Department Initiatives

Community Support Division, Ishinomaki Regional Center

Activity report of Ishinomaki Regional Center

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Introduction

Eleven staff members (including 3 seconded staff members) from the Ishinomaki Regional Center (referred to hereafter as, "Center"), Miyagi Disaster Mental Health Care Center (MDMHCC) provided support to two cities (Ishinomaki City and Higashimatsushima City) and one town (Onagawa Town). The staff members from our center (excluding staff members seconded to Higashimatsushima City and Onagawa Town) mainly provide support to Ishinomaki City. On April 1, 2005, Ishinomaki City was merged with some of the towns in Monou-gun (i.e. Monou Town, Kanan Town, Kahoku Town, Kitakami Town, Ogatsu Town, and Oshika Town of Oshika-gun) to form the new Ishinomaki City. The distance between our center and the farthest town in Ishinomaki City is 35 km. It takes one and a half hours to get to the city to provide support. This paper reports and discusses our activities.

Various activity reports

1. Support for residents

(1) Home-visit survey

According to the summary of activities carried out at our center by division (excluding the activities carried out by seconded staff), support for residents accounts for 66.8% (1366.1 hours out of 2044.7 hours) of all activities. Figure1 depicts the support activities. As shown in Figure 2, home-visit support accounts for the highest percentage of our support activities.

Figure 1. The percentage of activities carried out at Ishinomaki Regional Center (unit: hours).

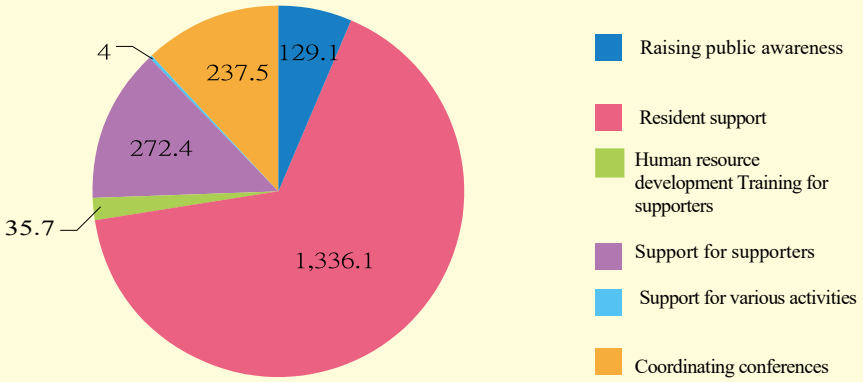
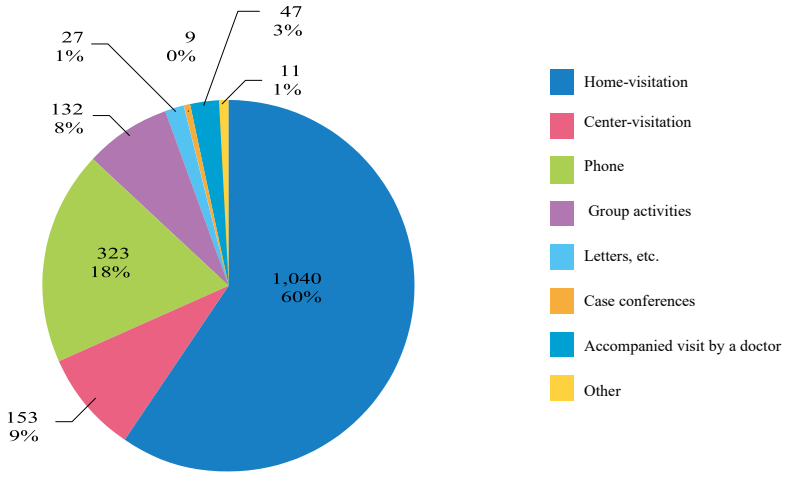


Table 1. Support activities at the Ishinomaki Regional Center

Home-visitation	Center-visitation	Phone	Group activities	Letters, etc.	Case conferences	Accompanied visit by a doctor	Other	Total
1,040	153	323	132	27	9	47	11	1,742

Table 2. Support activities of the Ishinomaki Regional Center



Our center conducted a home-visit health survey of the residents of disaster-recovery public housing in Ishinomaki City, to which we mainly provided support as a model activity in FY 2014 to (i) examine the health status and day-to-day needs of the residents; (ii) help those who required follow-up support to connect to appropriate health support projects; and (iii) collect data for the future development of a support system for the residents of disaster recovery public housing. As a result, we were able to understand the health status and the current living conditions of the residents. We also received many individual health consultation requests. Therefore, we decided to continue the home-visit health survey of the residents of disaster-recovery public housing in FY 2015.

The Health Promotion Division, Department of Health, Ishinomaki City (referred to hereafter as the Health Promotion Division) entrusted the home-visit health survey of the residents of disaster-recovery public housing to the Medical corporation Jinsenkai, The General Incorporated Association CANNUS Tohoku and the Miyagi Prefectural Nursing Association asked our center to collaborate. Support of 1,136 households was delegated to or requested of our center in Ishinomaki City. The number of surveyed households was 1,104 households (a response rate of 83.9%).

Following a request on April 1, 2015, to conduct a health survey of 440 households based on the health questionnaire data from the residents of disaster-recovery public housing during the application for occupancy, we (along with seconded staff from Ishinomaki City) conducted a home-visit health survey of 378 households, which ran until March 25, 2016. Table 2 shows the number of households requested to be surveyed and the number of households surveyed.

Table 2　Number of surveys requested by Ishinomaki City

Number of households requested to be surveyed	Number of households surveyed	Response rate
440	378	85.9%

We, along with seconded staff, summarized the data on 164 individuals (out of378 households) who needed to be connected to support services or whose information needed to be shared with other related organizations.

According to the criteria developed by the Health Promotion Division for patients who need to be seen, those with the highest priority needs were ①single-person households (especially senior citizens and males), followed by ②those with a K6 score of 13 or less, ③those with a history of the psychiatric disease who had not made use of any services, ④those with a certified need for long-term care insurance who had not made use of any services, and ⑤those who were identified to require follow-up support at the briefing for the residents of disaster-recovery public housing.

