Beyond Snow White's Poisoned Apple:
The Toxicity of the New Orange Plan and the Era of Mass Hospitalization of Dementia Patients
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On the Japan Psychiatric Hospitals Association's vested interest in maintaining psychiatric beds

> Although the number of psychiatric beds are said to decrease as a result of community placement, Manabu Yamazaki, President of the Japan Psychiatric Hospitals Association (JPHA), warns, "It's better not to rush the process of eliminating beds." Mr. Yamazaki points out that psychiatric hospitals must address their role in responding to behavioral and psychological symptoms of dementia (BPSD) in regional areas with increasing dementia patients due to population aging.
> (CBNews management: December 8th, 2014).

This quote is from a paywall website geared towards hospital owners. While this article interviewing President Manabu Yamazaki of JPHA stirred up a continuous heated debate, the government announced "Japan's National Dementia Strategy (New Orange Plan)" on January 27th, around two months after its publication.

Let us take a closer look at the developments across these few months. First, it was at the November 2014 international conference, "Global Dementia Legacy Event," that Prime Minister Abe declared to "create a dementia policy program for the first time as a national strategy." During his closing remarks, Minister of Health, Labor and Welfare Shiozaki responded as follows:

> “We will implement an Integrated Community Care System for Dementia by year 2025, the year baby boomers turn 75 years old and older. Early diagnosis and early support is key to this system. Healthcare services and long-term care services should be coordinated systematically and should be provided seamlessly as the stages of dementia progress. People with dementia can also benefit from a circulating system. When physical complications and BPSD - such as delusions, depression, and wandering - are observed, another care coordination setting should be in place so that they can continue living in the community after receiving hospital or institutional care.”

Here we already see the expression of "circulating system" at use. As I will note later in the article, this word choice holds significance in indicating the dynamic between the New Orange Plan and psychiatric hospitals.

Following this remark, Mr. Yamazaki made his comments as written above. On January 7th of the following year, before the government publicly announced the plan on January 27th, the "New Orange Plan" was introduced to the ruling Liberal Democratic Party (LDP), Komeito Party and the Japan National Press Club.

In "The Fundamental Framework for the New Orange Plan" unofficially released on the 7th, the document grandly declares to "work towards a society in which people with dementia may continue to live

in a good environment as much amongst the communities they have lived in as possible, with their wills respected." To support this statement, the document proposes seven pillars, namely to: "promote the dissemination of knowledge and understanding on dementia," "provide timely and appropriate medical and nursing care," and "emphasize the viewpoints of people with dementia and their caretakers." If one were to simply read these pillar statements, they seem fairly comparable to global standards.

However, the word that Health and Welfare Minister Shiozaki mentioned at the summit - "a circulating system" - had already been used as a significant compromise. Buried amongst the joyous voices of dementia caretakers and other parties involved in "emphasiz[ing] the viewpoints of people with dementia and their caretakers," most of the ruling and oppositional party and journalists did not seem to notice this. Taking advantage of this lack of criticism, the official New Orange Plan document announced three weeks later on January 27th included further alterations.

Although the media reported on this official New Orange Plan with mostly positive feedback in general, those who had been following the developments with a critical eye did not miss the dangerous implications. For example, Kyodo News delivered a warning with the following article:

> In the final version of the national strategy, the descriptions on the psychiatric hospitals included the most wording edits. The alternation includes adding phrases such as "including hospitalization as part of the medical and nursing care circulating system," and "some cases may require long-term specialized medical care." "We edited some parts to reflect requests from Liberal Democratic Party members to further increase the role of hospitals," a high-ranking official of the Ministry of Health and Welfare revealed. In Japan, more than 53,000 dementia patients are hospitalized in psychiatric hospitals, of which 30,000 spend a long-term stay of over a year. Given the unusual statistic amongst developed countries, international organizations have been seeking improvements. This wording edit reveals a prioritization of hospital operations. Atsushi Nishida, Chief Researcher at Tokyo Metropolitan Research Institute of Medical Science, who compares strategies across countries, criticizes that "Japan's strategy contradicts itself: it declares an ideology emphasizing the direct party's viewpoints while also affirming the status quo idea of 'centering the service providers'." (January 27th, 2015, Kyodo Tsushin).

