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アジアヒューマンサービス研究会

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ヒューマンサービスとは「人を援助する」「支援する」上で直面する社会的課題を映し出す言葉であり、社会福祉分野、医療・看護分野、心のケアにかかわる心理臨床分野、長寿社会のヘルスプロモーション分野、育児や保育などの家族支援分野、生涯学習時代に対応した教育、雇用流動化に対応したキャリア開発分野など、ヒューマンサービスと総称できる領域が急速に拡大している。

ヒューマンサービス分野の研究はその方法が科学的であれば、国際的に通用する分野であり、共同の試みによって、より発展することが期待される。

そこで本研究会では、ヒューマンサービスに関する科学的な研究・実践活動を通じ、日本を始めアジアのヒューマンサービス分野の進歩・発展に寄与することを目的としている。

The word 'Human Services' is used when someone faces social challenges for 'help' or 'support'people.

'Human Services' is expanding rapidly its area such as field of social welfare, medical ・nursing, psychology clinical related mental care, health promotion for aging society, assist family for infant and child care, special supporting education corresponding to vocational education, education support sector corresponding to era of lifelong learning and fluidization of employment corresponding to the area of career development.

Human Services area, if its research methods are scientific, is internationally accepted and greater development is expected by collaborative research which is performed by multinational and multi-profession.

This journal aims to contribute to the progress and development of Asian Human Services through scientific research and actual activities on Human Services.

ISSN の取得について

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原著論文

短　報

実践報告

ORIGINAL ARTICLE 1

Employment Policies for Older Individuals in Advanced Countries:Implications for Employment Policies for Older Individuals in South Korea

In-Jae LEE [1)] Ju-Hee HWANG [2)]

1) Professor of Department of Social Rehabilitation
At the Hanshin University
411 Yangsan-dong, Osan-si, Gyonggi-do, South Korea
leei@hs.ac.kr

2) Lecturer of Department of Social Rehabilitation
At the Hanshin University
Ssangyong Yega APT 402/104, Noryangjin-dong, Dongjak-gu, Seoul, South Korea
juhee.rehab@gmail.com

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ABSTRACT

Over the past decade, population ageing has become one of the most challenging issues facing OECD countries. Policymakers are paying increasing attention to the ageing of the workforce. Furthermore, increasing earlier retirement combined with greater longevity will place substantial pressure on public finances regarding older individuals in most OECD countries, especially in terms of the effect these phenomena will have on the workforce. The continuation of these trends has serious implications for the sustainable development of society as a whole. Consequently, employment services for older individuals should focus on keeping them employed with their current work for as long as possible.

When viewed through the experiences of OECD countries, the mutual obligations between governments and older individuals regarding employment matters should be recognized. Employment policies for older people have targeted individuals over the age of 40, since workers in their 40s are now regarded as 'nearly old.' The purpose of public policies for older individuals in many countries is to extend their working lives mainly through public employment services.

As measures can be taken to motivate workers to work longer, this study proposes various public policies in developed countries that provide retirement incentives and stimulate employers to hire older workers. We examine employment policies for older people in various countries, and conclude with a proposal to adopt employment policies in developed countries. This study will prove valuable in highlighting good practices in employment services in other countries, and thus contribute to improving employment services for South Korea's ageing workforce.

＜Key-words＞

public policies, older individuals, aging, aging workforce, public supports

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Ⅰ. Introduction

Over the past decade, population ageing has become one of the most challenging issues facing OECD countries, and policymakers are paying increasing attention to the ageing of the workforce. Indeed, older individuals are retiring earlier than before, despite sustained increases in longevity. Increasing earlier retirement combined with greater longevity will place substantial pressure on public finances regarding older individuals in most OECD countries, especially in terms of the effect these

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phenomena will have on the workforce. The continuation of these trends has serious implications for the sustainable development of society as a whole. When viewed through the experiences of OECD countries, the mutual obligations between governments and older individuals regarding employment matters should be recognized.

Generally, older people experience greater difficulty using employment services compared with young and middle-aged people. Furthermore, it is difficult for older individuals who are laid off to obtain re-employment in most countries. Policies in Germany and France, therefore, help older workers to remain in the work force longer and the governments of those countries encourage older individuals to remain at work longer. Consequently, employment services for older individuals should focus on keeping them employed with their current work for as long as possible. Opportunities should be provided enabling older individuals in the labor market to make job transitions if they want to.

Ⅱ. Employment Policies in Advanced Countries

1. Employment supports and employment protection

1) Employment Supports

In developed countries, productive aging through a person's working life becomes a key element of public policies addressing the issue of an aging society. In 2008, the employment rate of older workers among OECD countries increased to 55.9%, while the employment rate among older workers in South Korea (hereafter Korea) was higher (61.8%) than in most other OECD countries. The higher employment rate among older people in Korea may be the result of a lack of retirement income security systems as well as the large segment of the population who earn a living from agriculture.

In Japan, the focus of employment policies for older people has shifted from a system of supporting companies to a system of serving older workers themselves. Public policies in Japan are striving to develop suitable employment in the fields of long-term care, child care, or related social services. Consequently, the number of commercial older workers over 65 has increased by 84% between 2005 and 2008 (270,000 in 2005 and 490,000 in 2008). The Law for the Stabilization of Employment of Older Workers in Japan offers a comprehensive framework to encourage better employment opportunities for older workers. Through successive reforms of this law, 99.9% of companies which have over 500

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employees have adopted the Employment Continuation Benefit for the Aged (ECB) as a kind of wage subsidy to employers. In theory, this allows employers to reduce the wage level of their older workers by up to the maximum amount of the benefit without lowering the overall income they derive from their work.

The labor participation rate among people aged between 55 and 64 in Germany has reached 53.8%, resulting in an increased mandatory retirement age of 67. The effect of this is to restrict the early earning of retirement income. In the United States(hereafter USA), the labor force aged between 16 and 24 is expected to decline by 6.9%, but older workers aged between 65 and 73 are projected to increase by 83.4% by 2016 (Kim, 2009). As a result, encouraging older people to remain in the workforce longer is an important key to boosting economic growth and reducing the burden of future public expenditures on social security and Medicare.

Generally, older people have relatively few opportunities to re-enter the workforce. To support older people to remain in the workforce longer, particular employment programs tailoring the needs and skills of older workers to fit the workplace need to be developed in advanced countries. Britain's New Deal 50 Plus, which is delivered by the Employment Service and Benefits Agency, aims to help people aged 50 and over who are looking for or considering returning to work and receive public income supports, which are part of the government's welfare-to-work program. In the USA, the Senior Community Service Employment Program (SCSEP) operated by the Department of Labor, has been developed for low-income persons aged 55 and older. SCSEP has characteristics similar to the Public Employment Service (PES) in Korea. Low-income participants in these programs are typically placed in subsidized minimum-wage community service jobs. As community service and work-based training programs, SCSEP and PES engage workers for an average of 20 hours per week, provide on-the-job training, and show them how to use newly acquired skills. The intention of these programs is to ensure that older workers will increase economic self-reliance by supporting their employment in jobs that are not subsidized by federal or private funds (Yeoun, 2010).

2) Employment Protection Rules

Faced with low employment rates for older workers, most OECD countries have experimented with employment protection for older workers by imposing taxes on firms for firing such workers and offering subsidies for hiring them (OECD, 2006). Additional fiscal penalties for firms who lay off older people in

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countries such as Belgium, Finland, France, Japan, Korea, and Norway include the imposition of longer notice periods or higher severance pay. Employment protection policies may decrease the likelihood of hiring older workers due to the extra costs that will be incurred in the form of higher taxes and subsidies on hiring. However, special employment protection policies are still necessary for older people since employers are reluctant to retain older workers beyond a certain age, often as low as 55, and older people are finding it difficult to get a new job in the labor market. In spite of some employers' reluctance to retain older workers, protection policies could make it costly for employers to dismiss them because of the longer period of notice required or a mandatory, enlarged retirement benefit for older workers who are laid off. As a result, older individuals are able to stay in their jobs. Simultaneously, however, restrictive employment protection legislation may create disincentives for the employment of old workers, and the number of employees could decrease because of the increased cost of hiring older workers. Such provisions may lead both to greater retention of old workers and to a reduction in hiring them. In theory, it is difficult to predict the impact employment protection rules will have on labor market consequences for older workers (Vodopivec & Dolenc, 2008).

To promote the employment of older workers, the French Government created 'Contrat première embauche' (CPE – the First Employment Contract or Beginning Workers Contract). It aims to encourage the creation of new jobs for older workers. Under this contract, employers can dismiss workers under the age of 26 during the first two years of a contract without justification. This system, whereby the French Government contracted private companies to hire senior citizens, aged 50 and older, was created in 1995. Companies that hire older, unemployed individuals receive a social security subsidy from the government. France has additional contracts to support older people. First there is the 'Contrat Emploi Solidarite (CES: the Employment-Solidarity Contract),' which was created in 1989 to help unemployed minorities, such as those over 50; the disabled; single parents; as well as people who have great difficulty finding a job (OECD, 2005). The second contract is 'Contract Emploi Consolide (CEC: the Consolidated Employment Contract),' which was created in 1992 to help people who have no job or training prospects at the end of their contracts to get back to work on a CES contract. However, the effects of these contracts that protect jobs for older people have not yet been accurately assessed (OECD, 2005).

If employers' expenses are a crucial obstacle to hiring older workers, reforming the method of determining wages or offering wage subsidies can be ways of

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removing the barriers for older workers to be employed. Many countries chose to provide wage subsidies instead of altering the means of wage determination. Some countries introduced a special wage system that offers more generous eligibility only for older individuals among various social groups. Others, which have high non-wage costs such as social security premiums, take the step for employers to deduct their contribution to social security. However, it is hard to find reports of successful wage subsidies attempted by OECD countries. Various studies have found that wage subsidies have opposite effects, including the substitution effect, stigma, and negative attitudes (Yeoun, 2010).

2. Job Training

The nature of work in our society has changed from manufacturing-based jobs to service- and knowledge-based employment. As a result, most jobs no longer involve heavy physical demands and are therefore suitable for older workers. In other words, employees also need to acquire new skills or upgrade their skills to easily adopt the labor market environment. Workers of all ages require participation in vocational training and lifelong learning activities. If older workers anticipate their working lives to be longer, they will be more motivated to take vocational training. Adult education especially, is able to enhance the employability of older individuals since older people generally have less training opportunities. Having training opportunities may become a prerequisite to increase the employability of older people.

In most of the advanced countries, the number of training cases is decreasing across all ages, and cases of training older individuals are very limited. Unemployed older participants in employment service programs do not show much interest in training. The British Government covers training expenses for participants involved in New Deal 50 Plus, but few participants are interested in training (Yeoun, 2010). The reasons for this situation could be a lack of coordination in training curriculums between younger trainees and older trainees. This could be a fundamental barrier due to the differences between younger people and older people in the process of training provided by the government. The duration and contents of the training process can be disadvantages for older workers. Training for older people should be processed with time to spare, be exceedingly relevant to the work environment, and emphasize a self-directed learning process rather than formal classroom training (OECD, 2005).

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3. Age Discrimination and Public Relations

Employers may play a key role in shaping the employment prospects of older workers. Three factors that interfere with the continued employment of older workers are: (1) a negative attitude about aging (age discrimination); (2) increased costs of employing older workers due to increased overall compensation costs or the seniority-wage system; and (3) strict employee protection rules. Most employers have stereotypical attitudes toward older people aging. These stereotypes against aging can be called Ageism. It occurs "where an opportunity is denied to a person solely because of his or her chronological age and age is irrelevant to the person's ability to take advantage of that opportunity" (Human Rights and Equal Opportunity Commission, 2000, p. 11). Ageism is not a universal, cross-cultural phenomenon, regardless of the degree of hiring older workers. Accordingly, age discrimination in the workplace by employers is an important obstacle inherent in the labor market.

Another issue employers may encounter includes the increased costs of hiring older workers due to increased overall health, life insurance, and pension costs. As a result, employers have a tendency to hire younger workers. Additionally, since the key to progress lies clearly with employers, conducting information campaigns as well as promoting guidelines about the employment of old workers for employers are also expanded in various countries.

1) Age Discrimination

The majority of developed countries have laws against workplace discrimination regarding ethnicity, religion, gender, and disability. However, only a few countries have laws prohibiting age discrimination. The Age Discrimination and Employment Act (ADEA) in the USA is the oldest legislation within OECD countries and is implemented at state level. This Act, adopted in 1967, was intended to protect older workers against discrimination in hiring and layoffs in the USA. Amendments in 1978 and 1986 finally banned the practice of mandatory retirement (Taqui, 2002).

To date, most countries do not provide legal protection against age discrimination. For example, specifying age in job advertisements is illegal in the USA, but it is true that a lot of countries allow filling out the date of birth (DOB) in job application forms. Many people think age restrictions are applied only for physically demanding jobs. Nevertheless, only very few exceptions are admitted in a number of jobs in which age is a reasonable qualification, such as police, airline pilots, and fire-fighters. In these cases, ADEA merely allows states to set mandatory retirement ages. Many people believe mandatory retirement can be a tool for creating employment opportunities for new arrivals on the labor

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market, opening up promotion potentials and allowing enterprises or organizations to rejuvenate (Taqui, 2002). Many countries where salary scales are based essentially on seniority maintain mandatory retirement due to the higher cost of older workers. By now, all employers should have reviewed any potential age-discriminatory elements and an appropriate action plan. Germany, Portugal, and the United Kingdom (hereafter UK) have adopted a default retirement age of 65.

Empirical studies state that ADEA in the USA or other legislations related to age discrimination in other countries are more likely to offer some degree of protection in delaying retirement, but they may not provide a positive impact in creating new positions for older workers (OECD, 2006; Williamson & Higo 2007). Due to seniority bonuses, most employers in Japan and Korea encourage early retirement by providing monetary compensation. As a result, age discrimination legislation is able to decrease the rate of lay off of older workers by increasing termination costs, but these results in older workers experiencing difficulty in getting new jobs.

Whether official retirement is allowed or not could be an important issue related to age discrimination legislation. Sometimes, the issue of official retirement age generates controversial outcomes. For example, some countries, including the USA which has age discrimination legislation, do not offer older workers the option of early retirement when older workers have a collective agreement or justification for early retirement. In other countries that don't legislate against age discrimination, employers still support the retirement age and unions since they are afraid of delaying retirement income if they prohibit retirement age. As a result, legislation alone is insufficient to change the labor market (Yeoun, 2010). Age discrimination legislation again primarily targets employers' attitude towards older workers.