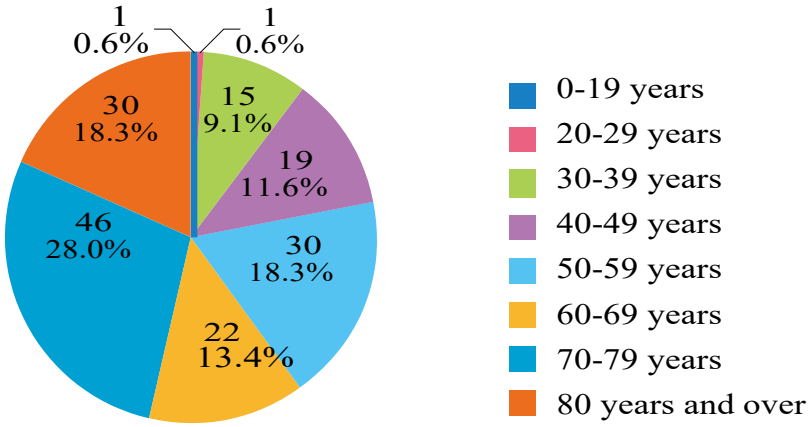
The details of 164 individuals who needed to be connected to support services or whose information needed to be shared with other organizations are as follows:

① In terms of household composition, one-person households (59 households, 46.1%) were the most common, followed by two-person households (44 households, 34.4%), three-person households (14 households, 10.9%), and then households of 4 or more. (11 households, 8.6%). Single or two-person households accounted for more than 80% of people.

② Slightly more males required follow-up support than did females: (85 males [51.8%] vs. 79 females [48.2%]).

③ Most of the patients who required support or whose information needed to be shared with related organizations after the home-visit health survey were in their 70s (n = 46, 28.0%), followed by those who were aged 80 years and over (n = 30, 18.3%); 54.3% of the patients were senior citizens aged 65 years and older (Figure 3).

Figure 3. Age groups that required follow-up support etc.



④ In terms of the severity of mental illness (as determined by the K6 score), about 20% of patients (n - 31, 18.9%) had poor mental health (K6 score of 13 points or more) even after being relocated to disaster-recovery public housing (Figure 4). Even today, 59 residents (36.0%) report having trouble sleeping.

Figure 4. The severity of mental illness (K6 score) in patients who require follow-up support etc.

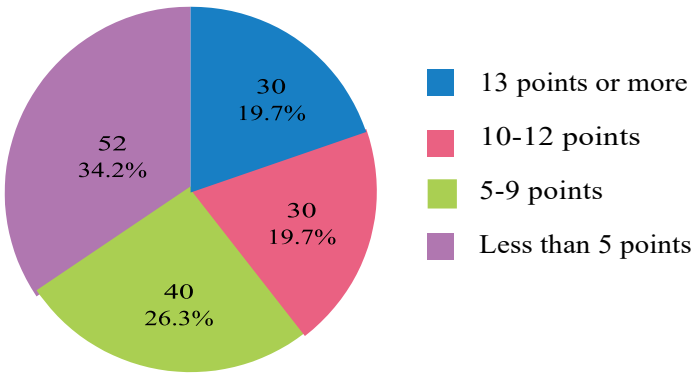


Figure 5. **Organizations that provide support to those who required follow-up support after the home-visit health survey**

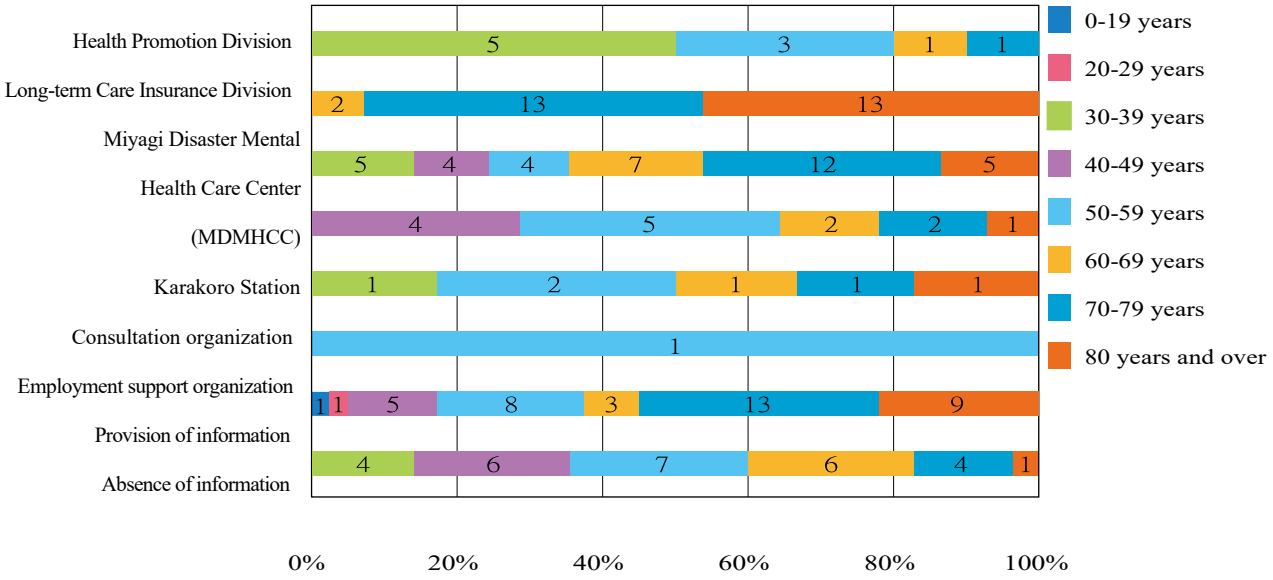
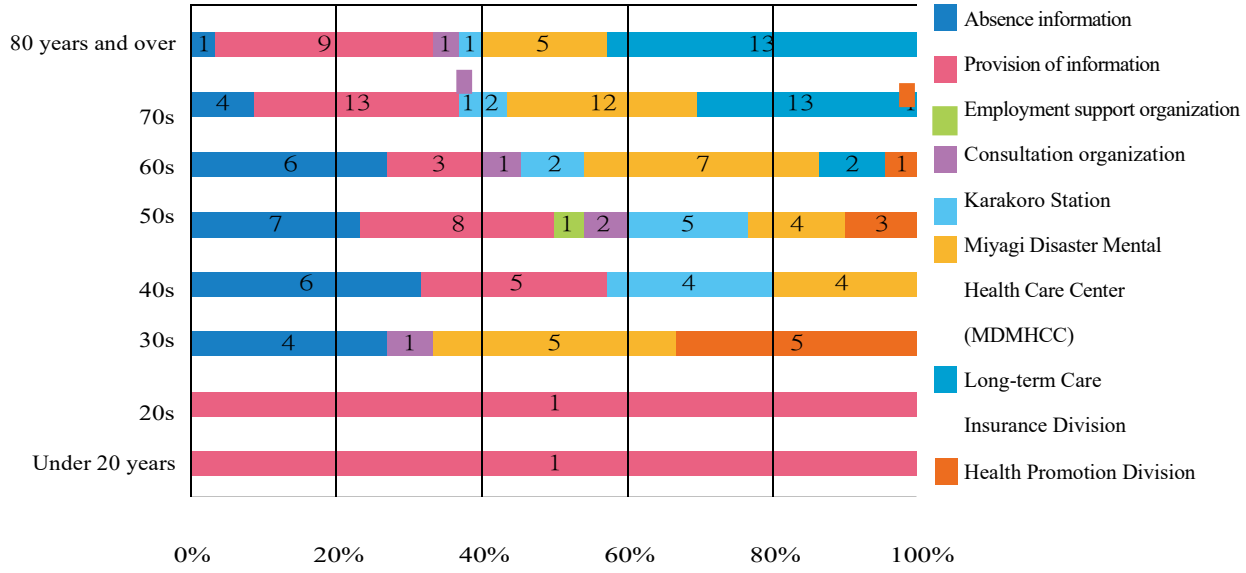


