(Arai et al. 2011) (Hayashi et al. 2009) (Kayama et al. 2009) (Kawauchi et al. 2013) (Kayama et al. 2014) (Watanabe et al. 2005) (Watanabe et al. 2009)
3. Rehabilitation and Living support	Day care	(Iwasaki et al. 2006) (Koishi et al. 2000) (Okamoto et al. 1998) (Oyama et al. 2015)
	Chronic disease management programs	(Fujita et al. 2010)
	Home help services	(Igura et al. 2015) (Nashiro et al. 2009)
4. Case management and public health centers	Case management (Consultation support services)	(Cho et al. 2000) (Ishida et al. 2011) (Ishiwata et al. 2014) (Kimata et al. 2009) (Kitamura et al. 2014) (Matsumoto et al. 1998) (Onoda et al.2011)
	Public health centers	(Akazawa et al. 2014) (Hatashita et al. 2014-2) (Shimasawa 2016) (Ueda et al. 2007) (Uwadaira 2008)
5. Community-based residential care	Special Nursing homes	(Nakanishi et al. 2012)
	Group homes	(Furumura et al. 2011) (Funamoto 2015) (Maekawa 2006)
	Halfway houses	(Yamazaki et al. 1980)
6.Work and Occupation	IPS	(Oshima et al.2014) (Unoki 2010)
	Workshops	(Mihara et al. 2005) (Yoshizumi et al. 1985)
	Vocational rehabilitation programs	(Sakai et al. 2009)
	Vocational support by Public health centers	(Hatashita et al. 2014-1)

Most of the facilitators overlapped with the barriers because facilitator was often described as the opposite of barrier (See Table 2 for list of major facilitators and barriers extracted from the selected studies in the appendix). There are facilitators and barriers repeatedly mentioned in the six categories which are: number of staff in the community, staff knowledge and skills, staff support including supervision and educational opportunities, number of community recourses, linkage and coordination among community resources, clear roles and leadership among local agencies and organizations, collaboration among multidisciplinary service providers, internal and external information-sharing among service providers, and funding shortage. These overlapping results were further grouped into three core themes for the analysis: funding, staff management, and collaboration among community resources. As shown in Figure 1, funding is the most important factor as since it affects feasibility of achieving the other two factors.

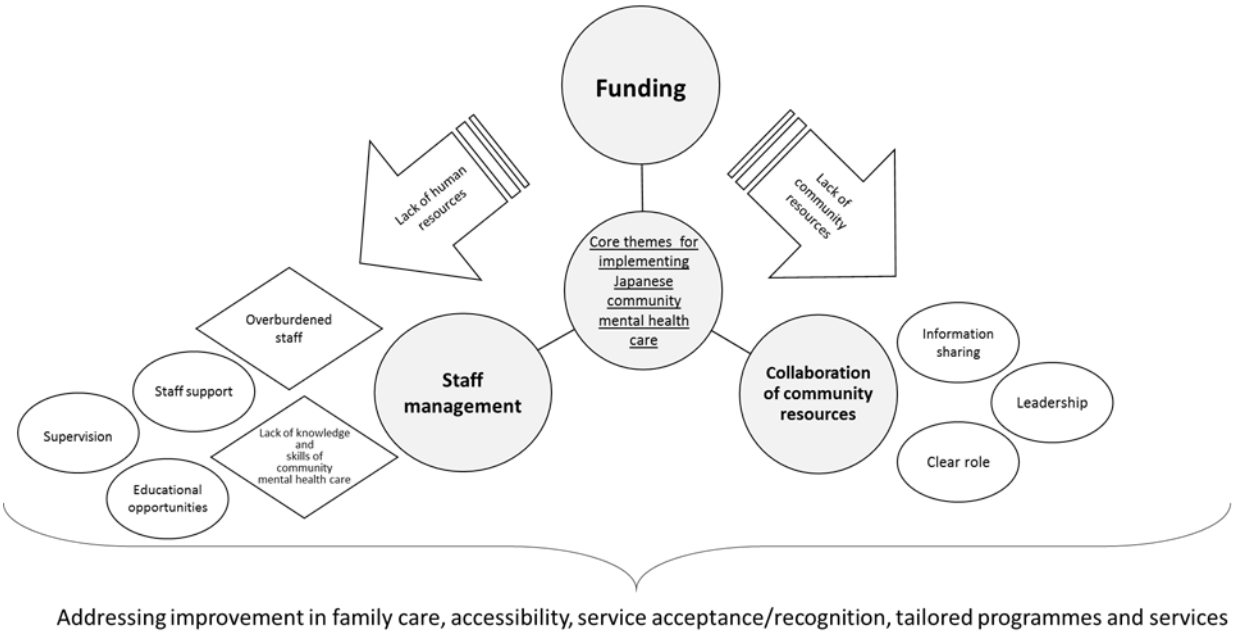

Figure1: Core themes of facilitators and barriers for implementing community mental health care in Japan

DISCUSSION

The final analysis identified three core themes from facilitators and barriers for implementing community mental health care in Japan: funding, staff management, and collaboration among community resources.

