From NRCD, Japan

The Support Systems for Persons with Cognitive Disorder due to an Acquired Brain Injury: A Higher Brain Dysfunction Support Promotion Project in Japan

Reported by Dr. Kumiko Imahashi, Dr. Reiko Fukatsu, Dr. Yasoichi Nakajima, Mr.Yuzuru Kamezawa, and Dr. Kozo Nakamura, WHO CC

It is a known fact that the memory, attention, executive function and social behavior are impaired following a traumatic brain injury (TBI) and cerebrovascular accident (CVA), and as a result, those affected individuals are often excluded from social participation. Since those impairments are not readily apparent, they are sometimes referred to as “invisible disabilities,” and patients often have difficulty obtaining public understanding and supports. Younger generation patients especially face a major challenge of returning to school or work.

We have 2.3 such new patients per 100 thousand people each year in Japan, and the total number of the patients is estimated to be approximately 300 thousand nationwide, and among which 70 thousand patients are younger than 65 years of age.

NRCD has been playing a central role in the operation of a Higher Brain Dysfunction Support Promotion (HBDSP) project, which is funded by the Ministry of Health, Labour and Welfare (MHLW), since 2005, and expanding support networks for these patients nationwide through local governments. The purpose of the project is to facilitate their returning to school, work and communities. Some of the project accomplishments include:

- Development of diagnostic criteria
- Development of a standard rehabilitation program
- Establishment of 70 local base support organizations for people with higher brain dysfunction nationwide (for which appropriate existing facilities including university hospitals, municipal hospitals, welfare institutions and health centers were designated by each local government)
- Distribution of approximately 300 support coordinators
- Provision of approximately 70 thousand consultations a year
- Construction of local support networks by each base support organization
- Organization of biannual conferences by NRCD (in which local officials and coordinators gather to report their efforts and study common issues in group work)
- More than 200 publications

Research and Project Partnership

In parallel to the project, NRCD has been conducting several research funded by the MHLW and Health and Labour Sciences Research Grants. Under NRCD, the 70 local base support organizations are grouped into 10 geographical blocks, each of which is headed by a local academic expert, for this project.

National Summary Data

The following information is based on data from the HBDSP National Database:

- Demographic characteristics: average age = 42, male (82%)
- Cause of disability: TBI (54%), stroke (33%), encephalitis or encephalopathy (9%), brain tumor (2%) and others (2%)

- Average time from the date of injury to admission to support centers: 96 days
- Average stay in rehabilitation unit: 97 days
- The most frequently provided services in both inpatient and outpatient settings: occupational rehabilitation services
- The average time of the inpatient occupational rehabilitation: 208 minutes a week for 3 months per person (physical rehabilitation was 190 minutes/week, speech rehabilitation was 174 minutes/week, and psychological rehabilitation including psychological assessments was 142 minutes/week)
- Average duration of mainly provided occupational and speech therapies after discharge: 80 to 120 minutes per week for 4 to 5 months
- Employment: employed one year after injury (24%). 31% of the participants who were employed pre-injury returned to work or found open employment
- The percentage of participants who have returned to work: 47 % provided that performing a household task and studying are also included in the definition of work

For more information:

- NRCD, Japan. Rehabilitation manual 19: Guide to Support for Persons with Higher Brain Dysfunction 1. Tokorozawa.2006. http://www.rehab.go.jp/english/pdf/E19.pdf
- NRCD, Japan. Rehabilitation manual 22: Guide to Support for Persons with Higher Brain Dysfunction 2. Tokorozawa.2008. http://www.rehab.go.jp/english/pdf/E22.pdf

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From Sidney, Australia

Assessing and Measuring Mental Health Recovery

Reported by Dr. Nicola Hancock and Dr. Anne Honey, Centre for Disability Research and Policy, University of Sydney, Australia

Mental illness is the leading cause of non-fatal burden of disease and injury in Australia (24%). Around 7 million Australians experience mental illness during their lifetime, at any point in time there are around 206,000 Australians with mental illness who experience severe or profound limitations to their daily activities.

People with lived experience of mental illness describe recovery not as medically defined cure or amelioration of symptoms, but rather, as a process of attaining a meaningful and satisfying life regardless of the presence or absence of reoccurring symptoms (e.g., (Anthony, 1993; Bellack, 2006; Davidson & Roe, 2007; Onken, Craig, Ridgeway, Ralph, & Cook, 2007). The goal of recovery is increasingly reflected in Australian policy (Department of Health and Ageing 2009) and needs to be reflected in the goals, interventions, and outcomes of services. To do this, a way of measuring recovery is needed.

Whilst a plethora of recovery-based instruments have been developed internationally over the last decade, many of these have remained in early stage development with limited psychometric testing and ongoing development (Burgess, Pirkis, Coombs & Rosen, 2011). The Recovery Assessment Scale (RAS) is one of the more developed, evaluated and used of these measures. However, our study, which