Figure 6. Organizations that provide support to those who required follow-up support etc. after the home-visit health survey by age



Support providers after home-visit health surveys are shown in Figure 5, and support providers by age are shown in Figure 6.

Using the current home-visit health survey as an opportunity, those who have started support at the center and those who have received support from the center since before the home-visit health survey were reported to the Health Promotion Division as requiring follow-up support. Information was also provided to those who received invitations to exhibit their work at the exhibition to be held in March. Information was shared via report meetings set up by the Health Promotion Division for those already receiving support from the National Disaster Mental Health Care Network Miyagi Kara koro Station or for absent households who could not be contacted even when absentee votes were sent. Support from the regional general support center and the provision of long-term care insurance services were rapidly provided by reporting anyone suspected of having dementia or who was thought to require long-term care insurance services to the Health Promotion Division.

This time, out of the 378 households with whom the Center conducted home-visit health surveys, we revisited 164 individuals who were provided with support or whose information we supplied to associated organizations. We were able to confirm that, when reflecting upon their routine lifestyles, where they received administrative agency requests and implemented them as business duties, they were able to specifically grasp their role in analyzing future support methods and directions and reported to them by the administration and that they were able to fulfill their roles a specialized group.

Additionally, the situation in Higashi-Matsushima city was such that individuals were being transferred to disaster-recovery public housing, individual recovery has started in earnest due to collective relocation, and the occupancy rate of container-type temporary housing has begun to decrease with the gradual closing of container-type temporary housing lots. Follow-ups on disaster-recovery public housing health surveys starting in FY 2015 indicated that it has been two years since the first individuals had moved into disaster-recovery public housing.

It has been four years since we dispatched to Higashi-Matsushima city but, in FY 2015, these activities were conducted by a single psychiatric social worker. The social worker's assignment continues to be at the Disability Welfare Group, Welfare Division, at the Department of Health and Welfare in Higashi-Matsushima City. The main activities include container-type temporary housing, health questionnaires on privately-rented temporary housing ("FY 2015 questionnaires on health and lifestyle" conducted by Miyagi Prefecture), follow-ups on "Questionnaires on mental health," during specified health check-ups, and secondary follow-ups from screening test results conducted by city public health nurses and based on home-visit health surveys conducted after moving into disaster-recovery public housing, with follow-ups of health questionnaires on disaster-recovery public housing conducted by the Miyagi Prefecture conducted from FY 2015 onwards.

(2) Salon activities for regional residents (Group activities)

(1) Koko farm project

We had heard during our home-visit activities that victims living in container-type temporary housing or privately-rented temporary housing had said, "We have nowhere to gather socially, and I don't know anybody," and, "I have nothing to do and just drink alcohol from the morning", so we have implemented the "Koko farm project," in collaboration with farmers from Higashi-Matsushima city since 2015, which provides a location for recreation and exchange using the cultivation of vegetables and flowers, to restore the mental and physical health of these victims. We also started a "Kokedama (Japanese Moss Ball) classroom" based on participants' requests to teach Kokedama making to everybody. The status of implementation in FY 2015 is as seen in Table 3. Although the number of events had decreased by three compared to 2014 due to inclement weather, the number of participants increased to 33, and an average of approximately 16 individuals participated per event (compared with 12 individuals per event in 2014). Of the 33 registrants, seven individuals participated without the assistance of a caregiver because public transport in the area has not been maintained. In 2016, activities were generally conducted with center staff (excluding dispatched staff), and it was not possible to increase the current number of participants, so it is currently thought that the group of participants will be reduced to those who do not need the assistance of a caregiver.

Table 3. Koko farm project implementation status in FY2015

Implementation period and time	Number of events	Content	Total number of participants
9:30-11:30 on the 2nd and 4th Thursdays in April-March	17	Cultivation of pumpkin, onion, radish, cucumber, eggplant, tomato, sunflower, ornamental kale, etc.	273
October 1 (Workshop on Kokedama [Japanese Moss Ball])	1	Held with participants as lecturers	8

***A total of six irregular Koko Farm sessions were held (four sessions by the volunteers only and two sessions by the volunteers and staff members). The total number of volunteers and staff members was 42 and 103, respectively.**

② Handicraft workshops (college class)

Handicraft workshops were opened in FY2013 to provide a place of exchange for residents in privately-rented temporary housing, but in FY2015, the workshops were conducted with the target framework expanded to “victims”. The implementation status in FY 2015 is shown in Table 4.