2) Dissemination of Information Campaigns and Public Relations

It is vital not only to legally prevent age discrimination, but also to understand the characteristics of older workers and promote guidelines for employers about hiring older workers (Vodopivec & Dolenc, 2008). Public campaigns in Finland and the UK to promote age diversity may have contributed to a greater awareness among workers in these countries about age discrimination in the workplace. Especially, when NGOs participate those campaigns are more significant. With this approach, it is vital to create an age-friendly working environment for older people by enhancing the phase of

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older workers, providing education programs to address age discrimination, establishing advisory groups, providing information about the labor market or current job trends, supplying vocational training or life-long education, and improving accessibility to the labor market.

A number of countries, such as Australia, Finland, Netherlands, Norway, and the UK have conducted large-scale government-sponsored information campaigns aimed at conquering employer unwillingness to employ and retain older workers (ILO, 2011). Employer age discrimination regarding adoptable workplace skills and productivity is one of the factors that inhibit new employment and employment retention. To improve employers' negative perceptions, campaigns and public relations have played a major role in overcoming age stereotypes in Finland and the UK. Government campaigns to raise awareness can help combat negative attitudes and misconceptions about older workers (Yeoun, 2010). Such campaigns may include guidelines for employers to expand awareness of issues related to ageing and work. For instance, the UK Age Positive campaign initiated in 1999 would be a good example. This campaign raises awareness of the benefits of an age- diverse workforce through a practical guide for business in the areas of recruitment, selection of candidates, promotion, training and development, layoffs, and retirement, with detailed explanations of the guidelines and indicators for assessing conformity with them (UK 2007). Finland also executed a national plan for older workers between 1999 and 2002 and adopted the slogan, "the experience of older people is a national asset" (Yeoun, 2010). Ageing has been incorporated in all Finland's workplace development programs in some way.

4. Pension Reform and Employment Policies

Whereas old-age pensions and other welfare schemes often promote financial disincentives for older individuals to remain in or return to work, these systems also provide a number of advantages to maintain or return to work as well. For example, as the amount of state pension funds increases, the attractiveness of retirement for older workers increases; this is called the 'income effect.' Older individuals, however, expect a 'substitution effect' that lets them calculate how long they have to work to optimize their pensions or other benefits (OECD, 2005).

There are three ways to provide incentives for working longer. The first is to shrink the system of pensions by increasing the age of eligibility. With this scheme, it is possible to save costs associated with pensions or social security benefits by strictly regulating age eligibility. The second way favors a gradual adjustment of the

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retirement age of the police of older workers. This means compensations and benefits for older people would differ according to the timing of their retirement. More stringent measures would be applied to reduce excessive bonuses associated with early retirement and delayed retirement. The last scheme is that the government decides on raising the minimum age for diverse retirement benefits such as social security benefits, public or private pensions, or welfare benefits. With this scheme, the government is likely to reduce the burden of pensions as well as to remove early retirement incentives. During the past few years, many countries have decided to increase age eligibility in their basic public pension systems. Various changes to pension systems, including increasing the age for retirement eligibility have been performed or discussed as a strategy for old people to stay longer in the workforce. Early retirement makes it more difficult in these situations.

1) Changed Retirement Age and Employment Issues

Countries are promoting efforts to diminish public pension expenditures. When pension spending has to increase to accommodate an increased number of elderly people, public pension expenditures will impose a huge burden on public pension systems (Kim, 2009). Thus, during the past two decades, OECD countries have reformed their pension systems. These reforms have aimed at improving the financial situation regarding public pension systems and to change work incentives at the same time. The general modifications affect work incentives as well as directly block the pathway to early retirement. The general scheme, which reduces the expectation of pensions through income effect, will affect early retirement incentives. Changes in pension eligibility and retirement age eligibility have been implemented in numerous OECD countries.

In the USA, a phased retirement program which enables older workers to participate in the workplace rather than retire has been in operation, as this program lets old people gradually reduce the number of hours they work or changes their job roles or responsibilities. With this, the process of retiring often occurs gradually over several years. For example, 37% of men and 32% of women aged 55 to 64 who received an income from a pension in 2008 were employed in 2009 (Purcell, 2009). In the European Union (EU), a phased retirement program has been stimulated by supplementing reduced wages from the public sector instead of reducing the number of hours older workers work. On February 17, 2011, the UK government published the draft Employment Equality Regulations 2011 which aim to prohibit employers unreasonably discriminating against employees on grounds of age. The regulations also have the effect of abolishing

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the default retirement age set at 65 in the UK. Programs that utilize a network with local universities, companies, unions, and labor agencies in Germany have succeeded in supporting the employment of older workers (Kim, 2009). The Japanese Government has been revising the Elderly Employment Stabilization Law in order to increase the mandatory retirement age to 65 and they have adjusted eligibility of the pension age to 65 by FY 2013. Compared with OECD countries, 29.4% of males and 12.7% of females are employed among older Japanese. A study reported that the working motivation of older Japanese people is very high (Ministry of Health, Labor, & Welfare, 2008).

The extent to which arrangements permit part-time work during a period in between a full-time career job and full retirement would affect older workers' decision to continue working. Buddelmeyer, Mourre, & Ward (2005) also supported that increasing the flexibility of labor markets by stimulating part-time employment prolonged old workers' work time. However, pension systems often restrict opportunities to work part-time at the end of a career. Thus, a basic objective in all countries is to avoid conditions that discourage part-time work. For example, the UK is taking steps to remove the restriction on the right of private pension schemes to pay benefits to people still in their jobs (OECD, 2005). To execute gradual and flexible retirement for older workers, Germany introduced a part-time system in 1996. Finland has gone further in recent years by giving active subsidies to encourage older people to work part-time (OECD, 2005). However, whether these initiatives will have an impact on aggregate labor supply is still not clear.

Some countries have recently introduced measures to increase penalties for early retirement and also to enhance delayed retirement compensations. For example, the UK has improved the level of compensations for working between the ages 65 and 70, and at the same time has offered an option to receive a lump-sum payment rather than pension benefits. Finland offers high earnings on pensions of older workers who remain employed. Finland has also announced an invigorated phased retirement plan in which older workers reaching retirement age are able to receive proportionate pension benefits when they reduce working hours.

2) Pension Reform and Adjusting Retirement

Pension reforms have an effect on the timing of decisions regarding retirement by shifting the motivation to work longer. It would be helpful for older workers to increase their participation in the workforce (1) by reducing the old age pension

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replacement rate, which is a measure of how effectively a pension system provides income during retirement, to replace earnings which were the main source of income prior to retirement, (2) by lengthening retirement, (3) by increasing pension benefits through delaying the timing of retirement, (4) by providing flexibility to combine work and pension benefits simultaneously. In 2007, the German legislature passed the Statutory Pension Insurance Age Limit Adaptation Act (SPIALA) which aims to gradually increase the state pension age from 65 to 67 years in the future. Starting in 2012, older workers will need to work until age 67 to be entitled to their full normal state pension benefits under the new rules (Yeoun, 2010). The USA is to strengthen work incentives for older workers to work longer and to increase the earliest age of eligibility for a full social security pension from 65 to 67 (Yeoun, 2010).

Pensions cannot be successfully reformed unless there are incentives, tax benefits, and welfare systems regarding early retirement. Long-term care benefits, disability benefits, or unemployment benefits and tax structures that may affect comparative compensation schemes in work and retirement all may induce early retirement. To reduce early retirement incentives, it would be essential to consider the relationship between various welfare benefits and pension benefits. However, existing policies in force in OECD countries concerning the relationship between various welfare benefits and pension systems are still temporary and limited.

5. Employment Policies for Older Individuals in Advanced Countries

Recent policies for older individuals in most OECD countries emphasize active living and continuing employment of older workers. Active-aging policies and measures would be possible to implement if old people are able to work as they want by upgrading them with life-long education. Furthermore, this could be achieved through participation in economic activities even after retirement, reconsideration of personal abilities, and the continued maintenance of a healthy lifestyle. One of the major policy directions is responding appropriately to issues concerning labor shortages and aging. Policies that maintain employability and increase active employment for old people have been prominently considered by policymakers in most countries (Jeon, Jang, Hwang, Uh, & Lee. et al., 2005).

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1) Employment Policies in France

In France, older individuals are principally classified among the vulnerable employment groups, which also include youth, women, and individuals with

disabilities. Policies relating to older individuals comprise (1) an employment process that includes recruitment, employment, and retirement; (2) a system of early retirement; (3) an unemployment insurance system; and (4) a retirement system. An age discrimination act has been implemented in the process of recruitment and employment promotion contracts. For example, the First Employment Contract or Beginning Workers Contract (CPE) targets private sector employers. Under this contract, employers can receive government subsidies, social insurance expenditures, and subsidized training costs. Furthermore, workers' guardianship systems may apply when employing senior citizens, aged 50 and older through contractual obligations between private companies and the French Government. To promote older workers in public sectors, the 'Contrat Emploi Solidarite (CES: the Employment-solidarity Contract)' was created in 1989 to help unemployed minorities such as those aged over 50, the disabled, single parents, as well as people who have great difficulty finding a job (OECD, 2005). The 'Contract Emploi Consolide (CEC: the Consolidated Employment Contract)' was created in 1992 to help people on CES contracts who have no job or training prospects at the end of their contract to get back to work (OECD, 2005). These systems were designed by local governments, nonprofit corporations, labor councils, and unions and designed for people who have difficulty supporting the objective of returning to the workforce. The agencies hiring the beneficiaries receive compensations and social security expenses as well as subsidies for vocational training. In addition, a number of individuals who are over 50 and disabled are considered as 1.5 people if companies hire them. When those companies offer 35 hours a week to older individuals with disabilities, they will get more benefits from the government. To control the layoff of older workers, the French Government utilizes regulations and institutional incentives simultaneously. When companies lay off their workers because of deteriorating business conditions or for economic reasons, more stringent regulations are applied for older workers.

2) Employment Policies in England

The UK has emphasized market principles such as voluntarily changes in market participation in issues relating to the promotion of older workers. To do this, the UK has applied various public campaigns to change employers' perceptions about aging and older workers. Britain's policies have focused on shifting employers' perceptions that determine the employment patterns of older workers. As a part of active labor market policy, Britain's New Deal 50 Plus aims

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to help people aged 50 and over who are looking for or considering returning to work. This help includes active support from public funds to promote employment for older workers through adult learning, continuing education, vocational education training, and job placement services. Within the program of New Deal 50 Plus, older individuals are able to have a personal advisor, who helps them at every stage of a new deal by continuously offering a variety of supports such as providing career planning, job search information, a selective training process, information about resumes and application forms, and education to improve confidence. Efforts to expand the employment infrastructure such as facilities, programs, and the expansion of personnel are vital to promote employment for older workers. From 2003, those moving into employment have been able to apply for a return-to-work credit paid under Working Tax Credit. Once an older individual finds a job, he or she may get financial incentives such as Working Tax Credit and an In-work Training Grant. Those who have a full-time job may get £60.00 a week for six months as Working Tax Credit and up to £40.00 a week for a part-time post (24-29 hours). A Training Grant of up to £1,500 may also be available for work-related training courses until an older individual starts to work. For employers, this program attracts subsidies of £75 pounds for 30 hours or more and £50 pounds for 16 to 29 hours (Jeon, et al., 2005). The UK Government also published the draft Employment Equality Regulations 2011 which aim to prohibit employers unreasonably discriminating against employees on the grounds of age. However, this has not had much of an impact on age discrimination in the workplace.

3) Employment Policies in Japan

Japanese employment policies for older individuals are characterized into three: (1) raising the minimum legal mandatory retirement age to 65 and introducing a system of continued employment up to 65 years old by revising the Elderly Employment Stabilization Law; (2) promoting re-employment supports; and (3) securing various job opportunities by aligning with motivation of employment and diversification of stamina. In particular, the Law for the Stabilization of Employment of Older Workers provides a comprehensive framework to promote better employment opportunities for older workers. The continued employment system is to continuously be employed after the mandatory retirement age of affected employees when he/she desires to continue working. To increase the ratio of the continued employment system, public employment security agencies assist older job seekers to find employment

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opportunities by advising and consulting with them, as well as through cooperation with regional economic organizations. For example, the Jump 65 Promotion Project, which is implemented by the Older Persons' Employment Security Center, is to promote a comprehensive employment environment by offering consultations and the assistance of advisors on elderly employment. Another measure to support coordination between older individuals and employers aims to help improve the employment environment for the elderly through incentive grants. Secure employment opportunities are established through cooperation with local economic organizations to pay particular attention to local-specific industrial characteristics.

Secondly, the policy of promoting re-employment of the elderly incorporates instructions and assistance to employers who help re-employ retired persons. To provide incentives for employers to rehire retired persons and older workers forced to retire, Japan is to promote the dissemination and use of re-employment assistance planning systems that offer guidance and assistance to business owners who provide re-employment assistance for older workers. This is also possible through Jump 65, which supports employment-seeking activities by assisting employers who re-employ the elderly. Grants will also be provided to employers to help develop skills and labor mobility for middle-aged or older workers. In addition, concerted and insightful efforts have been made to mitigate age restrictions in the process of hiring. Japan's aim in facilitating work opportunities regardless of age is ultimately to establish a foundation to promote business.

To facilitate the variety of employment and social participation for older individuals, the portfolio of Silver Human Resource Centers has been enhanced to provide employment opportunities and now incorporates a Senior Work Program, which subsidizes skills training and group interviews at the Federation of Silver Human Resource Centers, with the cooperation of business owners' associations. Any worker aged 60 and over who desires employment may become a member of a Silver Human Resource Center. Members agree to temporary or short-term work and other light jobs that are closely connected with community life. Those jobs offered by private citizens, businesses, and government agencies, and for which they are paid a set wage. Within this program are a variety of job-producing projects, including dispatches, volunteers, and One-Stop Carrier centers corresponding to the needs of older participants in society. Along with this, Japan encourages older workers to put their abundant work experience to use by opening their own businesses. For instance, Japan

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provides financial support to groups of people aged 60 and over who cooperate in creating self-employment opportunities, to help defray expenses incurred in acquiring the skills necessary to find or create jobs. Japan's initiatives related to employment opportunities for older individuals, such as the Silver Human Resource Centers, Senior Citizen Groups, and the Association of Employment Development for Senior Citizens, are dynamically operated even though they are government-subsidized private businesses, private enterprises, cooperatives, and NGOs.

4) Employment Policies in the USA

In the USA, the Older Americans Act (OAA) is the major federal discretionary funding source for home and community-based services for older adults. One-Stop Centers, required under the federal Workforce Investment Act, are another source. The One-Stop Career Centers are installed and operated through the Act. The workforce investment system serves a large number of older workers by ensuring a wide spectrum of One-Stop Career Center services. These services are provided through community-based partnerships with business and industry. They ensure personal choice of training programs and successful placement of older workers in jobs in response to business demands (Kim, et al., 2010).