First, funding shortage negatively impacted provision of community mental health care services. The existing fee-for-service system reimburses less for community mental health care services especially for comprehensive community treatment such as ACT, resulting in the limited number of mental health care professionals in the community[18]. It is recommended that more funding and human resources are allocated from inpatient care to community care services. The related authorities in the Ministry of Health, Labour and Welfare should consider ways of jointly financing ACT and other cross-sectoral services. In addition, establishing an incentive scheme for mental health care professionals in the community can promote their shift from hospitals to community.

Second, staff management was the most critical issue in the selected studies. The number of service providers in the community is limited and they are overburdened. Only few staff received training for mental health care in the community settings, and opportunity of psychological support and supervision for preventing their burnout is not adequate[19]. Service providers in the community requested more communication with their colleagues for case discussions, skills and information sharing, and emotional support[20-23]. It is essential to strengthen a staff management system for their capacity building and support which includes professional training tailored for the community settings, accessible support and regular supervision.

Third, it was an obstacle that community resources lacked collaboration, although they are limited. One of the reasons for this is because Japanese mental health care has been separately developed around large private sectors of medical, social welfare, and employment without strong coordination and a catchment area system. On the ground, community service providers lacked a clear demarcation of the professional roles and leadership confused after a series of the policy amendments. It is recommended that local government at prefectural or municipal level shows a clear policy and strategic framework for promoting collaboration of medical and social welfare services in the community[24]. This framework should (i) redefine roles of each agency, facility, and organization in the community, (ii) stipulate obligation to organize conferences for community service providers on a regular basis, (iii) specify the role of public health centers to take on leadership in organizing local community resources, and (iv) strengthen a catchment area system.

There are several limitations to this review. The review included informal databases Google scholar and CiNii to maintain sufficient number of studies for the review. Thus, the evidence level of the selected studies could be low. Due to limitation in the number of the selected studies, the results were inclined to the specific service models of outreach, case management, and services provided in public health center. The overall results might not be immediately generalized to the situation of the community mental health care service provision in Japan. Future review should include formal Japanese databases and collect comprehensive data of service models provided in the community.

CONCLUSIONS

Japanese mental health care has been traditionally hospital-based. Along with the recent policy changes, there has been a gradual shift towards community-based mental health care. This narrative literature review found that funding, staff management, and collaboration among community resources were critical for promoting Japanese community mental health care for adults and the elderly. These factors were closely entangled in the weaknesses of the existing mental health care system, such as low priority of mental health care in general health care system, resource concentration in hospitals, fragmentation of medical and social welfare sectors, and weak catchment area system. The following recommendations are made for planning community mental health care policy and strategy at national and prefectural/municipal levels: (i) to shift funding and human resources from inpatient care to community care services, (ii) to strengthen a capacity building system and supportive environment for service providers in the community, (iii) to show a clear policy and strategic framework for integrating medical and social welfare services in the community.

ACKNOWLEDGEMENTS

The author would like to thank advisors and supervisors from the Institute of Psychiatry King's College London and London School of Hygiene and Tropical Medicine, and researchers from Japanese research institutes who provided helpful guidance and comments for completing original version of this paper in 2014. The author is responsible for any remaining errors. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

GT is supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London at King's College London NHS Foundation Trust, and the NIHR Asset Global Health Unit award. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. GT acknowledges financial support from the Department of Health via the National Institute for Health Research (NIHR) Biomedical Research Centre and Dementia Unit awarded to South London and Maudsley NHS Foundation Trust in partnership with King's College London and King's College Hospital NHS Foundation Trust. GT is supported by the European Union Seventh Framework Programme (FP7/2007-2013) Emerald project.

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APPENDIX

Table2: Summary of major facilitators and barriers by six categories of mental health care service models

Categories	Facilitators	Barriers
1.Outpatient clinics	➢ Strengthening accessibility, Clear role, Provision of psychosocial support, Linkage with primary care (Kawano et al, 2007)	
2.Outreach services	ACT ➢ Staff motivation, Collaboration among multidisciplinary professionals, Focus on recovery, Leadership, Care plan including informal care, Case management in system, Person centered care, Family care (Ito et al, 2007) ➢ Family assessment (Sono et al. 2010) Home nursing ➢ Adequate number of home visit staffs (Kayama et al. 2009) ➢ Training opportunities for nurses (Kayama et al. 2009) (Kawauchi et al. 2013) ➢ Relationship with patients and families through providing tailored services, Provision of comprehensive direct care and case management, Focus on family support (Kayama 2014)	ACT ➢ Lack of funding and reimbursement for ACT (Ito et al. 2007) (Nishio et al. 2009) (Setoya et al. 2009) (Chow et al. 2011) ➢ Restriction to provide treatment for mental illness (Nishio et al. 2012) ➢ Low recognition of ACT (Ito et al. 2007) ➢ Lack of collaboration with other service providers (Chow et al. 2011) Home nursing ➢ Lack of linkage with other agencies and professionals (Watanabe et al. 2005) (Hayashi et al. 2009) (Watanabe et al. 2009) (Arai et al. 2011) (Onoda et al. 2011) (Kawauchi et al. 2013) ➢ Lack of staff knowledge and skills (Watanabe et al. 2005) (Watanabe et al. 2009) (Arai et al. 2011) (Onoda et al. 2011) (Kawauchi et al. 2013) ➢ Lack of psychiatric supervision for service providers (Hayashi et al. 2009) (Watanabe et al. 2009) ➢ Lack of meetings/communication among nurses (Hayashi et al. 2009) (Watanabe et al. 2009) ➢ Lack of nursing stations and other social resources (Watanabe et al. 2005) (Onoda et al. 2011) ➢ Lack of human resources (Onoda et al. 2011) ➢ Frequent policy changes (Arai et al. 2011) (Onoda et al. 2011) ➢ High stress of nurses (Arai et al. 2011) ➢ Building relationship with family (Arai et al. 2011) (Onoda et al. 2011)