Table 4 Handicraft workshop implementation status

Implementation period and time	Number of Events	Works	Total number of participants
April to March	12	collage	101
June 1st	1	beads	6

③ Life skills class (Initially handicraft workshops)

Support for community-dwelling people with mental illnesses has been provided upon request based on follow-ups after health surveys or from families of associated organizations. Victims receiving support often are connected to medical institutional consultation support, employment support organizations, and disability welfare services offices. However, some patients do not go out due to having few opportunities for safely being involved in activities or those who spend their time at home because they cannot independently go to consultations at medical institutions. We opened a handicraft workshop for those with mental illness who stay at home and who wish to apply to link these activities to the beginnings of rebuilding their confidence and independence. From September 2015, we conducted handicraft workshops that incorporated participants’ hobbies that they used to be involved in.

At the start, we planned to conduct comprehensive reviews of these activities continued over six months. The following four points were raised during conversations within the center: (1) initiatives like salons still being inactive in disaster recovery public housing, (2) only a few locations being available for facilitating activities among community-dwelling people with mental illness, (3) there being a family member who can now independently go to the hospital as was possible for that individual before the earthquake, and (4) the implementation date being once a month. Participating members’ opinions were also incorporated.

When the question of the continuation of the “handicraft workshops” was raised during the session on March 15th, the workshop was popular among participants and many wished for it to continue. Thus, the project was continued. In all, implementation content included button sewing, how to use a sewing machine, knitting (of scarves, for example), and cooking practice, and so the session was continued under the new name of the “Lifeskills class”, held every third Tuesday of the month with a maximum attendance of five individuals, targeting community-dwelling women in their 20s to 40s with mental illness, using the Ishinomaki city health consultation center as a venue. The class was managed by three staff members with the support of occupational therapists dispatched to Ishinomaki City. The FY 2015 implementation status is as shown in Table 5. Through these activities, we aimed to help participants regain confidence and to provide support so that the participants themselves could set up their lifestyle plans.

Table 5 Lifeskills class Implementation status

Implementation period and time	Number of Events	Works	Actual number	Number of Events
September to March	9	Handicrafts and cooking	5	25

2. Support for supporters

We shared information at various conferences and meetings held by municipal governments and the Life Support Center for Disaster Victims run by the Social Welfare Council. In the meantime, we provided support for individual cases by providing consultation to supporters and accompanying visits which were carried out by municipal health promotion staff and public health nurses in the branch. Results for FY 2015 are as shown in Table 6.

Table 6 Support for supporters

Report after a home-visit or interview		10
Guidance and advice from professionals		89
Number of times in total	Alcohol-related problems	43
	Depression	3
	Abuse	3
	Other	44
Local issues		4
Need for continuous detailed mental health support		2
Case conference (With the presence of the client)		34
Establishing mental health consulting service		2
Health examination support		13
Other		14
Total		247

(1) Case conference and area meeting attendance

Upon request by Ishinomaki City and each general branch, the social welfare council, the Miyagi prefectural nursing association, the regional general support center, and various medical institutions, we attended case conferences relating to problems around alcohol, mental illness, dementia, and trouble between residents, and investigated how each support organization interacted and their respective roles. We also attended area meetings that were attended by Ishinomaki City, the social welfare council, the regional general support center, the nursing association, and professional organizations, and we studied the sharing of information, support methods, and suitable support organizations. As residents continue to move into disaster-recovery public housing, the area meetings have evolved to include the distribution of information to these residents.

(2) Individual support consultation

Upon request by Ishinomaki City, we have been dispatched to the city office once a week to conduct individual support such as providing advice for public health nurses. However, starting from the middle of the year, we only responded when necessary.

(3) Temporary facility care worker training support

Upon a request from a care worker in the Ishinomaki City Kahoku temporary regional facility, we conducted case study meetings with the support of the Medical Corporation Tohokukai Hospital, with a total of 10 care workers participating.

(4) Support for infant health checkups

Based on requests for infant health check-ups conducted in The Kahoku district of Ishinomaki city (Kahoku, Kitakami, Ogatsu) and Oshika town, we dispatched a public health nurse and a clinical psychologist for consultations with mothers and children. The number of times support was provided was 12 times in Kahoku district, 3 times in the Oshika branch, and the public nurse conducted a conference after health examinations for providing mental care advice to mothers and children as well as consultations for those requiring continued support.

(5) Cooperation in orientation meetings for residents in disaster-recovery public housing

Following requests from Ishinomaki City, our center staff participated in orientation meetings held on weekends (Saturday, Sunday) for residents of disaster recovery public housing. The center staff acted as facilitators during informal talks conducted among residents of disaster-recovery public housing so that they could have informal discussions in a calm environment. In FY2015, these disaster-recovery public housing resident orientation meetings were attended from April to February, and throughout this period, the staff cooperated 18 times (23 individuals in total).

(6) Activities at Higashi-Matsushima Cityand Onagawa Town

Staff dispatched to Higashi-Matsushima City responded, as public health nursing assistants, to various cases of mental illness, social withdrawal, senior citizens being in need, and so on. They also participated in consultations conducted by doctors, attended case conferences and care conferences, and cooperated in collaboration with other organizations. The Community Support Division Stem Center Director Fukuchi cooperated in mental health consultations for children once a month and acted as an advisor for activities related to suicide prevention to collect information on suicide cases and families of suicide victims, as well as suicide case reviews. The center manager is affiliated with the regional liaison council for suicide prevention in their capacity as a committee member.

At Onagawa Town, staff cooperated as assistants during interviews of industrial, government-employed physicians and responded to consultations of temporary housing care workers.

3. Raising public awareness

(1) Alcohol training session in Kahoku district of Ishinomaki City

On March 11th, 2014, the Health and Welfare Division of the Ishinomaki City Kahoku general branch (referred to hereafter as the Kahoku branch) received aid for an individual support meeting in collaboration with Tohokukai Hospital to assist people with alcohol-related problems who lived in container-type temporary housing. It was opened with 16 participants from each associated organization that supports these individuals. During this time, each associated organization met each other for the first time, where they both had a frank exchange of opinions regarding support for alcohol-related problems and confirmed the directions that they would take for providing support.