In the case of public sector employment for older workers, key drivers for policy development have been recognition of age as an equality issue by improving laws and regulations in the USA. SCSEP has provided the work experience and training necessary to bring back into the workforce a segment of the population that has been largely discounted. Participants work an average of 20 hours a week, and are paid the highest of federal, state, or local minimum wage in the place in a wide variety of community service activities at non-profit and public facilities such as day-care centers, senior centers, schools, and hospitals. One-Stop Career Centers have an important role to play in linking older workers with employers through employment and training services. There were approximately - throughout the American Association of Retired Persons (AARP), a United States-based non-governmental organization and interest group for people age 50 and over. The AARP provides information about jobs, while National Career Centers for Senior Citizens support recruitment, payroll processing, and personnel management. Those centers have achieved good results with teams of experienced workers.

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Ⅲ. Concluding Statements on Policy Implementation in South Korea

The main characteristics and challenges related to employment policies for older individuals in developed countries are summarized into three categories. First, the issue of the employment of older workers has featured prominently in European policy documents for over a decade. Studies of European labor market policies, including policies for older individuals and disadvantaged groups, reported positive policy outcomes. However, it is difficult to expect a successful outcome from those policies in new cases of hiring, wage subsidy programs, and vocational trainings. In other words, workers over the age of 50 in most OECD countries are less likely to be tapped for formal training to upgrade their job skills. For example, the British Government provides training expenses for participants who are involved in New Deal 50 Plus, but the number of those interested in training is small (Yeoun, 2010). Therefore, programs are needed to extend the working lives of older people.

Secondly, empirical studies state that ADEA in the USA or other legislation related to age discrimination in other countries are more likely to offer some degree of protection in delaying retirement, but they may not provide a positive impact in creating new positions for older workers (OECD, 2006; Williamson & Higo 2007). As a result, age discrimination legislation is able to decrease the lay-off rate of older workers by increasing termination costs, but this has made it difficult to find new recruits for employment among older workers. Age discrimination legislation is targeted primarily at employers' attitude toward older workers. Legislation alone is insufficient to change the labor market (Yeoun, 2010). Therefore, a number of countries, such as Australia, Finland, Netherlands, Norway, and the UK have conducted large-scale government-sponsored information campaigns aimed at conquering employer unwillingness to employ and retain older workers (ILO, 2011). Age discrimination caused by employers regarding workplace adoptable skills and productivity is one of the factors that inhibit new employment and employment retention. To maintain employment for older people, campaigns and public relations programs must be implemented to overcome age stereotypes.

Lastly, various countries have decided to raise the minimum age for diverse retirement benefits such as social security benefits, public or private pensions, or welfare benefits. Over the past two decades, OECD countries have considerably reformed their pension systems to improve work incentives affecting the closure of pathways to early retirement or restriction of access to them. Various changes to pension systems, including increasing the age of eligibility for a pension have been implemented or discussed as strategies for keeping old people in the workforce longer.

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Pension reforms would not be possible without incentives, tax benefits, and welfare systems regarding early retirement. To reduce early retirement incentives, it would be essential to consider the relationship between various welfare benefits and pension benefits. Early retirement makes it more difficult in these situations. However, solving the twin-faceted nature of the problem of the aging workforce - employment and retirement - requires increased flexibility in the labor markets by stimulating part-time employment or by using a phased retirement system to prolong the working life of the elderly. The extent to which arrangements permit part-time work during the period between a full-time career job and full retirement would influence the decision of older workers to stay working.

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ORIGINAL ARTICLE 2

Evidence-Based Practices for Rehabilitation Services in Asian countries : Applications and Recommendations

Hyun-Uk SHIN[1)]

1) Professor Hyun-Uk Shin. Ph. D., Department of Rehabilitation, The University of Jeonju, 45 Baengma-gil, Wansan-gu, Jeonju 560-759, South Korea
vexme@hanmail.net

ABSTRACT

There is no disputing the fact that rehabilitation services in the US have entered an age of Evidence-Based Practices. As rehabilitation interventions enhance in effectiveness and efficiency, more studies of rehabilitation also are needed in other countries and cultures. In spite of numerous efforts to enhance the quality of life of people with disabilities among Asian countries, there are still several social barriers and unscientific service approaches which might not be proven by effective research results. The rehabilitation system in these countries would have been more developed if researchers and professionals had applied the evidence-based practices into specific rehabilitation services. In order to apply and disseminate evidence-based practices into Asian countries' rehabilitation services, several applications and recommendations were addressed. By integrating existing advanced knowledge and information of evidence-based practices, professionals could enhance the quality of life of people of disability. Also, the rehabilitation system in Asian countries might be upgraded into an ideal direction.

＜Key-words＞

Evidence-Based Practices, Rehabilitation Services, Asian Countries

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Ⅰ. Introduction

There is no disputing the fact that rehabilitation services in the US have entered an age of Evidence-Based Practices (EBP). Even though there are some difficulties in applying the methods of evidence-based practice to rehabilitation research, it is clear that rehabilitation services will continue to move in this direction (Cicerone, 2005). Until about 1980 rehabilitation in the US lacked any strong evidence, however over the last 25 years the quantity of important evidence has developed significantly as well as quality. Therefore, it is now achievable to practice many rehabilitation services on the basis of evidence (Wade, 2006).

As rehabilitation interventions enhance in effectiveness and efficiency, more studies of rehabilitation also are needed in other countries and cultures (Drake et al., 2003a). Specifically, diverse rehabilitation services such as independent living, assistive technology, supported employment, sheltered workshop, psychiatric rehabilitation, and rehabilitation counseling in the US have inspired the rehabilitation systems in several Asian countries. However, in spite of numerous efforts to enhance the quality of life of people with disabilities in Asian countries, there are still several social barriers and unscientific service approaches which may not be proven by effective research results. The rehabilitation system in these countries would have been more developed if researchers and professionals had applied the evidence-based practices into specific rehabilitation services. Therefore, the purpose of this paper is to describe the evidence-based practices and research outcomes in the US, as well as to suggest specific applications and recommendation for future rehabilitation services in Asian countries.

Ⅱ. Evidence-Based Practices

Since the Congress passed the Health Maintenance Organization Act in 1973, the American healthcare systems has experienced a considerable revolution in implementing managed care measures which designed to control the rising costs of health care services (Mullen, 1995 as cited in Chronister et al., 2005). This new model of health care system has changed the rehabilitation healthcare system and compelled researchers and clinicians to provide evidence to support the efficacy of their services.

According to Drake et., (2003b), “Evidence-based practices are interventions for

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which there is consistent scientific evidence showing that they improve client outcomes" (p. 2). Also, evidence-based practice should be comprehended by a total processes; what clinical questions to ask, how to achieve the best practice, and how to essentially assess the evidence for authenticity to the specific care situation. Further, a clinician has to apply the best data to the consumer's exclusive values and needs. Ultimately, the effectiveness of care and the improvement has to be evaluated continuously (DePalma 2002, as cited in Chronister et al., 2005). In order to confirm these processes and improve the quality of services, the several criteria should be adhered to.

1. Operational Criteria

At first, the practice should be obviously identified, have a list of practice standards, and be evaluated by rigid principles. Also, a clinician must be provided with a practice manual which provides specific instructions for its performance. Further, the target group for evidence-based practices should be specified (Bond and Campbell, 2004).

In particular, to illustrate the best evidence for evidence-based practice, a series of research study results should prove the effectiveness of a detailed treatment approach. As a gold standard for scientific evidence, randomized clinical trials should have been fulfilled (Chronister et al., 2005). The basic idea of randomized clinical trial is that treatments are allocated to subjects at random. This ensures that the different treatment groups are statistically equivalent. Further, Chambless and Ollendick (2001) stated that at least 2 precise experimental studies showing therapy should be better than placebo or another treatment. In order to confirm this effect, meta-analysis could be another gold standard for proving effectiveness.

According to Bond and Campbell, "the practice must demonstrate the capacity to be implemented in a wide range of settings" (2005, p. 6). In particular, the implementation of a practice could be generalized in various settings. Therefore, research limitations such as cost, complexity of the intervention, and biased intentions of researchers must be carefully considered before applying the practice to specific settings.

2. Three Levels of Evidence

In order to score evidence-based practices, the Agency for Healthcare Research and Quality has classified levels of scientific evidence. The agency developed the diverse practice guidelines in the 1990s and exemplified this approach by using three levels of evidence: Level A is defined by good research-based evidence, with some expert

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opinion. Level B refers to fair research-based evidence, with considerable expert opinion, to support the recommendation. Level C indicates a recommendation based primarily on expert opinion, with minimal research-based evidence (Drake et al., 2003b). By categorizing these levels, researchers and practitioners could easily distinguish statistical and clinical significance, clinical utility, and cost-effectiveness between various research outcomes.

3. Evidence-Based Practices in Rehabilitation Applications

Initially, Evidence-Based Practices were interventions which improve client outcomes in the medical model. From 1980, evidence-base practices have expanded significantly in rehabilitation system. However, in spite of similar theoretical rationale, comparing to the medical model, the rehabilitation application of evidence-based practices has a couple of specific distinctions. Primarily, the main outcome of rehabilitation practices is usually at the level of activities or participation, and various factors influence these outcomes beyond the treatments. Further, the central aspects of rehabilitation seem to be associated with more to process than specific interventions (Wade, 2006). For example, supported employment programs are extraordinarily effective of the employment of people with specific disabilities, but the employment outcomes could be associated with the various factors such as socio-economic status, education, social support, and demographic variables. Therefore, rehabilitation researchers and practitioners should carefully consider these unique differences when facilitating rehabilitation services and researches.

Ⅲ. Evidence-Based Practices in Psychiatric Rehabilitation

Innumerable empirical researches have demonstrated that rehabilitation applications of evidence-based practices are effective in improving the lives of people with disabilities. Researchers from various fields have attempted to distinguish which factors in rehabilitation processes impact outcome variables and how evidence-based practices improve the quality of rehabilitation interventions. In order to demonstrate specific rehabilitation applications of Evidence-Based Practices, factors, programs and evidence which were applied in people with psychiatric disabilities will be presented.

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1. Demographic Factors

Over the past few decades, a number of studies have studied the relationship

between clinical and demographic factors and later vocational outcomes of persons with disabilities. According to Anthony and Jansen (1984), employment history, one of the demographic variables, is the most predictive of future vocational outcome, accounting for between 27%-53% of the variance in employment status of people with mental illness. Also, vocational outcomes have been examined to correlate with the other clinical and demographic factors such as number of previous hospitalizations, length of last hospitalization, marital status, race, and occupational level (Rogers et al., 1997).

Researchers have struggled to find the relationship between employment outcome and psychiatric symptoms. A variety of studies have indicated that there is little relationship between future work performance and various assessments of psychiatric symptoms. However, Tsuang and Coryell (1993) conducted long-term follow-up studies with respect to rehabilitation outcomes. Results indicate that psychotic-like features were connected with poorer role functioning and low employment outcomes.

An additional outcome study was conducted by Rogers et al., (1997) to examine the relationship between the clinical and demographic variables and vocational outcome for persons with psychiatric disabilities. The authors administered clinical, demographic, work skills, and vocational outcome measurements to 275 individuals at three psychosocial rehabilitation centers. During 39 months, vocational outcomes data were collected quarterly. Results indicate that demographic variables are correlated with work skills and future vocational outcomes. Nonetheless, the authors indicate, “Diagnostic category was not predictive of work outcome” (p. 110) even though the research may have some limitations with respect to reliability of measures of symptomatology.

2. Cognitive and Clinical Factors

In attempting to discern the possible role of cognitive impairments which impact social and occupational deficits of people with schizophrenia, Green (1996) indicated these cognitive impairments as ‘rate-limiting’ factors for success in both social and occupational domains of outcome. Numerous studies have found that cognitive function is related with parallel measures of adaptive function such as work performance. Over the past few years, researchers have chiefly examined the predictive utility of cognitive performance on future vocational success. In numerous studies, the results show a shared conclusion: that cognitive functioning was associated with competitive employment among a group of people with psychiatric disabilities.

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More recently, in order to examine how cognitive impairments in schizophrenia are associated with social problem solving, social and vocational functioning, and psychosocial skill acquisition, Evans et al., (2004) attempted to examine the relationship of cognitive functioning, as well as clinical symptoms, to vocational outcomes among people with schizophrenia. 112 individuals with schizophrenia were administered by the neuropsychological measurements such as verbal learning, and memory, attention, speed of information processing, and executive functioning. In order to evaluate clinical symptoms, employment outcome and work performance, the Positive and Negative Syndrome Scale (PANSS) and the Work Behavior Inventory (WBI) were administered. Results indicate that negative symptoms, learning and memory performance, processing speed, and executive functioning were associated with hours, weeks, and wages earned on the job.

Taken together, to succeed in the vocational rehabilitation for people with schizophrenia, two factors are vital; professionals should find and support the appropriate jobs for people with schizophrenia. Also, individuals with schizophrenia may have the proper work behaviors and skills necessary to retain a competitive employment.

3. Individual Placement and Support (IPS) Program

By 1987 supported employment programs had been applied to the psychiatric rehabilitation field (Bond et al., 2001). A paradigm shift occurred lately in understanding the course of people with psychiatric disabilities: Recovery in not only a possibility, but the goal (Ralph & Corrigan, 2004 as cited in Corrigan & McCracken, 2005).

In order to understand the current supported employment model, both Train-Place model and Place-Train model will be briefly addressed. In Train-Place model, service providers seem to view recovery as an outcome that must be accomplished before vocational and independent living goals can be achieved. On the contrary, in the Place-Train model, recovery occurs when people pursue their personal goals in spite of experiencing symptoms and disabilities. Also, recovery as a process provides a possibility to accomplish goals for people with psychiatric disabilities who may never be completely free of symptoms. Therefore, recovery at work only takes place when the person is on the job at real-world employment (Corrigan & McCracken, 2005).

According to Drake et al., (1996), the Individual Placement and Support (IPS) model has become an important issue in rehabilitation field over the past two decades. The authors attempted to compare Individual Placement Support (IPS) program and Group Skills Training (GST) in two distinctive sites. They surveyed 143

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adults with severe mental illness by several standardized instruments such as the Employment and Income Review, the Global Assessment Scale, the expanded Brief Psychiatric Rating Scale, the Rosenberg Self-Esteem Scale, and the Quality of Life Interview which were administered by volunteers. Also, participants were assessed at baseline, 6, 12 and 18 months. Results indicate that the IPS program is more successful at helping people with severe mentally disability to achieve competitive employment. Also, people in IPS obtained jobs faster and maintained their improvement during the 18 months of the study.