Ensuring the Poisonous Nature of the New Orange Plan

Upon further examination, it is clear that the part that was altered from the original plan was the second of the seven pillars, to "provide timely and appropriate medical and nursing care," which pertains to psychiatric hospitals. In the following section, I will describe the issue in detail using excerpts from welfare journalist Sumikazu Asakawa (former editor of Nikkei Shimbun), taking full responsibility for the content.

1) The New Orange Plan purports that the psychiatric hospital is "a place that focuses on providing specialized medical services" and that "such behavioral and psychological symptoms of dementia (BPSD) require intensive professional medical services."
In the same section in the original version, the role of psychiatric hospitals is limited to "a place that provides short term and intensive professional medical services" and that "it is desired that the care load is

appropriately divided between nursing care services and institutions that provide long-term and continuous life support services."

The word "short-term" that was included in the original version was removed from the official document. The division of care load indicated earlier was switched to the psychiatric hospital's "long-term" responsibility and role.
This directly affirms the current status of psychiatric hospitals handling both "short-term and long-term" care and long-term hospitalization of elderly dementia patients.

2) The document was revised to emphasize the importance of the role of psychiatric treatment. The original version stated, "It is important for psychiatric and geriatric professionals to provide medical expertise to nursing care businesses as logistical support." The role of psychiatric hospitals, at this point, was for "logistical support."

However, the official document declares "...to provide medical expertise to nursing care businesses as logistical support with control tower functions," adding the "control tower functions." Logistical support and control tower hold extremely different meanings. Literally, the role of psychiatric hospitals shifted from backend support to commanding rights. This expression confirms how medical care has overridden nursing care businesses.

3) The original edition sternly states that "psychiatric treatment must ‘make visible’ its function and structure in order to become a more familiar and reliable presence in local communities." This section was then deleted from the official document.

4) In a critical edit in the original version, the document notes "...to encourage smooth discharge and returning home from psychiatric hospitals," whereas the official version changed to "...to encourage discharge and returning home from medical institutions and nursing care facilities." The original version highlighted the psychiatric hospital as a place to leave, an expression closer to Western standards. However, the final version added nursing care facilities and blurred the expression to the standard "de-hospitalization, deinstitutionalization" rhetoric.

(Sumikazu Asakawa: Dragged to the psychiatric hospital for Dementia. The Backwards Care of "A Comprehensive Strategy for the Promotion of Dementia Measures (New Orange Plan)": Diamond Online, February 4th, 2015, http://diamond.jp/articles/-/6618)

Hideki Ueno, who actively takes on home visit medical care for BPSD, has developed similar criticism on his blog. Ueno points out the issue in using the word "circulating" as below:

"Within 'a circulating system’ the people around the patient choose 'the best service within the best place' arbitrarily from existing services, fitting in the patient into the service. When conditions shift, this model "circulates the patient," which is close to passing the patient from hospital to hospital. By being circulated, the dementia patient experiences severe relocation damages. This is a highly problematic method.” (http://hidekiueno.net/, March 4th, 2015.)

Considering these differences (and alterations), Sumikawa laments, "This severe amount of rewriting makes it inevitable to change one's views towards dementia care. People will be 'convinced' that psychiatric hospitals are important for dementia care, not questioning further when recommended hospitalization."

To this point I have also heard the following grieving remarks from a physician who has been working hard in dementia care:
"Last week, a public health nurse working at a district's Community General Support Center politely came to greet me at a local medical association meeting, saying without hesitation, 'if you doctors find someone with dementia and let the Community General Support Center know, we will make sure to introduce a psychiatric hospital to ensure hospitalization...' I personally felt the horrors of the New Orange Plan and could not hide my astonishment."

Even taking this one incident, there's no choice but to be horrified at how the altered document's intentions are already infiltrating our everyday life.