On December 26th, 2014, a Kahoku branch public health nurse requested the opening of a workshop to target care workers involved in the care of individuals with alcohol-related problems to support them, with the help of the Danshukai, given the large influence of these individuals. In the Kahoku region workshop, we studied this strategy of consulting with the Tohokukai Hospital Community Support Division and requesting the help of the Danshukai. Additionally, the necessity of continuing a workshop that originated because there are alcohol-related problems in container-type temporary housing was discussed at the Kahoku branch, and we confirmed the continued support of the Danshukai in conducting these workshops. Attendees included the health and welfare division director, all public health nurses working at the Kahoku branch, and the regional support center manager; initiatives around alcohol-related problems for the Kahoku area were discussed.

On March 26th, 2015, a workshop titled, “Hearing from those who have quit drinking,” was held at the Kahoku branch with Danshukai members as lecturers, and there was a total of 46 individuals in attendance, including stakeholders and each associated organization’s care workers. Serious discussion on alcohol-related problems was subsequently held, and we confirmed that a deeper understanding of alcohol-related problems was developed and that it was determined that workshops would continue to be hosted.

On April 15th, 2015, a lecture on the theme of “how to deal with alcohol”, targeted at stakeholders, the general public and caregivers alike, was given in May by Dr. Okudaira from Tohokukai Hospital, followed by another lecture on “experiencing the Danshukai regular meetings”. They also co-hosted the Kahoku district workshops on alcohol-related meetings (mock Danshukai meetings) with the Kahoku branch with the cooperation of the Miyagi Prefecture Danshukai and Tohokukai Hospital in June. Events, including lectures, were held 12 times in 2015, with a total of 184 individuals participating. There are plans to continue hosting these events in 2016 as well.

(2) Other activities

Upon request for the dispatch of instructors from the government and various organizations, we sent instructors to the Ishinomaki city eating habits improvement promotion member liaison council workshop, Watanoha district health advocate workshops, the 2015 Ishinomaki city Yamashita regional general support center area care conference, the Oh dame administrative district mental health class, and the internal workshop of the special elderly nursing home, Yamoto Akai no Sato facility. Lectures relating to workplace mental health were given at the Yamoto Akai no Sato, and afterward, individual interviews of city officials were conducted.

(3) Exhibitions and meetings

Exhibitions and meetings were held from FY 2012, and there were many requests from visitors to conduct these exhibitions every year, so these events were also held in FY 2015, on March 4th (Friday) at the Miyagi Prefectural Office Complex in Ishinomaki City. There were 227 exhibition attendees, 26 individuals who exhibited individually, and 6 organizations who exhibited in collaboration. There were also collage and beadworks exhibits to showcase the work of those who participated in the handicraft workshops.

Exhibitions and meetings have been held four times to date, but in FY 2015, there were limits on how many of these events could be held with support from just the regional center and the Stem Center, as was demonstrated in the general confusion observed during the group planting. The center and the dispatched staff will need to discuss for 2016 whether they should host or cancel this event, taking into consideration the state of the exhibition and meetings, as well as the numerous alternative approaches. The implementation status for FY 2015 is as shown in Table 7.

Table 7 Implementation status of exhibitions and meetings

Date and time	10:00-15:00 on Friday, March 4, 2015
Place	Temporary conference room, Annex, Miyagi Prefectural Office Complex in Ishinomaki
Exhibited works	Pottery, collage, painting, calligraphy, Japanese paper dolls, patchwork, small hanging China dolls, cloth dolls (animals, etc.), knitted stuffed toy (wool works, beadworks), 26 individual and 6 organizational exhibitors
Content of the meeting	Spring group planting corner (pansy), collage, origami workshops
	Hand massage, Ochakko Salon
Number of visitors	227

4. Human resource development training for supporters

Upon request from administrative agencies, universities, professional associations, care workers for temporary housing, and the council of welfare and child welfare commissioners, lecturers for care workers who have many opportunities for direct contact with victims or those with disabilities were dispatched on 20 occasions. The distinct content of the center is presented below.

(1) Workshops on alcohol-related problems

Alcohol-related problems have surfaced with the occurrence of the Earthquake, and so staff members of the Tohokukai Hospital as well as members of the Japan social worker association for alcohol-related problems (ASW association) were invited as lecturers in coordination with administrative agencies and each care worker organization, and workshops on alcohol-related problems were held on 15 occasions in FY 2015 to support the region.

① Ishinomaki health care center

In collaboration with the center, ASW association members were invited as lecturers, and a workshop was held as a three-part series, with a total of 110 participants. The workshop was co-hosted with Ishinomaki City in 2015 but was co-hosted with the health care center in 2016. Subjects included staff from the nursing care support office but since there were many first-time attendees, the second workshop onwards needed to be shifted in terms of lecturing and practicing content to be more suited to beginners.

② Workshops in Higashi-Matsushima City

Workshops in Higashi-Matsushima city were planned with a central focus on city public health nurses, and care workers and regional workshops were each held four times in coordination with Tohokukai Hospital and the Miyagi Prefecture Danshukai. Aside from this, Workshops on alcohol-related problems and the support surrounding them were held with the Higashi-Matsushima City Council of Welfare and Child Welfare Commissioners. Regional workshops were held in model districts in 2015 for regional caregiver development, and we intended to change districts and continue these events for 2016.

③ Workshops in Onagawa Town

On July 10th, 2015 in Onagawa Town, the director of nursing in Tohokukai Hospital gave a lecture titled “hospital treatment for people with alcohol-related problems” to doctors, nurses, and town public health nurses of the Onagawa community health center, with the Onagawa town health medical welfare regulation committee location as the venue. The Tohoku Hospital director also gave a lecture titled, “effective support methods for caregivers: treatment and recovery for alcoholics,” on January 22nd, 2016. Considering progress in 2015, we have decided for 2016 to coordinate with Onagawa Town and Ishinomaki health care center for future activities, including hosting workshops in cooperation with the Onagawa town health medical welfare regulation committee and conducting case-study training with care workers, etc.