4. Further Evidence for an Evidence-Based Practice

A number of specific program elements such as reasonable case size, diverse employment settings, assertive outreach, and benefit counseling seem to have the relationship with better employment outcomes. Also, in order to clarify critical ingredients, client factors, community and economic factors, and program factors, further research is needed to refine these critical factors of supported employment (Bond et al. 2001).

An outcome study conducted by Jones, Perkins & Born (2001) attempted to examine the relationship between amounts of supported employment provider time devoted to travel, training, and non-employment advocacy and obtaining competitive work of people with psychiatric disabilities. Results indicate that there is a strong positive relationship between amounts of time and employment.

In attempting to uncover the factors that contributed to differences in competitive employment rates for people with severe mental illness between high and low performing programs, Gowdy, Carlson, and Rapp (2004) compared the five programs with the highest competitive employment rates to the four lowest performing programs. Results find notable and reliable differences between high performing group (5 programs) and low performing group (4 programs) in administrative practices and the roles of case managers and therapists. Unique differences were found in the practices of the two groups of programs; Program leaders in high performance emphasized the value of work talked to staff and consumers about employment. Program leaders in high performance discussed the strengths model, strengths training, or the strengths perspective of people with psychiatric disabilities. Also, program leaders in high performance tend to use vocational data to guide programming and practice. In high performance programs, staff do not view stigma against individuals with mental illness as a barrier to consumer's ability to obtain employment. Further, staff considers that consumers have a desire and motivation to work (Gowdy et al, 2004).

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Further, the authors show five ingredients which affect employment outcomes between high performance and low performance groups (Bond et al., 1999 as cited in Gowdy et al., 2004). High performance groups have frequent team meetings and a teamwork approach between case managers and other staff. Also, they show systematic ways of informing consumers about supported employment services. Further, the high performance group excels in rapid approval from vocational rehabilitation and rapid initial assessment. Finally, high performance group might focus on minimizing prevocational programming.

Ⅳ. Strategies for Disseminating the EBP to Asian Countries

Although many funds and innumerous efforts spent for establishing evidence-based practices, service providers may refuse to accept these innovations into their day-to-day service situation (Corrigan et al, 2003). This delay might be explained by a couple of barriers related to distribution and implementation of evidence-based practices.

For the most part, the lack of the basic knowledge and skills to incorporate evidence-based practices is one of the most critical barriers. Also, professionals' work-related factors such as burning out might weaken their interest with respect to new and innovative practices. Further, due to organizational barriers such as poor leadership, a change-averse culture, insufficient collegial support and bureaucratic restrictions, the team approach, one of the most important principles in evidence-based practices, might not be implemented and maintained (Corrigan et al, 2003).

According to Argyris (1993, as cited in Goldman et al, 2003), "the results of experimental studies that involve human interaction may not generalize to any great degree to typical treatment circumstances, because the complexity of social system cannot be captured in controlled experiments" (p. 111). At this point, although numerous rehabilitation programs and theories for people with disabilities were introduced from other countries to Asian countries, there are still several social barriers and unscientific service methods. Further, a number of professionals are complaining about the effectiveness of theories and programs which were initiated from other countries due to the complexity and difference of social and economic system between each nation. Therefore, the new theories and programs applied to Asian countries' rehabilitation systems necessitate critical thinking and flexible attention of professionals and researchers. In terms of evidence-based practices,

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professionals and researchers must discern how the evidence-based practices impact the unique cultural, social, and economic circumstances in Asian countries.

1 . Applications and Recommendations

In order to apply and disseminate evidence-based practices into Asian countries' rehabilitation services, several applications and recommendations will be addressed.

In the beginning, it is difficult to apply the principles of evidence-based practice to rehabilitation research and services straightforwardly. Also, to design and carry out well-controlled and highly defined studies on rehabilitation programs are not easy tasks (Cicerone, 2005). However, the same concerns have been pronounced many times before in the US. The rehabilitation system in several Asian countries is at the early stage of developing. Therefore, professionals and researchers in these countries must start these rigorous and demanding methods to make good clinical decisions and improve the quality of life of people with disabilities.

Particularly, to make evidence-based practices more accessible to staff, the development of treatment manuals and practice guideline is a crucial part. Also, these manuals might explain the specific steps which accomplish the goals of services (Corrigan et al, 2003). In some Asian countries, there are no proper treatment manuals and practice guideline for enhancing evidence-based practices to line-level professionals. To initiate these approaches, the evidence in the US could be applied and used in Asian countries' rehabilitation systems. However, in this process, professionals and researches must consider the differences of each social system and have the flexibility which enables modifications to establish the evidence-based practices in Asian countries' rehabilitation system. It might be beneficial to establish the research institutes which manage, collect, publish, and computerize the theories and contents of the evidence-based practices.

Further, it is imperative to train professionals to learn evidence-based practices. Education programs might target two different groups such as students and professionals in rehabilitation. Also, several researches indicate that professionals who complete evidence-based practice training programs have improved attitudes about innovative practices (Corrigan et al, 2003). Therefore, training system with respect to evidence-based practices in Asian countries must be founded in a short period of time. As a result, professionals might facilitate innovative practices and strengthen the quality of rehabilitation services.

Taken in total, although there are still several social barriers and unscientific service approaches which may not be proven by effective research results in several Asian countries' rehabilitation system, this system also has a great deal of

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possibility and optimism. In order to offer effective rehabilitation services to people with disabilities, rehabilitation professionals and researchers in these countries must understand the concept and process of evidence-based practices and apply these innovative practices to specific rehabilitation programs. By integrating existing advanced knowledge and information of evidence-based practices, professionals could enhance the quality of life of people of disability. Also, the rehabilitation system in Asian countries might be upgraded into an ideal direction.

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原著論文 3

特別支援教育に携わる教師としての専門性とバーンアウトとの関連
―教員に対するメンタルヘルスチェックの分析結果から―

Relationship between Teacher Expertise that Involved in Special Needs Education and Burnout Syndrome
― From the Analysis of Mental Health Check for Teachers―

森　浩平 1)（Kouhei MORI）　田中　敦士 2)（Atsushi TANAKA）

1)　琉球大学大学院　教育学研究科
〒903-0213　沖縄県中頭郡西原町千原１　琉球大学教育学部特別支援教育講座
ktv_m_kohei@yahoo.co.jp
2)　琉球大学　教育学部
〒903-0213　沖縄県中頭郡西原町千原１　琉球大学教育学部特別支援教育講座
atanaka@edu.u-ryukyu.ac.jp

ABSTRACT

本研究では、特別支援教育に携わる教師としての専門性とバーンアウトの関連について明らかにし、教師のストレス低減 の方法を検討することを目的とする。特別支援学校教諭免許状を未取得で特別支援教育に携わる教員に対するメンタルヘルスチェックの結果から、専門性の低い群は個人的達成感の後退に陥りやすいということが明らかとなった。また、教職経験年数とバーンアウトには関連性はみられなかった。教職経験年数に関わらず、専門性を高めることが個人的達成感の後退に陥ることを防ぎ、バーンアウトの改善へと繋がることが示唆された。

The purpose of this research is to disclose the expertise of special needs education relating to burnout syndrome and finding a way to reduce their stress. From the analysis result of mental health check of teachers that engaged in special needs education who doesn't have the special needs education license, it shows that the group with low expertise tends to fall into regression of personal accomplishment

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sense. There is no relationship between years of teaching experience and burnout. Without regarding to teaching experience, it is suggested that elevating the expertise could prevent teachers falling into regression of personal accomplishment sense and could refine burnout.

＜Key-words＞
バーンアウト, 専門性, 教師, 特別支援教育, メンタルヘルス
burnout, expertise, teacher, special needs education, mental health
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Ⅰ. 問題と目的

１．心理社会的ストレス研究の動向

現代社会はストレス社会と呼ばれるように、人は日常生活の中で少なからずストレスに晒され続けている。こうした逃れられないストレスによるうつ病等の精神疾患の増加、自殺者も年間 3 万人を超え、近年大きな社会問題として多くのメディアにとり扱われている。

このように社会に溢れている様々なストレッサー（ストレスを引き起こす刺激）とメンタルヘルスの関係について、様々な観点から分析した研究が数多く存在する。

これまでの心理社会的ストレス研究の先駆けとなったのは、「社会再適応評価尺度（Social Readjustment Rating Scale)」を作成し、個人のストレス量を査定することを試みた Holmes&Rahe（1967）の研究である。彼らは、生活上の変化をもたらす何らかの出来事を経験した場合、社会的に再適応する際に必要とされる労力をその出来事のストレス量として数値化し、その数値の合計が高いほど、将来病気に罹患する可能性が高いことを指摘した（岡安・片柳・嶋田ら，1993)。

こうしたストレスイベントに直面した場合、人はそこからストレスを少しでも低減するために何らかの行動を起こす。こうした行動を「コーピング（対処行動：coping behavior)」と呼ぶ。今田・上村（2001）は、このコーピングを積極的対処行動・適応的対処行動・逃避的対処行動の 3 因子 17 項目に分類している。また、コーピングはストレッサーが人の心身に及ぼす影響を調整する重要な要因であり、ストレッサーとそれによって生じるストレス反応との間に介在する変数として捉えられる（福岡，2001)。

日本では、坂田（1989）がコーピングの多面的分類を行い、19 因子 58 項目のコーピング尺度を作成した。さらに尾関（1993）は、坂田のコーピング尺度を最終的に 3 因子（「問題焦点型」、「情動焦点型」、「回避・逃避型」）14 項目に集約している。問題焦点型とは、情報収集や再検討などの問題解決に直接関与する行動であり、情動焦点型とはストレッサーにより引き起こされる情動反応に焦点をあて注意の切り替えや気持ちの調節

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などの行動である。また、回避・逃避型とは不快な出来事から逃避したり否定的に解釈したりするなどの行動である。実際にストレスを受けたとき、これらのコーピングは同時にあるいは継続的に行われ、相互に影響しあうことが多いと言われている。また、同じ出来事を経験しても、どのようなコーピングを行うかによって、結果として生じる心理的・身体的ストレス反応は異なってくる。コーピングは、ストレッサーが人の心身に及ぼす影響を調節する要因であり、ストレッサーとそれによって生じるストレス反応との間に介在する変数である（福岡，2001）。

近年の社会的ストレス研究では、生活ストレッサーと健康との直接的な関連性よりも、ストレス過程に影響を及ぼす要因やストレッサーのインパクトを緩衝する要因を究明することに大きな関心が向けられている（岡安・片柳・嶋田ら，1993）。

２．教師のメンタルヘルス悪化の問題

石川・中野（2001）が小・中学校・高等学校に所属する教師を対象におこなった調査では、日常の仕事の中でストレスを「非常に感じる」あるいは「感じる」と答えた教師が半数以上を超えている。このような調査から、子どもの成長を支える教師たちが、今、自分自身の危機に曝されていると言える（田上・山本・田中，2004）。

このような深刻な状況の中にあり、多くの教師のストレス改善のための研究が増え、教師のバーンアウト（燃え尽き症候群）に目を向けようといった動きが強まっている。こうした中で提唱された「教師バーンアウト」は、特に教師に限定した概念で、「教師が、理想を抱き真面目に仕事に専心する中で、学校のさまざまなストレスに晒された結果、自分でも気づかぬうちに消耗し極度の疲弊をきたすに到った状態」と定義されている（田上・山本・田中，2004）。かつて国際労働機関（ILO）が指摘したように「教師たちは戦場並みのストレスに晒されている」と言っても過言ではない（赤岡・谷口，2009）。

Maslach＆Jackson（1981）は、1,000 人を超える対人専門職を対象に調査研究を行い、バーンアウト傾向を測定する“Maslach Burnout Inventory”を開発した。この MBI は、３つの尺度、①情緒的消耗感、②脱人格化、③個人的達成感から成っている。MBI 尺度は、尺度研究の発展の契機となり、多くの研究者によって取り上げられた。バーンアウト尺度の研究は MBI を基幹として発展してきたといえる（落合，2003）。

教師のストレスの要因を高木・田中（2003）は職務自体・職場環境・個人的（家庭内）の 3 つの要因が影響しており、バーンアウトとの関連性があることを指摘している。このうち職場環境の影響によるストレッサーに関しては、役割葛藤・同僚との関係・組織風土・評価懸念の 4 因子 25 項目に分類がされている。

文部科学省の教育職員に関する統計調査（2010）によると、全国の公立小・中・高校、特別支援学校などの教員約 92 万人のうち、病気休職者が 8627 名、精神疾患による休職者は 5458 名で、休職者の約 63%が精神疾患という事態に陥っている。精神疾患に陥る教師は年々増え続け、教師のストレス増加に歯止めがかからない状態が依然続いている。

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３．特別支援教育に携わる教師の専門性とメンタルヘルスの関連

「教員の地位に関する勧告」（UNESCO，1966）では教師の仕事を専門職として定義し、「厳しい継続的な研究を経て獲得される専門的知識及び特別な技術を要求する公共的業務」と規定し、障害児教育教師の「専門性」は、複雑な教育的ニーズを抱えた障害児の増加を踏まえ、通常教育教師との専門性の差異は量的な差異とともに質的な差異も包含している（清水，2003）。

教職員の勤務の実態や意識に関する分析委員会（2008）によって沖縄県の公立小・中・高校、特別支援学校に在籍する本務職員 12,760 人を対象にした調査が行われ、「日頃、悩んでいること」について、「特になし」（29.4%）が最も多く、次いで「教師としての適性」（24.4%）、「子育て」（9.8%）、「自分の病気」（6.7%）の順であった。「教師としての適性」に悩んでいる教員の割合が４分の１を占めた。他の悩みに比べて特に多い結果となっている。

特殊教育から特別支援教育へと変わり、障害種の拡大・重度・重複化に伴う一人一人のニーズに応じた適切な指導及び支援の必要性、学校と福祉・医療・保健・労働機関等との連携など特別支援教育教員に求められる専門性は非常に高まっていると言える。こうした現状の中で特別支援教育に携わる教師のストレスも高まっていくことが考えられる。

４．目的

本研究では、特別支援教育に携わる教師のバーンアウトについて、教職経験年数、教師としての専門性、特別支援教育についての専門性等との関連性について分析し、教師のストレス低減のための対処法を検討することを目的とする。