As the Kyodo Tsushin article writes, "'We edited some parts to reflect requests from Liberal Democratic Party members to further incorporate the role of hospitals,' a high-ranking official of the ministry of health and welfare revealed," there was political pressure during the three weeks before the official announcement. It is clear from her position and background that House of Councillors member Midori Ishii, head of the "Council Group to Promote the Enhancement of Dementia Treatment," was involved the most in such pressuring. This group states the following in its prospectus written in May of 2014:

"To establish an Integrated Community Care System, it is necessary to solidify a circulating medical and nursing system that seamlessly connects institutional care and community care--one that precisely recognizes the nature of the illness without overemphasizing nursing and begins medical and nursing care through early diagnosis and intervention. Slogans such as "from medical care to nursing," or "from institutions to community" overlook each aspect's inseparable and mutually complimentary care effect. We are concerned about the possibility of hindering the seamless cooperation between medical care and nursing care."

Here this statement already uses the word "circulating," rejecting these slogans of deinstitutionalization as "hindering the seamless cooperation between medical care and nursing care." Undoubtedly, this led to Abe's and Shiozaki's comments at the Dementia Legacy Event in November. Two months later, their intent fully materialized as a national strategy.

The secret link between the Liberal Democratic Party's medical Diet member and Japan Psychiatric Hospitals Association

Midori Ishii is a medical Diet member of the LDP whose brother is Tomoyuki Ishii, the Chairman of Medical Corporation Tijinkai in Hiroshima. He is also the director of Maple Hill Hospital, which holds 146 dementia beds, 50 general psychiatric (physical complication type) beds, 100 long-term psychiatric care beds, and 90 internal long-term care beds. Further, Tomoyuki is the Chairman of the Hiroshima Psychiatric Hospital Association and a board member of Japan Psychiatric Hospitals Association (JPHA),

which endorsed Midori Ishii in 2013 along with LDP House of Councillor member Seiichi Eto and former House of Representatives member Yoshio Kimura as national candidates. In the same year, the Japan Psychiatric Hospitals Association donated 5 million yen (approx. $50,000), 8 million yen ($80,000), and 5 million yen to Ishii, Eto, and Kimura respectively.

JPHA also openly welcomed the revival of Abe's LDP regime, not simply as an eager celebration reflecting the current tide but to solidify its position in the future of Japanese mental health treatment and dementia care.

Recently, a group of psychiatrists supporting Shinzo Abe called Shinseikai has been actively planning meetings. On June 11th, the Prime Minister attended a Shinseikai meeting at a hotel in Tokyo. Abe attended with his Special Advisor, Koichi Hagiuda, who also works as his advisor, seemingly beginning to cultivate a close relationship with the group. The opening quote by JPHA Director Manabu Yamazaki then developed out of this chain of events and relationships.

Now let us return to Yamazaki's interview. The Ministry of Health and Welfare recently drew attention for predicting an era when the number of dementia patients reaches 8.6 million. Of that number, Yamazaki predicts that 5% will show symptoms of BPSD that require hospitalization at a mental health institution. In other words, under Yamazaki's estimation, 450,000 psychiatric beds would be necessary for dementia (already assuming a basis of long-term hospitalization), emphasizing the critical need for psychiatric hospitals to continue BPSD treatment. In the same article he reveals that 60% of new patients have dementia in his own 522-bed Saint Pierre Hospital, most of which are introduced from regional base hospitals. He clearly possesses an unwavering confidence in psychiatric hospitals' role in hospitalizing people with dementia.

No One is Safe: The Invisible Effects of the New Orange Plan

The current state of dementia care across nations is definitively shifting towards deinstitutionalization and avoiding the use of antipsychotics as much as possible. However, the seed of change planted in the Ministry of Health and Welfare's dementia strategy team's 2012 report, "On Future Measures Against Dementia"—which attempted to catch up to international dementia care standards by declaring hospitalization in institutions and psychiatric hospitals "unsuitable"—has hereby been completely eradicated.

Creeping upon us unnoticed, an age of mass hospitalization has slowly begun to grow its roots. This New Orange Plan reveals itself as a deftly poisoned fruit. A poisonous orange more potent than Snow White's poisoned apple, most Japanese citizens believe they have nothing to do with this issue.
Yet little do they know that those of us aging in Japan will suddenly wake up one sunny morning only to find ourselves helplessly stuck in a mental hospital's protection room.