(2) Mental health workshops

On October 16th, 2015, Professor Emeritus of the Department of Counseling at San Francisco State University (Inner Core 9 President) Dr. Mariko Tanaka gave a lecture titled, “Focusing on the mental health of children: how to unleash the potential of children,” to 127 participants including public health nurses and nursery teachers engaged in child support within prefectural municipalities, school officials such as teachers and nursing teachers, clinical psychologists, and the general public in the prefecture with the Aeon Cinema Ishinomaki as the venue.

(3) 13th mental health care meeting for disaster victims in Ishinomaki

After the earthquake in Ishinomaki City, Higashi-Matsushima City, and Onagawa Town, the 2015 mental health care meeting for disaster victims in Miyagihas developed executive committees while speaking about the current situation with individuals who are excited for the various support services provided and for strengthening ties with care workers. They are also prepared for the post-disaster mental health meetings in Ishinomaki City. The executive committee format was a first, but it received approval from the following administrative agency and organizations. As before, the primary sponsors were the Natural Disaster Mental Health Care Network Miyagi Karakoro Station and the Miyagi Prefecture Mental Health Welfare Association Miyagi Disaster Mental Health Care Center (MDMHCC) Ishinomaki Regional Center, and the Eastern health welfare office, Ishinomaki City Health Promotion Division, Welfare Division of Higashi-Matsushima city, Onagawa Town Health and Welfare Division, Miyagi Prefectural Nursing Association, Ishinomaki Welfare Council, Japanese Association of Social Workers in Health Services, and Jinsenkai were members of the executive committee. Participants spoke their thoughts during the 1st executive committee meeting. The committee then summarized their opinions, resulting in a discussion so intense that it began to look as though the meeting might not be held. The preparation progress is as follows:

[Implementation Committee Progress]

○ 1st executive committee meeting (December 18th, 2015)

・ Establishment of the executive committee

・Objectives for hosting the mental health care meeting for disaster victims

・Implementation of the mental health care meeting for disaster victims

・Group work

Themes: “Current regional status and challenges”, “What types of meetings do we want?”

○ 2nd executive committee meeting (January 13th, 2016)

・Confirmation of opinions raised at the 1st executive committee meeting

・Group work

Themes: “What types of meetings do we want?”, “What kind of groups do we want to attend?”

○ 3rd executive committee meeting (February 4th, 2016)

・Confirmation of opinions raised at the 2ndmeeting

・Discussions around meeting implementation

○ 4th executive committee meeting (March 9th, 2016)

・Final discussions on the meeting

・Face-to-face meetings with executive committee members, symposiasts, and advisors

・Group work discussions

○ Mental health care meeting for disaster victims in Ishinomaki (March 9th, 2016)

Theme: “Five years since the Earthquake: discussions on the present and future” Symposium:

Understanding the activities of regionally active organizations, and planning their coordination

Symposiasts:	Rainbow Crayon	Natsuki HOTTA
	TEDIC	Yu MOMMA
	Monk’s Café (Hofuku Temple Abbot)	Eisei YATSUMAKI
	Japan Legal Support Center – Higashi-Matsushima	Akira TOBISHIMA

Chairperson and advisor, Professor Katsuko SUENAGA, Department of Nursing,

Tohoku University School of Health Sciences

Group work: “Five years since the Earthquake: discussions on the present and future”, 78 participants

○ 5thexecutive committee meeting (March 25th, 2016)

・ Review by the executive committee

・Publication of reports on the mental health care meeting for disaster victims

The center has conducted support activities while remaining conscious of their face-to-face relationships with regional administrative agencies, the social welfare council, and the respective support organizations. We have participated in area meetings and various case conferences and engaged in activities that promote the sharing of information and coordination that allows for collaborative thinking. Many recovery initiatives have been conducted in the Ishinomaki area, but the contents of victim support have diversified as the recovery has progressed, and more emphasis has been put on individual support. For 2016, we would like to continue hosting these meetings while maintaining contact with all active individuals in the Ishinomaki area to provide all victims with the support they need to ensure a stable life and to continuously expand the circle of support by coordinating between care workers.

Discussion

For the support of disaster victims, we have developed activities (e.g., handicraft workshops, the Koko farm project, exhibitions, and meetings) that prevent the isolation of disaster victims and provide as pleasant a lifestyle as is possible given their conditions. These activities are for individuals who have few places to interact or few opportunities to participate in such activities otherwise. We also hosted several workshops and attended several support-organization conferences, and were engaged in the formation of a system to provide backup support for regional care workers. Concerning the alcohol-related problems that have surfaced in the region, we have been able to support residents with these problems and their families by coordinating with administrative agencies, the community support division of Tohokukai Hospital, the regional psychiatric Kodama Hospital, and the Miyagi Prefectural Danshukai. Furthermore, we were able to further our coordination with municipalities and health care centers in the area by continuing workshops on alcohol-related problems, and progress has been made on discussions that seek to deepen the content of these workshops.

We summarized conditions following home-visit health surveys for the first time among 164 individuals who were connected to support or who provided information to associated organizations, based on entries from health questionnaires distributed to 378 households at the time of disaster-recovery public housing occupancy applications between April 1st, 2015 and March 25th, 2016, conducted by the center (including staff dispatched to Ishinomaki City in 2015). We received requests several times from the Health Promotion Division, and we provided summaries each time. This time, we were able to confirm how these reports were being applied.

Until now, our center has accomplished the activities requested by the municipalities in the area and finished these assignments by reporting a summary. Afterward, only those from the center who continued to provide support were able to conduct follow-ups, but this time, we were able to deepen our activities relating to the role of our center, necessary information to be confirmed during home-visits, and future policies and judgments, by confirming the post-report situation. Finally, we were able to realize the meaningfulness of our work.

In 2015, the center conducted activities as an 11-person team, including four full-time psychiatric social workers, one full-time and two part-time public health nurses, one full-time secretary, two full-time psychiatric social workers from Higashi-Matsushima city and Onagawa town, and one full-time occupational therapist from Ishinomaki City, with a part-time psychiatrist as the president. They served across four different workplaces and communicated during the monthly general center meeting. Since the start of 2015, two center staff members and three dispatched staff members oversaw the planning of the workshops during these general meetings. From the middle of 2015, this was done as a single unit as a center-wide project. Dispatched staff began to participate in the operation of the monthly center-wide meetings, and communication among staff members improved.