Ⅱ．方法

１．調査対象

特別支援学校教諭免許状未所得で、障害児の指導を担当している教員 103 名を対象に質問紙調査を実施した。

２．手続き

2009 年 8 月 5 日の沖縄県教育職員免許法認定講習の休憩時間において、調査の趣旨説明を行いプライバシーの配慮をしたうえで調査票を 103 名へ配布、同日中に 94 名から回収した。個人結果の開示を希望した者に対しては、翌日に結果の一部を番号札と引き換えにフィードバックするものとした。

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3．調査内容

質問紙調査の内容は以下の通りである。

（1）フェイスシート

回答者の基本属性

・年齢

・性別

・教職経験年数

フェイスシートでは、回答者の基本属性として性別・年齢・教職経験年数についてたずねた。

（2）教師としての専門性・特別支援教育教師としての専門性の自覚度

適当な既存尺度がなかったため、「教師としての専門性をどの程度身につけていると思いますか？」「特別支援教育についての専門性をどの程度身につけていると思いますか？」の各１項目で専門性についてたずね、「１．ほとんど身についていない」「２．あまり身についていない」「３．どちらともいえない」「４．やや身についている」「５．よく身についている」の５件法で回答を求めた。

（3）バーンアウト尺度

バーンアウト(burnout ；燃えつき症候群)の症状を測定する尺度で、Maslach&Jackson (1981)に準拠して作成した田尾(1989)の尺度をさらに久保・田尾(1992)が改訂したものである。久保・田尾によって、信頼性・妥当性ともに確認されている。本尺度は、「情緒的消耗感」「脱人格化」「個人的達成感」の３因子から構成されていて、17 項目から成り、「1．ない」「2．まれにある」「3．時々ある」「4．しばしばある」「5．いつもある」の 5 件法で回答し、各因子の項目の評定値を加算後、項目数で除算した値が得点となる。

Ⅲ. 結果

1．フェイスシート

（1）回収率

本研究における調査のアンケート回収率は 103 名中、有効回答数は 94 名で、回収率は 91.3%であった。内訳は、男性 27 名（28.7%）、女性 65 名（69.1%）、不明 2 名（2.1%）であった。

（2）回答者の年齢

回答者の年齢については、「35 歳以上 40 歳未満」と回答した人が一番多く、27 名（28.7%）であった。次いで、「40 歳以上 45 歳未満」が 23 名（24.5%）、「30 歳

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以上 35 歳未満」が 16 名（17.0%）、「45 歳以上 50 歳未満」が 12 名（12.8%）、「50 歳以上 55 歳未満」が 6 名（6.4%）、「25 歳以上 30 歳未満」が 5 名（5.3%）、「55 歳以上」が 2 名（2.1%）、「25 歳未満」が 0 名（0.0%）、不明は 3 名（3.2%）であった。

（3）回答者の通算教職経験年数

回答者の通算教職経験年数の平均は 14.7 年（SD 6.6 年）であった。最大は 29 年、最小は 2 年 4 ヵ月であった。

通算教職経験年数が 1 年から 10 年未満の教員を「若手教員群」、10 年以上 20 年未満の教員を「中堅教員群」、20 年以上の教員を「ベテラン教員群」とした結果、「若手教員群」は 25 名（27.5%）、「中堅教員群」は 38 名（41.8%）、「ベテラン教員群」は 28 名（30.8%）となった。

（4）教師としての専門性の到達度

回答者の教師としての専門性の到達度については、「身についている」と回答した人が最も多く、38 名（40.9%）であった。次いで、「どちらともいえない」が 30 名（32.3%）、「あまり身についていない」が 22 名（23.7%）、「よく身についている」が 2 名（2.2%）、「ほとんど身についていない」が 1 名（1.1%）であった。教師としての専門性が「ほとんど／あまり身についていない」と答えた教員は、全体の約４分の１であった。

回答者の教師としての専門性の到達度にばらつきがあったため、３つのカテゴリーに分類した。教師としての専門性が「ほとんど／あまり身についていない」と自覚している人を「低専門性群」、「どちらでもない」と自覚している人を「中専門性群」、「やや／よく身についている」と自覚している人を「高専門性群」とした。その結果、「低専門性群」は 23 名（24.7%）、「中専門性群」は 30 名（32.3%）、「高専門性群」は 40 名（43.0%）であった。

（5）特別支援教育教師としての専門性の到達度

回答者の特別支援教育教師としての専門性の到達度については、「あまり身についていない」と回答した人が一番多く、35 名（37.6%）であった。次いで、「ほとんど身についていない」が 24 名（25.8%）、「どちらともいえない」が 17 名（18.3%）、「やや身についている」が 16 名（17.2%）、「よく身についている」が 1 名（1.1%）であった。特別支援教育教師としての専門性が「ほとんど／あまり身についていない」と答えた教員は、全体の約３分の２であった。

回答者の特別支援教育教師としての専門性の到達度にばらつきがあったため、３つのカテゴリーに分類した。特別支援教育教師としての専門性が「ほとんど／あまり身についていない」と自覚している人を「低専門性群」、「どちらでもない」と自

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覚している人を「中専門性群」、「やや／よく身についている」と自覚している人を「高専門性群」とした。その結果、「低専門性群」は 59 名（63.4%）、「中専門性群」は 17 名（18.3%）、「高専門性群」は 17 名（18.3%）であった。

２．バーンアウト（燃え尽き症候群）尺度

（１）通算教職経験年数別の比較

通算教職経験年数の 3 グループ「若手教員群」「中堅教員群」「ベテラン教員群」を独立変数、バーンアウトの下位尺度「情緒的消耗感」「適応的対処行動」「逃避的対処行動」を従属変数とした分散分析を行った。表 1 に各下位尺度の群別得点と分散分析の結果を示す。その結果、「情緒的消耗感」「適応的対処行動」「逃避的対処行動」のいずれにおいても有意な群間差はみられなかった。

表 1　　3 群のバーンアウト下位尺度平均点

	n	情緒的消耗感	脱人格化	個人達成感の後退
若手教員群	25	16.04±5.48	23.72±4.05	17.52±3.47
中堅教員群	38	14.11±4.55	22.13±5.24	19.00±4.13
ベテラン教員群	28	14.64±4.31	23.64±4.28	18.82±3.87
F		1.27	1.23	1.21
主効果(*p*)		n.s.	n.s.	n.s.

＊ $p<.05$

（２）教師としての専門性の到達度の比較

教師としての専門性の到達度の３つのグループ「低専門性群」「中専門性群」「高専門性群」を独立変数、バーンアウトの下位尺度「情緒的消耗感」「脱人格化」「個人達成感の後退」を従属変数とした分散分析を行った。表 2 に各下位尺度の群別得点と分散分析の結果を示す。その結果、「個人達成感の後退」において、$F(2, 90)=1.98$ であり 0.1%水準で有意な群間差がみられ、「低専門性群」＞「中専門性群」＞「高専門性群」という結果が得られた。

表 2　　3 群のバーンアウト下位尺度平均点

	n	情緒的消耗感	脱人格化	個人達成感の後退
低専門性群	23	12.91±4.57	22.30±4.27	20.87±3.36
中専門性群	30	14.87±4.94	22.33±5.20	18.40±3.00
高専門性群	40	15.32±4.65	23.70±4.21	17.30±4.13
F		1.98	1.04	7.15
主効果(*p*)		n.s.	n.s.	*

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＊$p<0.05$

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（3）特別支援教育教師としての専門性の到達度の比較

教師としての専門性の到達度の 3 つのグループ「低専門性群」「中専門性群」「高専門性群」を独立変数、バーンアウトの下位尺度「情緒的消耗感」「脱人格化」「個人達成感の後退」を従属変数とした分散分析を行った。表 3 に各下位尺度の群別得点と分散分析の結果を示す。その結果、「個人達成感の後退」において, $F(2, 90)=2.86$ であり 0.1%水準で有意な群間差がみられ、「低専門性」＞「中専門性群」＞「高専門性」という結果が得られた。

表 3　　3 群のバーンアウト下位尺度平均点

	n	情緒的消耗感	脱人格化	個人達成感の後退	
低専門性群	59	14.07±4.71	22.71±4.71	19.07±3.73	
中専門性群	17	15.24±5.11	23.47±4.27	18.65±3.66	*
高専門性群	17	15.71±4.71	23.06±4.56	16.59±4.05	
F		0.97	0.19	0.06	
主効果(*p*)		n.s.	n.s.	*	

*p<0.05

Ⅳ. 考察

１．通算教職経験年数とバーンアウトの関連

通算教員経験年数の３つのグループ「若手教員群」「中堅教員群」「ベテラン教員群」において、今回のデータからは有意な得点差は認められなかった。このことから、教員としての経験年数の差はバーンアウトを引き起こす重要な因子とはならないことが示された。教職経験年数に関わらずバーンアウトに陥るリスクがあり、経験年数に関わらず職務や人間関係等の職場環境の改善が必要と考えられる。学校という組織において教員が働きにくい環境とならないためにも、職場環境について今後検証する余地がある。

２．教師としての専門性と特別支援教育教師としての専門性

教師としての専門性において「ほとんど身についてない」「あまり身についていない」と答えた教員は 24.7%であり、同様に特別支援教育教師としての専門性において「ほとんど身についていない」「あまり身についていない」と答えた教員は 63.4%であった。

今回のデータより、教師としての専門性は身についていると自覚しながらも、特別支援教育教師としての専門性については自身を持つことができていない教員が多数存在していることが示された。特殊教育から特別支援教育へと変わり、障害種の拡大・重度・重複化に伴う一人一人のニーズに応じた適切な指導及び支援の必要性、学校と福祉・医療・保健・労働機関等との連携など特別支援教育教員に求められる専門性の高まりに伴

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って、教師達の関心が特別支援教育へと向けられたことが影響していると考えられる。

また、専門性とバーンアウトの関連性については、教師または特別支援教育教師としての専門性の双方において同様の傾向がみられた。教師または特別支援教育教師としての専門性が、メンタルヘルスへの影響因子であることが明らかとなった。

３．専門性とバーンアウトの関連

「教師としての専門性」「特別支援養育教師としての専門性」の３つのグループ「低専門性群」「中専門性群」「高専門性群」とバーンアウトの関連において有意な得点差が認められ、専門性が低ければ低いほど個人達成感の後退に陥りやすいことが明らかとなった。これは専門性が低いと感じている教員ほど、仕事に達成感や有能感を感じられない（またはその逆）ということを示している。

特別支援学校においては知的障害、肢体不自由、盲、聾、病弱のすべての領域において対応できることが求められており、少なからず手探り状態のままで仕事をしている現場もあると考えられる。また特別支援教育において、発達的視点についての専門性の低さから、児童・生徒の成長に気づくことが出来ず達成感を感じることが出来ていないとも考えられる。専門性が教師のバーンアウトに関わっていることは明らかであり、さらに具体的にどういった専門性が現場の教員に求められ、メンタルヘルスと関連しているのかを今後検証する必要がある。

付　　記

本研究は、科学研究費補助金基盤研究（C)「特別支援教育にかかわる教員の専門性とメンタルヘルスとの関連に関する実証的研究（研究代表者；田中敦士　課題番号21531032)」の助成を受けて行った。調査に協力くださいました学校教員の方々および情報提供を頂きました研究協力者の皆様方に感謝いたします。

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ORIGINAL ARTICLE 4

Study on the Institution, Law and Finance of Special Education in South Korea

Chang-Wan HAN[1)] , Moon-Jung KIM[2)]

1) The Center for Research and Development of Higher Education, Saga University
Graduate School of Economics and Management、 Tohoku University
Department of Internal Medicine and Rehabilitation Science, Tohoku University Graduate School of Medicine
#1308, 5-1-1, Nabesima Saga, 849-8501 Japan
Graduate School of Medicine, Saga University
hancw917@gmail.com

2) Graduate School of Economics and Management, Tohoku University
moonjung87@gmail.com

ABSTRACT

This study aims to understand the actual conditions of Institution, law and finance of special education in South Korea based on the diverse papers and to suggest improvement plans by considering the immediate problems of special education.

In South Korea, special education for disabled people is specifically prescribed in the Constitution, the Framework Act on Education, the Elementary and Secondary Education Act and the Act on Special Education for Disabled Persons, Etc.

In South Korea, it was reported that the persons subject to special education were 79,711 students and 150 special schools and 7,792 special classes have been installed in April, 2010.

Teaching certification of qualification for special education is stated in the Public Education Officials Act; there are 6,733 special education teachers in special schools and 8,271 special education teachers in general schools in April, 2010.

The total budget for the students who are the persons subject to special education is 1667.6 billion won; 1623.5 billion won for city and provincial offices of education, 41.4 billion won for national special schools and 2.6 billion won for national special

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classes.

Based on the current situation of special education, improvement plans are suggested as follows:

First, certifying process of special education teachers has to be standardized in the state level. In addition, the entrance quota of universities and graduate schools needs to be rationalized, considering the demand and educational needs by the disability-type, subjects and courses

Second, inclusive education has to be implemented according to the types and degrees of disabilities and the legal and institutional improvement is needed to provide tailored education according the types of disabilities.

Third, the plans to stably secure the financial resources have to be found by analyzing the factors to affect them.

＜Key-words＞

Special education institution, Act on Special Education for Disabled Persons, Etc. Financial Resources of special education, Current situation of the persons subject to special education

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Ⅰ. Introduction

The education for people with disabilities enables them not only to develop their latent ability and get out of the persons subject to protection for the weak, but also to live their independent life. In addition, the increase of social participation and activities of people with disabilities improves the interest of society as well as themselves and becomes the important factor for social integration (Dong-il Kim, 2004).

Therefore, the special education for people with disabilities has to vary the contents and methods of education based on the types and degree of disabilities to provide the most appropriate education for children with disabilities. Special education has to employ various educational measures, for it requires the therapeutic education, proper vocational guidance and medical services as well as simple subject education (Bong-do Jeong, 1991).

The ultimate purpose to provide education opportunity for people with disabilities is their perfect integration to society. The perfect integration to society is to enable people with disabilities not to restrict or isolate them as members of society, that is to

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say, to expand various social activities of people with disabilities (Dong-il Kim, 2004)

In December, 2009, the population of registered disabled persons is 2,429,000, which is 153.6% of increase comparing with its population in 2000 (Korea Employment Promotion Agency for the Disabled, 2010 Disability Statistics). The population of registered disabled persons has increased every year and simultaneously the number of students with disabilities who have given special education has also increased; in April, 2010, 79,711 of the persons subject to special education have been taught in special schools and special classes or general classes in general schools (Ministry of Education, Science and Technology, 2010 Annual Report on Special Education). The continuous increase of population with disabilities and persons subject to special education has raised the concern about the welfare and education for the disadvantaged based on the respect for the integrity and diversity of human being in South Korea. Especially as the education for people with disabilities has been emphasized, the concern and support for special education have increased (Hyun-sil Ha, 2010).