3.Rehabilitation and Living support	➢ Coordinating day care and day services (Koishi et al. 2000) ➢ Improved accessibility (Fujita et al. 2010) ➢ Clear role and leadership for integrated services, Shared goal among service providers, Staff awareness to collaborate with other resources (Oyama et al. 2015) (Igura et al. 2015) ➢ Opportunities for staff skill improvement, Support system for service providers with less experience, Network of multidisciplinary professionals (Igura et al. 2015)	➢ Lack of linkage among public, private, medical institutions, Lack of knowledge and training opportunities for home helpers (Nashiro et al. 2009) ➢ Difficulties to communicate with patients, Lack of support in system, lack of staff's confidence in providing care (Igura et al. 2015)
4.Case management Public Health Center (PHC)	➢ Clear role (Ishida et al. 2011) ➢ Linkage of PHCs and MC (Akazawa et al. 2014) ➢ PHC's leadership for organizing coordination meeting (Hatashita et al. 2014-2) ➢ Collaboration in community (Kimata et al. 2009) ➢ Public health nurses identify needs of patients at primary level, Coordination for service providers in the community such as home nurses (Shimasawa et al. 2016) ➢ Staff skill for coordinating with medical institution for early diagnosis/treatment of dementia, Community awareness raising activities such as attending liaison committee meeting, community involvement through events (Ishikawa et al. 2014)	➢ Lack of clear role, linkage, information sharing among local agencies (Cho et al. 2000) (Ueda et al. 2007) (Kimata et al.2009) (Kitamura et al. 2009) (Kitamura et al. 2014) (Akazawa et al. 2014) ➢ Role confusion between PHCs and municipals (Uwadaira 2008) ➢ Lack of human resources and social resources in the community (Ishida et al. 2011) ➢ Lack of staff knowledge and skills (Ueda et al. 2007) (Kimata et al.2009) (Akazawa et al. 2014) ➢ Staff burnout at PHCs (Hatashita et al. 2014-2) ➢ Lack of service recognition in the community (Ishida et al. 2011) ➢ Development of tailored care services (Cho et al. 2000)
5.Community-based residential care	➢ Communication between resident and staff, Adequate number of staff and residential units, Creating home like environment (Nakanishi et al. 2012) ➢ Staff building relationship with the community as a mediator (Funamoto 2015)	<u>Halfway house</u> ➢ Lack of collaboration among social resources, Overburdened staff (Yamazaki et al. 2009) <u>Dementia care facilities</u> ➢ Building dementia friendly community environment, Lack of adequate equipment for dementia care (Maekawa 2006) ➢ Lack of human resources (Maekawa 2006) (Nakanishi et al. 2012) ➢ Lack of staff support, Lack of staff knowledge and information of dementia care, Low staff salary (Furumura et al. 2011)
6.Work and Occupation	➢ Disclosing disabilities to employers, Shorter initial working time and trial employment (Unoki 2009) ➢ Program tailored by patients' educational level (Sakai et al. 2009) ➢ Application of "Place to train" model, Multidisciplinary professional team (Unoki 2009) ➢ Redeploying existing clinical staff (Oshima et al. 2014)	➢ Lack of opportunities for employment and acceptance from employers, low wage (Yoshizumi et al. 1985) (Mihara et al. 2005) (Unoki 2009) (Hatashita et al. 2014-1) ➢ Lack of job coach scheme (Unoki 2009) ➢ Lack of funding (Yoshizumi et al. 1985) (Mihara et al. 2005)

	➢ Linkage with other workshops in the community (Mihara et al. 2005) ➢ Coordination with other resources such as local PHCs and medical institutions (Yoshizumi et al. 1985) (Hatashita et al. 2014-1)	➢ Lack of human resources and staff burden (Yoshizumi et al. 1985) (Mihara et al. 2005) ➢ Acceptance of IPS by service users (Oshima et al. 2014) ➢ Lack of space, Lack of support from family members, Lack of support from PHCs and hospitals, Crowded facilities, Lack of community participation (Yoshizumi et al. 1985)