With regards to coordination with other institutions, information was exchanged once a month with each municipality and four times a year with health care centers, with information exchange conducted with the participation of mental health welfare centers. Additionally, mental health care for disaster victims in Ishinomaki city was held under the executive committee system, which allowed for frank conversations and promoted mutual understanding such as the request for support in the specialized field of each organization in the context of daily activities.

Summary

Five years after the Great East Japan Earthquake, recovery in the disaster area has slowly but surely started to become visible (for example through the completion of disaster-recovery public housing) and although victims have shown self-recovery and have relocated to disaster-recovery public housing, there remain some who have not been able to move out of container-type temporary housing and it has become increasingly clear that there are disparities in the recovery rate of the region. Health surveys within disaster-recovery public housing in 2015 revealed that many elderly households and consultations also revealed many problems relating to dementia, family relationships, mental illness, and alcohol. Based on 2015 trends, it is thought that further consultations with people traumatized by the disaster, those with financial or health concerns, those with mental health problems, and those with mother-child / family relationship problems will be necessary for the future.

We provide support by humbly lending an ear to victims and extracting their "inner potential", but we want to continuously support victims through handicraft workshops and the Koko farm project, etc., so that they can have as pleasant a lifestyle as possible. Additionally, the center has received many requests for individual support meeting attendance or workshop lecturers, due to advances in cooperation with each associated organization (e.g., administrative agencies, the social welfare council) through various activities. As we move forward, we are actively promoting regional activities that will allow for mutually supportive relationships between each associated organization and residents within their regions. With regards to support for children, ever since we were involved in activities based around the community child mental health care regional project in 2016, we have continued workshops for staff members of associated organizations and with regards to individual support, we continue to move forward while establishing strong relationships with associated organizations. Alcohol-related problems have begun to surface and resident awareness of this issue is high, so we would like to continue raising public awareness as well as engaging in public awareness activities while cooperating with health care centers and each municipality. There has been an increase in the number of consultations caused by discrepancies in recovery speed, such as relocations from container type temporary housing or the lack of life goals due to the earthquake, and even more than before, we would like to construct a system that provides local support in close cooperation with administrative agencies and each support organization. Simultaneously, with regards to responses to victims and support recipients, we humbly wish to provide support for victims based on the fundamental aspect of "listening" to them, as well as to work on improving local mental health welfare.

The development of infrastructure in the disaster zone of the Ishinomaki area has gradually progressed with time since the Great East Japan Earthquake and signs of recovery have become visible but coinciding with this is the gradual withdrawal of recovery support organizations from the disaster area. Altogether, progress has been made in administrative agency organizational structure and the implementation of support systems, as well as system changes. Four years have elapsed since the establishment of our center as well, and our activities up to now will need to change according to recovery conditions. We believe that this year will be one where the entire staff comes together to think about what we as a center can do and to continue fulfilling our duties while in search of these answers.

Finally, the psychiatric social worker, Hiroyuki KIMURA (currently at the Kesennuma regional center), has summarized the Koko farm project conducted by the center as a regional resident salon activity (group activity) as the 2014 "Koko farm" victim communication support project questionnaire survey results, so we present these results here.

“Koko farm” victim communication support project questionnaire survey results

1. Introduction

The Ishinomaki regional center of the Miyagi Disaster Mental Health Care Center (MDMHCC) began activities in April 2012 and tended to various concerns of victims through activities such as home-visits. Among these victims, one voiced the opinion, “I want to do farm work as I did before the earthquake”, and so we began the “Koko farm” victim communication support project (“Koko farm”) in April 2013 to provide a communication space using farm work. 2015 marks its third anniversary but the number of participants has increased annually from its original number of six participants in 2012and we feel that the “Koko farm” has been readily accepted by the victims. With this in mind, we thought that determining the characteristics of the participants and their motivations for participating and establishing which individuals found this project useful would serve to inform the planning of future activities, so we conducted a questionnaire survey.

2. Koko Farm Summary

The Koko farm is composed of farm work and teatime and its duration is about 3 hours, depending on the season. Farming activities include seed sowing, weeding, and harvest, tailored to the physical condition of the participants and set up to allow for breaks at their own pace. There are seven staff members, whose occupations are public health nurses and psychiatric social workers. There are also two volunteers cooperating with staff for farming guidance and they help during non-workdays in the peak season.

The activity location is in Higashi-Matsushima City and we have borrowed land approximately 1000 m^2 in size (equivalent to about two basketball courts) from members who have agreed to our proposal. The activity location is inaccessible with public transportation and approximately 80% of all participants cannot reach it on their own. For these reasons, the staff has transported participants, and this transportation period has also provided opportunities for communication between participants and staff.

Activities are conducted one to two times a month for the ten months between March and December (excluding the winter period when work cannot be done), and activities were conducted 17 times in FY 2015, which was three times less than 2014 due to suspensions caused by bad weather. Harvests were distributed among participants, with staff delivering products to those who could not participate during this round. Additionally, a harvest festival is conducted during the last activity in December, where participants and staff reflect on the activity while having lunch together. No fees are collected from the participants during regular activities, with fees collected only during the harvest festival.

There were 273 participants (14 male, 16 female) throughout 2015, with an average number of participants of 16 per round. There was a wide age range, from participants in their 20s to those in their 80sand there were many among both males and females who were in their 60s and 70s. The average age was 63.3 years, with no significant differences between men (average age 61.4 years) and women (average age 65.4 years). The participation rate (number of times participated / number of times individuals were approached*) was 63.6%, with higher participation rates among men (54%) than women (72%). Men in their 70s and onwards, and women in their 50s and 60s participated relatively more often. When classified by residence, there were many participants from container type temporary housing, similar to in 2014, but in 2015, there were more participants who resided in disaster recovery public housing or who were rebuilding their homes, and progress in the relocation process was observed here as well.

* The number of individuals participating during the registration period minus those who could not participate, e.g., due to hospitalization.