This study aims to understand the actual conditions of institution, law and finance of special education based on the diverse papers in South Korea and to suggest improvement plans by considering the immediate problems of special education.

Ⅱ. Current Situation of Special Education in South Korea

1. Institution of Special Education

1) Students as the Persons Subject to Special Education

The persons subject to special education prescribes as the person who needs special education pursuant to the Article 15, Act on Special Education for Disabled Person, Etc. Special education has to be implemented to satisfy the educational needs of persons subject to special education to special education by providing both curricula suitable for each characteristics and service related to special education for the people with disabilities including visual disability, hearing impairment, mental retardation, physical handicapped, emotional disturbance, behavioral disorder, autistic disorder, communication disorder, learning disorder, health impairment and developmental retardation, etc.

In South Korea, the population subject to special education has grown to 79,711 in April, 2010 from 4,524 in 2009. The numbers of people subject to special education by the types of disabilities has ranked as 42,690 people with mental retardation, 10,369 with physical handicap, 1,394 with developmental retardation and 1,591 with

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communication disorder in descending order.

The population subject to special education by educational courses was the highest in elementary school and the least in the course for infants with disabilities; 35,294 and 290 respectively.

The increase of students subject to special education is because of the increase of registered students subject to special education due to the expansion of educational opportunity and the reinforcement of service for students subject to special education (Ministry of Education, Science and Technology, 2010 Annual Report on Special Education).

Table 1 Number of Students Subject to Special Education

Type of Disability		Number of Special Schools	General Schools		Special Education Support Center	Total
			Special Classes	General Classes		
Total Number of Students Subject to Special Education		23,776	42,021	13,746	168	79,711
Disabilities	Visual Disability	1,563	390	428	7	2,398
	Hearing Impairment	1,150	1,056	1,491	29	3,726
	Mental Retardation	15,316	23,806	3,537	31	42,690
	Physically Handicapped	3,238	4,033	3,032	64	10,367
	Emotional disturbance, Behavioral Disorder	895	2,007	681	5	3,588
	Autistic Disorder	1,267	3,667	526	3	5,463
	Communication Disorder	79	828	682	2	1,591
	Learning Disorder	15	4,996	1,309	-	6,320
	Health Impairment	24	496	1,652	2	2,174
	Developmental Retardation	229	742	398	25	1,394
	Total	23,776	42,021	13,746	168	79,711

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C	Infants	122	-	-	168	290
o	Kindergarten	794	815	1,616	-	3,225
u	Elementary School	7,095	22,886	5,313	-	35,294
r	Middle School	6,045	10,230	3,100	-	19,375
s	High School	7,309	8,085	3,717	-	19,111
e	Major Subject	2,411	5	-	-	2,416
s	Total	23,776	42,021	13,746	168	79,711

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

2) The Special Education Institutions

In South Korea, persons subject to special education can be provided education in the general class in general school, special class in general school and special school pursuant to the Article 17, Act on Special Education for Disabled Persons, Etc.

As the inclusive education for students with disabilities has been expanded, the number of special schools has not increased, but the number of special classes has increased; 619 classes a year have increased for the last five years. As the students subject to special education who are given inclusive education in general schools have increased, special schools tend to be chosen by students with severe and multiple disabilities.

Table 2 Tendency of the Change of Number of Special Schools and Special Classes by Year

	2005	2006	2007	2008	2009	2010
Number of Special Schools	142	143	144	149	150	150
Number of Special Classes	4,697	5,204	5,753	6,352	6,924	7,792

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

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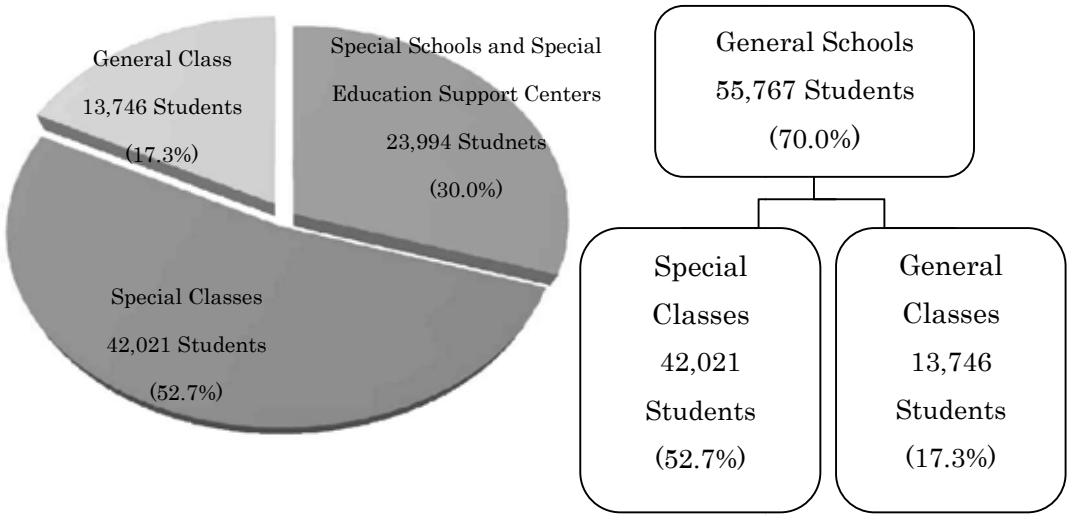
Figure 1 Displacement of Persons Subject to Special Education



Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

① Special Education at General Class in General School

In April, 2010, total 13,746 students subject to special education are placed to general classes in general schools; 1,616 in kindergartens, 5,313 in elementary schools, 3,100 in middle schools and 3,717 in high schools. The number of students subject to special education who have been placed to general school has increased every year; 1,740 persons have increased comparing with those in 2009.

Table 3 Number of General Schools and General Classes by Education Course

Course	Number of Schools	Number of Classes
Kindergarten	1,091	1,459
Elementary School	2,891	4,845
Middle School	1,592	2,765
High School	1,201	3,306
Total	6,775	12,375

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

② Special Class in General School

In South Korea, special classes have been installed since 1971 and total 7,792 classes have been operated in April, 2010. 40 classes are run by state-run schools, 7,641 by local-government-run schools and 111 by private schools; 98.6% of total

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special classes are run by state-or local-government-run schools.

Proportion of schools with special classes to general schools is 29.5% on average and the number of special classes in elementary schools is the highest among other courses; 2.5% (274 classes) in kindergartens, 60.9%(4,682 classes) in elementary school,, 42.9%(1,748 classes) in middle schools and 28.5%(1,088 classes) in high schools.

Table 4 Number of Special Classes in General Schools by Education Course

Course	Total Number of General Schools (Percentage[1)])	Number of Schools[2)]	Number of Special Classes
Kindergarten	8,327 (2.5%)	207	274
Elementary School	5,1918 (60.9%)	3,604	4,682
Middle School	3,129 (42.9%)	1,343	1,748
High School	2,254 (28.5%)	624	1,087
Major Subject	-	1	1
Total		5,797	7,792

Remark 1) Proportion of schools with special classes to nationwide general schools

Remark 2) Number of general schools with special classes

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

Pursuant to the Article 27, Act on Special Education for Disabled Person, Etc, the capacity per each special class is 4 students for kindergarten, 6 for elementary and middle school and 7 for high school; in reality, it has reported that 3.1 students for kindergarten, 5 for elementary and 6.1 for middle school and 7.5 for high school are given education per each special class.

③ Special School

In South Korea, special schools have increased to 15 times in April, 2010 comparing with those in 1962 when the special education had begun. On the basis of statistics of April in 2010, there were 150 special schools nationwide and 60% (90 schools) of them were private schools.

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Table 5 Number of Special Schools

	Division	Number of Schools
Number of Schools by Establishment	Goverment	5
	Local Government	55
	Private Sector	90
	Total	150
Number of Schools by Education Courses	Infant Class	18
	Kindergarten	118
	Elementary School	140
	Middle School	139
	High School	136
	Major Subject	83
	Total	150

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

The numbers of special schools by the types of disabilities are as follows; 95 schools for mental retardation, 18 for physical handicap, 18 for hearing impairment, 12 for visual disability and 7 for emotional disorder; the schools for mental retardation occupied 63.3% of schools.

Table 6 Number of Special Schools by Establishment and Types of Disabilities

	State	Local Government	Private Sector	Total
Visual Disability	1	2	9	12
Hearing Impairment	1	4	18	18
Mental Retardation	1	48	51	95
Physically handicapped	1	5	12	18
Emotional Disturbance	1	1	5	7
Total	5	55	90	150

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

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3) Teachers in Charge of Special Education

① The Certificate of Qualification of Special Education Teacher

As the Act No. 285, Public Education Officials Act has announced on April 18, 1953, the qualification criteria of special education teacher were stipulated (Ministry of Legislation, 2000a).

The qualification criteria of special education teachers have been prepared when the Education Act was partially amended as the Act No. 4523 in 1992. The reason to partially amend the Education Act was the development of special education for people with disabilities. The qualification criteria of principal, vice-principal and teacher had been reinforced to be equal with those of elementary and secondary schools; the qualification criteria of special education teacher were divided into first grade regular teacher, second grade regular teacher and assistant teacher as the same with those of general elementary and secondary schools and were prepared for each grade. After the amendment, the principal and vice-principal of special school were able to become those of elementary and secondary school, which was impossible before the amendment; the teachers with the certificate of special education teacher and 9- or over-9-year teaching experiences became to acquire the certification of qualification of principal of special school; and the criteria that the certificate of teacher was able to be acquired with the authorization of the Minister of the Ministry of Education, Science and Technology based on the recommendation of the Qualification Examination Committee of Teachers, was added to the qualification criteria of principal of special school(Ministry of Legislation, 2000a).

② Number of Teachers in Charge of Special Education

Special education teachers in special schools were 6,738 in April, 2010, which shows the increase of 126 comparing with 2009; the special education teachers in general schools have increased to 8,271 in 2010, which shows the increase of 1,143 comparing with 2009.

The global tendency of special education is not the segregated education, but the inclusive education; in the inclusive class, students subject to special education study together with general students. In this context, the teachers in charge of special classes were 44,937; teachers with the certification of special education teachers were 613(1.4%), teachers with 60-and-over-hours training 10,066 (22.4%), teachers with 30-and-over-hours training 2,021 (54.5%) and teachers without any training 32,237 (71.7%). It was found that significant number of teachers is teaching without any certificate or training for special education.

Act on Special Education for Disabled Persons, Etc. prescribes that the number of

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students per teacher has to be 4 students per 1 teacher and in 2010, the number of students per teacher was 5.2.

2. Acts Related to Special Education

There are many laws and ordinances to stipulate the special education for people with disabilities, but, if limited to the laws that are directly related to policy implementation of special education, Six(6) Acts related to special education may be selected as below;

(1) Constitution, Article 31 (1): All citizens shall have an equal right to receive education corresponding to their abilities.

(2) Framework Act on Education

Article 3 (Right to Learn): Every citizen shall have a right to learn through life and to receive education according to his or her abilities and aptitudes.

Article 18 (Special Education for the Handicapped): The State and local governments shall establish and manage schools for those who need special educational care due to physical, mental and intellectual disabilities and shall devise and implement the policies to support their education.

(3) Elementary and Secondary Education Act

Article 12 (Mandatory Education): (2) A local government shall establish and operate elementary schools, middle schools, and special schools, which provide the elementary and middle school courses, necessary to educate all persons subject to mandatory education in its jurisdiction.

Article 12 (Mandatory Education): (3) Where the local government has difficulty in educating all the persons subject to mandatory education in the elementary schools, middle schools, and special schools established by the local government in its jurisdiction, it may establish and operate elementary schools, middle schools and special schools jointly via consultation with adjacent local governments, or may educate certain persons subject to mandatory education by commissioning them to an adjacent local government, national or private elementary schools, middle schools or special schools.

Article 55 (Special School): The purpose of special schools is to provide education equivalent to elementary, middle and high schools as well as knowledge and techniques necessary for everyday life and social adaptation education for those who need special education due to physical, mental or intellectual disabilities.

Article 56 (Installation of Major Departments): Special schools with high school courses may have major departments with more than one year of school years in order to provide professional technical education to the graduates of the competent

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year (including the graduates of special classes of high schools).

Article 57 (Special Classes): Schools lower than high schools may have special classes after obtaining the approval of competent offices for the students who need special education.

Article 58 (Recognition of Academic Achievements): Any person who completed the education courses equivalent to elementary, middle and high school education at special schools or special classes shall be considered to have equal academic qualification as those who graduated from the corresponding schools.

Article 59 (Integrated Education): The State and local self-governing bodies shall take necessary measures for integrated education such as preparing extra entrance procedures and education courses when those who need special education want to receive education at various schools equivalent to elementary, middle and high schools.

(4) Enforcement Decree of the Elementary and Secondary Education Act

Article 40 (School Teachers of Special Schools Etc.): ① Principals and assistant principals shall be placed at special schools in accordance with Article 19 of the Act provided, however, that no assistant principal shall be placed at schools with less than five classes, and assistant principals may be placed at branch schools with more than three classes. ② Placement standards of special education teachers at special schools shall be determined by the Presidential Decree. ③ Counseling teachers and librarians may be placed at special schools.

Article 43 (Subjects): Special schools and technical high schools: Subjects as determined by the Minister of Education, Science and Technology

Article 45 (School Days): Elementary schools, middle schools, high schools, technical high schools and special schools (excluding kindergarten classes): More than 220 days for each school year provided, however, that where it is deemed necessary for the operation of the academic curriculum in the case of natural disasters, practice of 5 day classes per week, operation of research schools, and operation of autonomic schools as provided under the provisions of Article 105 etc., class days may be reduced within the range of 1/10 and it shall be reported to the competent office 30 days before the beginning of the next school year where the school days are reduced.

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(5) Act on Special Education for Disabled Persons, Etc. (Partial amendment in June, 2011)

Act on Special Education for Disabled Persons has been amended and announced

in 2008 through the Special Education Promotion Law in 1977.

The purpose of this Act is to contribute to the self-realization of both the disabled and those who require special education, and to the unification of the society by providing an integrated educational environment to both the disabled and those who need special education by the State or local self-government and implementing education according to the life-cycle by considering the characteristics such as types and degree of the disability as provided under Article 18 of the 'Framework Act on Education'(Act on Special Education for Disabled Persons, Etc. Article 1).

The Act is composed of 6 chapters and the contents related to duty of state and local self-government, selection and school placement of persons subject to special education, infant, elementary and secondary education and higher education and life-long education are prescribed thoroughly.