3. Overview of the questionnaire survey

Subjects were 27 individuals who participated at least once in FY 2015, with responses obtained from 21 individuals (78% retrieval rate). There were 8 men and 13 women, with an average age of 67.8 years. Questionnaire surveys asked about ① farming experience, ② reasons for participation, ③ lifestyle changes resulting from participation, and ④ contentevaluation. Upon discussion among staff, eight choices were created for the "reasons for participation" section, and this was designated as a multiple-choice format with a maximum of three choices to clarify what participants prioritized.

4. The results of the questionnaire survey

(1) Farming experience

Farming experience before participation is as follows: "I was a farmer", (10%); "farming was my hobby", (29%); "little to no experience", (60%).

(2) Reasons for participation

Reasons for participation included, in descending order: "I need more exercise for my health", "interactions with other participants and staff", "I enjoy nature and vegetable gardening", "it is a reason to get out of the house", "I can feel like I'm with friends by working together", "I can feel like I'm needed", "I don't have anything else to do", and "because there is transportation". When divided by sex, the most common response for both men and women was "I need more exercise for my health", but this was particularly high for women, at 85% (Table 1). The second most common reason was "interactions with other participants and staff", but the same reason for men was only the fourth most common response. In contrast, "I can feel like I'm with friends by working together" was the 3rd most common response for men and the 5th most common response for women, and "I enjoy nature and vegetable gardening" was the 1st most common response for men and the 4th most common response for women, highlighting gender-based differences in the reasons for participation. When sorted by age, the reasons "I need more exercise for my health" and "interactions with other participants and staff" became more common as participant age increased, whereas "it is a reason to get out of the house" was a common reason among younger participants (Table 2). When divided by experience, the more experienced group ("I was a farmer" and "farming was my hobby") more often cited "I need more exercise for my health" and "I enjoy nature and vegetable gardening" more often as reasons for participation over the inexperienced group ("little to no experience"). Meanwhile, the inexperienced group often cited "it is a reason to get out of the house" and "interactions with other participants and staff" as reasons for participation (Table 3).

(3) Lifestyle changes

Improvements in health were reported in four out of the seven participants who reported "little to no appetite", four out of the seven who reported "poor" or "no" sleep, and six out of the ten who reported "moderate" or "poor" physical conditions. Additionally, "increased" physical activities were reported among four out of the eight individuals who reported "few" exercising opportunities, five out of the seven who reported "few" opportunities to go out, and five out of the eight who reported "few" opportunities to meet other people. Some participants reported "worsened" health or "decreased" activity, but this was due to physical illness.

(4) Content evaluation

Over 76% of participants responded with “good” for all items (project contents, duration, work volume).

5. Summary

Before the questionnaire, the farming experience was thought to be the motivation of many participants (similar to that of the victims), but results showed that 60% had little to no experience. Results also showed that the experienced group was motivated by the work itself, whereas the inexperienced group participated to use farming as a way of leaving the house and communicating with others. Reasons for participation independent of gender were health-related, with men prioritizing non-verbal communication through shared experience and work over verbal communication. During the actual activities, female participants often actively engaged in conversation, whereas the male participants silently engaged in work. There were sentiments among men that “they were happy to see other participants”, so men may prefer non-verbal communication during work.

The opportunities provided by the Koko farm were for activities and exercise but also for a sense of self-efficacy in the form of self-confidence and competence through work and the establishment of trusting relationships based on collaboration between participants and staff. These were all cited as reasons for why over half of the participants showed lifestyle improvements.

Inaba has referred to these types of connections as social capital and has defined this as “trust, norms, and networks that accompany the external soul”[1]. Many studies have been done on social capital and it is known to subjectively influence health. Koko farm is thought to have been an impetus for developing this social capital.

Additionally, many participants mentioned that they shared harvests that they could not finish with relatives and neighbors and it is thought that there were ripple effects in the formation of social capital beyond the activity itself. The current questionnaire surveys revealed that the reasons for participation vary by experience, gender, and age. It is thought that we can apply these characteristics to conduct more satisfactory salon events that are more focused on participant needs.

Table 1 Cross-tabulation of gender and reason for participation

Item	Men(N=8)		Women (N=13)		total (N=20)	
I enjoy nature and vegetable gardening	5	63%	5	38%	10	48%
I need more exercise for my health	5	63%	11	85%	16	76%
It gives me a reason to get out of the house	2	25%	6	46%	8	38%
I don’t have anything else to do	1	13%	1	8%	2	10%
Interactions with other participants and staff	3	38%	9	69%	12	57%
Because there is transportation	2	25%	0	0%	2	10%
I can feel like I’m with friends by working together	4	50%	4	31%	8	38%
I feel like I’m needed	2	25%	1	8%	3	14%
Other	0	0%	0	0%	0	0%

Table 2 Cross-tabulation of age group and reason for participation

Item	30s (N=1)	40s (N=0)	50s (N=3)	60s (N=8)	70s (N=6)	80s (N=3)
I enjoy nature and vegetable gardening	0%	-	33%	50%	67%	33%
I need more exercise for my health	100%	-	67%	63%	83%	100%
It gives me a reason to get out of the house	100%	-	67%	38%	17%	33%
I don't have anything else to do	0%	-	0%	13%	17%	0%
Interactions with other participants and staff	100%	-	33%	50%	67%	67%
Because there is transportation	0%	-	0%	13%	17%	0%
I can feel like I'm with friends by working together	0%	-	33%	63%	17%	33%
I feel like I'm needed	0%	-	0%	13%	17%	33%
Other	0%	-	0%	0%	0%	0%

Table 3 Cross-tabulation of farming experience and reason for participation

Item	I was a farmer (N=2)		Farming was my hobby (N=6)		Little to none (N=12)	
I need more exercise for my health	2	100%	4	67%	4	33%
It gives me a reason to get out of the house	2	100%	6	100%	8	67%
I don't have anything else to do	—	—	1	17%	7	58%
Interactions with other participants and staff	—	—	1	17%	1	8%
Because there is transportation	—	—	3	50%	9	75%
I can feel like I'm with friends by working together	—	—	1	17%	1	8%
I feel like I'm needed	2	100%	1	17%	5	42%
I need more exercise for my health	—	—	1	17%	2	17%
Other	—	—	—	—	—	—

References

1) Inaba, Y (2011): Introduction to social capital: from isolation to social bonds. Chuko Shinsho (Chuokoron-Shinsha), pg. 27.

Acknowledgments

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