(6) Enforcement Decree of Act on Special Education for Disabled Persons, Etc. (Partial amendment in July, 2010)

The purpose of this Decree is to define the matters delegated by the 'Act on Special Education for Disabled Persons, Etc.' and matters necessary for implementation thereof(Enforcement Decree of Act on Special Education for Disabled Persons, Etc., Article 1).

Enforcement Decree of Act on Special Education for Disabled Persons, Etc. prescribes the period of the compulsory education as follows;

Article 2 (Implementation of Compulsory Education): The compulsory education for the disabled shall be implemented in turn according to any of the following subparagraphs.

1. School Year of 2010: Kindergarten course for children not less than five years old and high school course;
2. School Year of 2011: Kindergarten course for children not less than four years old; and
3. School Year of 2012: Kindergarten course for children not less than three years old.

3. Special Education Finance

Special education finance is a series of public economic activity to secure, allocate, spend and evaluate the budget to support special education activities of the state and local public entities.

In addition, special education finance can be considered as all the expenditure to all the special schools, special classes and special education research institutes

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regardless of state-run or private entities in the sense that it is managed and used through the procedure of public accounting (Yoon-hee Choi, 2003)

Students subject to special education in 2010 were 29,711 and the budget for state-run and local-government-run special schools and general classes and special classes in general school in 2010 was 1667.6 billion won; 1623,5 billion won for city and provincial offices of education, 41.4 billion won for state-run special schools and 2.6 billion won for state-run special classes.

Of 1623.5 billion won for city and provincial offices of education, only 3.8% is for special education budget.

Reviewing the expense of special education for a person subject to special education by year, it has increased every year except in 1999 and 2000; the expense of special education for a person subject to special education in 2010 was 20,921,000 won and 14,705,000 won has increased comparing with that in 2000.

Moreover, the proportion of special education budget in the budget of education sector in the Ministry of Education, Science and Technology has consistently increased; the proportion of special education budget in the budget of education section in the Ministry of Education, Science and Technology in 2010 was 4.3%, which means that 2.5% has increased comparing with 1.8% in 2000.

Table 7 Special Education Budget by Year

(Unit: 1,000 won)

Year	Budget of Ministry of Education, Science and Technology	Special Education Budget	Percentage (%)
2000	19,172,028,020	340,225,173	1.8
2001	20,049,279,000	406,310,075	2.0
2002	22,278,358,000	443,073,183	2.0
2003	24,404,401,310	564,394,700	2.3
2004	26,384,088,000	666,840,034	2.5
2005	27,438,044,595	822,051,094	3.0
2006	29,426,304,000	1,051,284,265	3.6
2007	31,044,748,000	1,145,295,143	3.7
2008	35,897,425,000	1,352,939,269	3.8
2009	38,698,867,000	1,545,753,946	4.0
2010	38,595,975,000	1,667,641,925	4.3

※ The budget of 2000~2007 in the Table 7 was that of the Ministry of Education and Human Resources Development. After 2008 when the Ministry of Education and Human Resources Development has been

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integrated to the Ministry of Education, Science and Technology, the same criteria has been applied and the budget since 2008 is the budget of education section in the whole budget of Ministry of Education, Science and Technology.

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

Of the budget for special schools, the budget for private special school was 306.9 billion won. Even though there are only 60 state and local government-run special schools and 90 private special schools, the budget for private schools was only 51%.

There are large regional differences from the budget for private special schools; while the private special schools in Seoul and Gyeonggi-do were provided 61.2% and 77.4% respectively from state or local government, those in Gangwon and Gyeongnam areas were provided 11.9% and 7.4% respectively.

Ⅲ. Discussion

1. Problems and Improvement Plans for Institution

In the results of the analyses of special education institution in South Korea, the problems and the future tasks for special education institution are as follows:

First, the improvement plans for inclusive education.

Currently the inclusive education that students subject to special education are placed to general classes in general schools, but the support for students subject to special education has to be advanced for the stabilization of inclusive education system. Specifically, by identifying the demands of special education support for students subject to special education who are placed to general classes, the support, e.g., itinerary education may be considered. The awareness of student without disabilities for inclusive education disabilities needs to be improved; consistent programs to help understanding disabilities by using mass media, music concert and nationwide events for students can be attempted.

Second, the problems related to special education teachers.

Special education teachers have to be equipped with the qualification as a general teacher, expertise in Subject education and specialized knowledge and skills to educate students with disabilities. However, recently as the institutions to raise special education teachers have rapidly increased, the institutions that are not equipped with enough facilities and faculty to cultivate teachers who can deal with students with severe and multi disabilities and inclusive education have also increased.

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Moreover, the name of Department for Special Education, they have identical title although they educates students separately to be elementary school teachers or secondary school teachers. It makes inconsistency between each department as they educates different contents such as liberal arts course or major subjects to each students. It also causes lack of speciallized knowledge for students that special education teachers must have since only general and introductory knowledge is usually being educated.

Therefore, for the cultivation of special education teachers, the entrance quota for university and graduate schools is needed to be rationalized by considering the demand by the types of disabilities, subjects, educational courses and educational courses and the educational needs. In addition, the procedure of certificate of qualification of special education in the state level has to be standardized and to improve the teaching skill of special education teachers, individual practices during semesters have to be institutionalized.

Third, the problems of the establishment and operation of special schools.

To eradicate the regional imbalance of the establishment and operation of special schools, the demand of special schools and special schools by regions has to be considered first. In addition, to get rid of the imbalance of special schools by the types of disabilities, special schools need to be operated based on the type of comprehensive special school rather than special schools that are separated according to the types of disabilities.

2. Problems and Improvement Plans for Relevant Laws

Based on the results of the analyses of relevant laws on special education in South Korea, the problems of the Act on Special Education for Disabled Persons and Etc. and tasks for the future are as follows:

First, the purpose of the Act on Special Education for Disabled Persons and Etc. is to contribute to the self-realization of both the disabled and those who require special education, and to the unification of the society by providing an integrated educational environment to both the disabled and those who need special education by the State or local self-government and implementing education according to the life-cycle by considering the characteristics such as types and degree of the disability. However, the contents related to the guarantee of the right to learning or the growth through education have not been discussed in this article.

In other words, the views on education and disability including what people with disabilities are need and how to deliver them for the self-realization are discussed in the points of view of people without disability. Therefore, what people with

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disabilities require for self-realization is needed to be stipulated to the law.

Second, Act on Special Education for Disabled Person, Etc. prescribes that 'the education of kindergarten, elementary school, middle school and high school shall be implemented as compulsory education and also convenience for the compulsory education shall be provided. However, compulsory education is perfectly secured by law, but in reality, children with disabilities are still isolated from it (Seon-min Gang, 2011).

Therefore, education system has to be legally and institutionally repaired to provide the education for children with disabilities according to the types and degrees of disabilities and to establish the diverse types of special schools and special classes in general schools. Moreover, the procedure for children with disabilities to guide the entrance into school has to be repaired and proper educational measures according to the types and degrees of disabilities have to be implemented.

Third, Act on Special Education for Disabled Persons, Etc. clarifies the definitions of many terms, but they are being used appropriately in the Act, Enforcement Decree and Enforcement rules.

Especially, the term of 'special education institution' needs to be defined broadly as the institution that implements special education and the terms such as special school and special class have to be omitted; because the term of 'special education institution' can be easily to be misunderstood to call not the place to provide special education services, but only the place (Hyun-min Han and Eu-jeong Kim, 2008), the only terms that have to be defined need to be defined.

3. Problems and Improvement Plans for Finance

Based on the results of the analyses of current situation of special education finance in South Korea, the problems of special education finance and the future tasks are as follows:

First, special education expense per student and the proportion of special education budget to the budget of Ministry of Education, Science and Technology by year have gradually increased since 2000. In spite of this kind of tendency, the special education finance is only 4.3% to the budget of Ministry of Education, Science and Technology, which is still insufficient. Therefore, based on the analyses of the factors to affect the financial state, the ways to stably secure the finance for special education has to be found.

Second, even though, in South Korea, the rate of reliance on private schools is high, as there are 60 special schools run by state and local-governments and 90 by private schools, the financial support for private special schools by city and provincial

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support is still 51%; private special schools are usually situated in the urban areas and the regional differences are large. Therefore, institutional improvement is needed to enable private special schools to secure the finance regionally and equally. Institutional improvements, e.g., investment performance evaluation for special education, to induce local authority governments to expand the investment for special education are required.

Third, to increase the efficiency of special education finance, let superintendents who are responsible for special education finance in city and provincial offices of education take the whole responsibility for special education. The administrative support of special education needs to be specialized more strongly by posting persons who major in Special Education at the position of special education superintendent.

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原著論文 5

韓国における一人暮らしの高齢者ケアサービスの効果と政策的課題

The Effect and Policy Tasks of Care Services for the Elderly Living Alone in South Korea

Jung-Don KWON [1)] , Gi-Min LEE [2)] , Hyun-Mi KIM [3)]

1）牧園大学校 社会福祉学科教授
大田広域市西区モゴンギル２１牧園大学校社会福祉学科
kjd716@hanmail.net

2）韓国老人総合福祉館協会事務総長、ソウル市麻浦区龍江洞 45-5 イヨンビル３階
kaswcs@hanmail.net

3）独居老人総合支援センター室長、ソウル市麻浦区龍江洞 45-5 イヨンビル２階
1661-2129@hanmail.net

ABSTRACT

With the number of senior citizen who lives alone increasing from 930,000 in 2008 to 1,020,000 in 2010 and being predicted to increase steadily to 1,110,000 by 2012, the need for governmental support policy has been raised.

Therefore, this research has been carried out around old people care basic service, governmental support policy for an aged living alone in Korea.

Old people care basic service has begun with the name of 'dispatching guidance counselor for senior citizen who lives alone' since June 2007 and been providing as part of the social service for living alone elderly persons since 2009 up to now after being renamed as 'old people care basic service' in 2008.

This study is made up of not only analyzing the living condition and welfare desire of living alone elderly persons, the beneficiaries of the service, but evaluating the

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effectiveness of the service. (evaluating how the service can solve the living problem of old people and satisfy their welfare desire effectively)

Also, Measures for improving and developing service of the old people care basic business, along with setting up relation, integrating or connecting with similar old people care service, will be proposed as a project of governmental support policy for senior citizen living alone in the future.

＜Key-words＞

living alone elderly persons, basic care service, ensuring safety, living service

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Ⅰ. はじめに

韓国における 65 歳以上の一人暮らしの高齢者は、2011 年現在、約 106 万 5 千人で、高齢者人口の 19.2%に上っていると推計されており、今後も継続して増加すると予測されている（統計庁、2006.11;統計庁、2010.12)。韓国社会で一人暮らしの高齢者は、鰥寡孤独（身寄りのない人）と、社会的保護を必要とする集団の中で最も優先的な保護を必要とする集団である（クォン・ジュンドン、2010)。しかし、一人暮らしの高齢者という理由だけで社会的保護の優先的対象になるわけではない。一人暮らしの高齢者が他の高齢者集団に比べて、所得・健康・住居・余暇・社会参加など、生活の全般にわたって多様かつ深刻な問題を抱えている上、福祉ニーズも高いため（保健福祉部、2009)、一人暮らしの高齢者は最優先的な社会的保護の対象とされる。

このように複合的な問題を抱えている一人暮らしの高齢者数が急増していることを受け、政府は、老人福祉法第 27 条の 2 の「一人暮らしの高齢者に対する支援」に関する条項に基づき、2007 年から一人暮らしの高齢者ケアサービス[1]を提供している。同サービスは、世界的な経済危機の影響により社会的雇用の創出に対する関心が高かった 2007 年度に社会的雇用創出事業の一環として開始されて以来、継続的にサービスの対象を拡大している。

同サービスは、短期間かつ急速に拡大しているが、その一方で、いくつかの限界を持っていることが明らかになった（保健福祉部、2010)。そのため、同サービスの効果や成果、サービス提供の過程における問題点を把握し、サービスの質と有効性を向上する

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[1] 一人暮らしの高齢者に対するケアサービスの正式名称は、一人暮らし高齢者ケアサービスだが、読者の便宜を図るため、以下では「一人暮らしの高齢者ケアサービス」と表記する。

ための方策を確立する必要がある。それを受け本研究では、同サービスの有効性と成果を評価し、それに基づいてサービスの発展方策を模索したい。

Ⅱ. 理論的背景

1. 韓国における公的高齢者ケアサービスの体系

家族主義のモデルに依存して高齢者ケアサービスのニーズを満足してきた韓国の高齢者ケアサービスは、1980 年代後半から絶対貧困層を対象とする選別主義の原則に基づき、公共財政による無料サービスを非営利組織が提供する公的扶助モデルが導入され、政策基調の転換が行われた（クォン・ジュンドン、2009）。この政策基調は、バウチャー（voucher）方式と社会保険方式の導入で、再度の画期的な転換が行われる。韓国の現行の公的高齢者ケアサービスの政策基調は、①在宅中心サービスの拡大、②普遍主義サービスの拡大とサービスの市場化、③消費者中心主義（イ・ジェウォン外、2009;チョン・ソヨン、キム・ウンジョン、2009）である。そのため、韓国の公的高齢者ケアサービスは、①租税支援による供給者中心のサービス、②租税支援とバウチャー（voucher）方式が混在するサービス、そして、③社会保険方式のサービスが混在している。韓国の公的高齢者ケアサービスのうち、①租税支援方式の代表的なサービスは、一人暮らしの高齢者を対象とした一人暮らしの高齢者ケアサービスであり、②バウチャー方式の代表的なサービスは、高齢者ケアの総合サービスである。また、③社会保険方式の代表的なサービスは、訪問介護サービスである。このような韓国の公的高齢者ケアサービスの特徴を目的・サービスの対象・サービスの内容・サービスの時間とコストを中心に、特徴を比較してみると＜表 1＞の通りである。

＜表 1＞韓国の公的高齢者ケアサービスの比較

区分	サービス分類	細部内容
目的	一人暮らしの高齢者ケアサービス	❍ 一人暮らしの高齢者の生活実態や福祉ニーズの把握、定期的な安全確認、保健福祉サービスの連携と調整、生活教育などを通じ、一人暮らしの高齢者に対する総合的な社会的セーフティーネットを構築
	高齢者ケアの総合サービス	❍ 独立した日常生活が困難な高齢者への家事支援や活動支援サービスを提供し、安定した老後の生活を保障するとともに家族の社会的・経済的活動の基盤を構築

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	訪問介護 サービス	❍ 在宅で日常生活をしている高齢者の中で、身体的・精神的障害により厳しい環境に置かれている高齢者に、地域社会の中で健全かつ安定した老後の生活ができるよう療養保護士が家庭を訪問し、身体活動や家事など、必要とする各種のサービスを提供
サービスの内容	一人暮らしの高齢者 ケアサービス	❍ 直接訪問や電話による安全確認サービス、老後の生活情報を提供する生活教育、地域社会サービスとの連携などの予防サービス
	高齢者ケアの総合サービス	❍ 食事・洗面のケア、着替え、体位の変更、身体機能の維持・増進、トイレのケア、外出の同行、生活必需品の購入、掃除・洗濯など
	訪問介護 サービス	❍ 身体活動の支援サービス：洗面、口腔ケア、清潔、身なり、着替え、入浴、排泄、食事、体位の変更、移動、身体機能の維持・増進など ❍ 家事支援サービス：炊事、生活必需品の購入、掃除洗濯など ❍ 個人的な活動支援サービス：外出時の同行・支え、日常的な業務の代行など ❍ 感情的な支援サービス：話し相手、奨励・慰め、生活相談、コミュニケーションの支援など
サービスの対象	一人暮らしの高齢者 ケアサービス	❍ 所得水準、扶養義務者の有無、住民登録上の同居者の有無に関係なく、実際に一人で暮らしている 65 歳以上の高齢者の中から、現況調査を通じて把握した所得・健康・住居・社会との触れ合いなどの水準を評価し、サービスのニーズが高い一人暮らしの高齢者を事業の対象として選定
	高齢者ケアの総合サービス	❍ 65 歳以上の高齢者の中から世帯所得・健康状態などを考慮し、ケアサービスが必要であり、世帯所得が全世帯の平均所得の 150%以下で、老人長期療養等級 A、B（認知症・中風、老人性疾患などで身動きが不便な高齢者）の者
	訪問介護 サービス	❍ 長期療養等級の1～3等級。ただし、等級外の者のうち基礎受給権者及び扶養義務者から適切な扶養を受けていない者で、一人で日常生活を営むのが困難であるため、在宅サービスの提供が必要な者
サービスの時間とコスト	一人暮らしの高齢者 ケアサービス	❍ サービス消費者が利用できる時間の制限がなく、提供者の営業時間のみに制限している ❍ 提供者の業務時間：月～金曜日、1 日 5 時間（13:00～18:00） ❍ 本人負担金：無料（供給者支援方式）

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	高齢者ケアの総合サービス	❍ サービスの対象者の所得水準とサービスの時間に応じて自己負担額とバウチャーの支援額が異なる ❍ 毎月一定額の本人負担金を前納すれば一定額のバウチャーを支援 – 前払い本人負担額：月 18,000 ウォン～48,000 ウォン – バウチャー支援額：最低月 212,400 ウォン～最大月 306,200 ウォン – サービス単価：一時間 9,200 ウォン
	訪問介護サービス	❍ 30 分～4 時間以上利用可能 ❍ 在宅給与の月限度額の範囲（1 等級：1,140,600、3 等級 814,700）以内 ❍ 訪問（一回当たり）介護給与費：30 分以上 10,680 ウォン～240 分以上 39,500 ウォン

＊資料：保健福祉部（2011b）。老人保健福祉事業のご案内。

2. 一人暮らしの高齢者ケアサービスの理解

韓国の一人暮らしの高齢者ケアサービスは、前で説明したように、バウチャー（voucher）方式の高齢者ケア総合サービスや社会保険方式の訪問介護サービスとともに韓国の高齢者ケアサービスの中核を担っている。一人暮らしの高齢者ケアサービスは、「一人暮らしの高齢者へのニーズに合わせて、安全確認、生活教育、サービスの連携など、オーダーメード型の福祉サービスを提供し、一人暮らしの高齢者に対する総合的なセーフティーネットを構築する」ことに目的がある（保健福祉部、2011a）。

一人暮らしの高齢者ケアサービスでは、所得水準・扶養義務者の有無・住民登録上の同居者の有無に関係なく、実際に一人で暮らしている 65 歳以上の高齢者を対象に現況調査を実施し、住宅の位置、前の週に欠食した回数、 日常生活でケアが必要となる行動の数、社会関係（家族、友人、隣人）という 5 つの要素を点数で定量化し、社会的保護の必要点数が高く、他の高齢者ケアサービスを利用していない一人暮らしの高齢者をサービスの対象として選定する。市郡区別サービスの対象の規模は、お年寄りケアヘルパー1 人当たり 25 人を基準に、サービス対象者を決める。

一人暮らしの高齢者ケアサービスの主な内容は、安全確認・生活教育・サービスの連携の 3 つだが、これらのサービスを効率的に提供するために、一人暮らしの高齢者の現況調査と地域社会の保健福祉サービスの現況調査と発掘をしなければならないため、サービスの内容は、5 つで構成される。これらのサービスを提供する上で活用するサービ

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スの方法論は、ケース管理（case management）だが、一人暮らしの高齢者サービスの管理者は、一人暮らしの高齢者の個人的ニーズや問題点に応じて安全確認・サービスの連携・生活教育などの個人に合わせたサービスの提供計画を策定し、お年寄りケアヘルパーが一人暮らしの高齢者の家庭を訪問し、個別に組み立てられたサービスを提供する。安全確認のサービスは、お年寄りケアヘルパーが定期的に一人暮らしの高齢者の家庭を直接訪問したり、安否の電話を通じて間接的に安全を確認するサービスで、訪問安全確認サービスを週 1 回以上（1 回当たり 1 時間）、電話を利用した間接確認サービスを週 2 回以上（1 回当たり 5～6 分）提供する。一人暮らしの高齢者のための生活教育事業は、地域社会で生活する一人暮らしの高齢者を対象に、運動および健康管理・栄養管理・日常生活の行動訓練・余暇活動の指導・住宅の安全や様々な機能回復訓練など、保健・福祉･教育･文化などに関する多様なプログラムを教育または情報を提供するサービスで、小集団の形で月 2 回以上実施する。サービスの連携は、一人暮らしの高齢者のニーズと生活の問題を解決するために、地域社会内の公共機関と民間機関が提供する様々なサービスを連携させるとともに、類似サービスの重複利用など、不要にサービスの重複が発生しないように調整する。

一人暮らしの高齢者ケアサービスのサービス提供者は、一人暮らしの高齢者に直接サービスを提供するお年寄りケアヘルパーと一人暮らしの高齢者のケース管理を担当するサービス管理者で構成される。サービス管理者は、社会福祉士 2 級以上所持者であり、週 40 時間常勤する非正規雇用者で､一人暮らしの高齢者のニーズに合わせたケース管理サービスの計画、サービスの連携および調整などの仕事を担当する。お年寄りケアヘルパーは、学歴や年齢に関係なく、基本的な教育と実習教育を含め、計 50 時間の教育を受けた者で、週 25 時間の非常勤の労働をし、一人暮らしの高齢者の安全確認サービス、サービスの連携、生活教育サービスを直接提供する。

一人暮らしの高齢者ケアサービス機関は、市郡区単位で委託審査を経て選定し、高齢者数の規模に応じて 1～2 つのサービス機関を設置･運営する。高齢者ケアサービス機関の財政は、人件費・運営費・退職積立金で編成されるが、人件費は、お年寄りケアヘルパー1 人当たり月 62 万ウォン､サービス管理者 1 人当たり 124 万ウォンが編成される。また、運営費は、お年寄りケアヘルパー1 人当たりの年間 75.3 万ウォン、サービス管理者 1 人当たり年間 147.3 万ウォンが編成される。運営費は、教育費・使用者負担の社会保険料・生活教育材料費・ユニフォームの制作費・その他必要な付帯費用（遠距離交通費、電話代など）で施行される。

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Ⅲ. 研究方法

本研究では、韓国の一人暮らしの高齢者ケアサービスの効果と成果を評価するために2009年を基準にして、高齢者ケアサービス機関の実績データの分析、サービスの受給権者である一人暮らしの高齢者に対するアンケート調査、サービス提供者であるお年寄りケアヘルパーへの定量的な調査を実施した。各調査の内容と研究方法は以下の通りである。

第一に、一人暮らしの高齢者ケアサービスの投入人数、財政、サービスパフォーマンスに関するデータを分析し、サービスの有効性と効率性を評価した。本研究では、一人暮らしの高齢者ケアサービスに投入されるサービス提供者の人数、サービス対象、予算に関するデータを集め、その適正性を分析した。また、安全確認サービス・生活教育サービス・サービスの連携が事業の案内で決められている算出目標を達成したかどうかに基づいて有効性を評価し、サービスに投入されたコスト対サービスの経済的価値の生産額を比較することで一人暮らしの高齢者ケアサービスの有効性を評価した。その際、一人暮らしの高齢者ケアサービスの経済的価値の生産額を計算するため、韓国社会福祉共同募金会（2009）の配分事業に提示された講師費の目安と社団法人韓国物価情報（2007-2009）が発行する「物価情報」品目別の価格基準を活用した。

第二に、一人暮らしの高齢者ケアサービスのサービス受給者を対象に、サービスの有効性を評価した。本研究では、全国244ある事業遂行機関から所得水準（国民基礎生活保障制度の受給権者、次上位階層、次上位階層以上）とサービス対象の種類（優先事業対象者、一般事業対象者）に基づいて 10 人のサービスの受給者をサンプリングし、計2,440 人を対象にアンケート調査を実施した。調査内容は、高齢者の特性、サービスの利用期間と実態、サービスの利用形態、サービス利用後の生活の変化、生活の満足度などである。調査方法は、調査対象に当たる一人暮らしの高齢者にサービスを提供していない他のお年寄りケアヘルパーが高齢者の家庭を訪問し、1 対 1 の面接調査を実施する形で2,240人を調査した。調査を完了した調査資料は、符号化とエラーの確認作業を経て、「社会科学のための統計パッケージ（SPSS ver.14.0）」を活用して統計分析を行った。

第三に、高齢者ケアサービスのサービス提供の実態とサービス過程での問題点・改善方策について意見を集めるため、サービス提供者を対象にアンケート調査を実施した。本研究では、調査時点当時サービス提供者の資格を持っていたサービス管理者244人とお年寄りケアヘルパー5,080 人の計 5,324 人を対象に自己報告方式で調査を行った。調査内容は、服務の実態、サービスの提供実態とサービスの品質、ケース管理、サービス

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提供の過程で発生する問題点と改善策などである。サービス提供者 5,064 人に対して調査を行い、符号化とエラーの確認作業を経て、「社会科学のための統計パッケージ（SPSS ver.14.0）」を活用して統計を分析した。

Ⅳ. 研究結果

本研究では一人暮らしの高齢者ケアサービス機関の事業実績の分析、サービスの受給権者およびサービス提供者に対するアンケート調査の結果を総合した。一人暮らしの高齢者ケアサービスの有効性と成果評価の結果は以下の通りである。

1. 投入評価

一人暮らしの高齢者の生活の質を向上するための支援政策がうまく推進されるためには人材、財政、施設などの資源を適切に投入しなければならない。一人暮らしの高齢者ケアサービスを実行するため、一人暮らしの高齢者ケアサービス機関の実績データを分析し、サービスに投入された資源が適切かどうかを評価した結果は以下の通りである。

1）人材投入評価

サービス対象者に適切なサービスを提供するためには、適正規模のサービス提供者が投入されなければならない。一人暮らしの高齢者ケアサービスでは、市郡区の一人暮らしの高齢者数の割合を中心に、サービス提供者を配置する。2009 年の一人暮らしの高齢者ケアサービスでは、248 カ所の事業遂行機関に割り当てたサービス管理者は 241 人、お年寄りケアヘルパーは 5,194 名と、計 5,435 人だった。運営費の制約を補完するために割り当て人員の 1 割の範囲内で事業遂行機関が自主的に人員を増減することを認めている。これは前年度に比べてサービスの提供者を拡大したものであり、実際にほとんどの事業遂行機関で、割り当てられたサービス提供者だけを採用しているため、サービス提供者の投入は、適切なものと評価できる。

＜表 2＞サービス提供者投入の適切性評価　　**（単位：名、%）**

事業遂行機関（箇所）	サービス管理者（A）			お年寄りケアヘルパー（B）			サービス提供者（A＋B）		
	配置人数(C)	採用人数(D)	採用率(D/C)	配置人数(E)	採用人数(F)	採用率(F/E)	配置人数(C+E)	配置人数(D+F)	採用率(D+F/C+E)
244	241	244	101.2	5,194	5,080	97.8	5,435	5,324	98.0

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2)財政投入評価

高齢者ケアの基本サービスにおける 2009 年の予算は、中央政府予算の 317 億 3,900 万ウォンと地方政府の予算 131 億 5,200 万ウォンを合わせ、計 448 億 9,000 万ウォンである。これをサービス対象者 1 人当たりの予算に換算すると、一人暮らしの高齢者 1 人当たり年間 31 万 4600 ウォンが投入されることが分かった（保健福祉部、2009)。一人暮らしの高齢者は 1 人当たり月平均最低 7 時間以上のサービスを利用していることが明らかになった。しかし、サービスの難易度などを考慮し、2009 年度の老人長期療養保険制度の 3 等級の判定を受け、月 4 時間の訪問介護サービス（4 時間のサービス利用の給与額 39,500 ウォン）を利用する高齢者と高齢者ケア総合サービス（サービス単価 : 1 時間 9,200 ウォン）を月に 4 時間利用する次上位階層以上の高齢者に投入されるコストと比較してみると、訪問介護サービス利用の高齢者に投入される費用が 1 人当たり年間 47 万 4000 ウォンである上、高齢者ケア総合サービスを利用する高齢者に投入される費用が 1 人当たり 44 万 1000 ウォンであるのに対して一人暮らしの高齢者ケアサービスは、1 人当たり 31 万 4600 ウォンが投入され、コストパフォーマンスが非常に高いことが分かる。

＜表 3 ＞サービス財政の適切性評価　　（単位： 名、%）

投入予算(百万ウォン)			サービス対象者 (C)	サービス提供者 (D)	一人当たり予算（千ウォン）	
中央政府 (A)	地方政府 (B)	総予算 (A+B)			サービス対象者 (A+B/C)	サービス提供者 (A+B/D)
31,739	13,152	44,890	143,142	5,324	314.6	8,431.6

2. 過程評価

一人暮らしの高齢者ケアサービスの過程を体系的に評価するためには、現況調査、ニーズ査定、サービスの計画および提供など、一人暮らしの高齢者のケース管理の全般について評価しなければならない。本研究では、サービス提供者であるお年寄りケアヘルパーを対象にしたアンケート調査の結果をもとに、サービスの過程について評価した。その結果は以下の通りである。

お年寄りケアヘルパーは、週 25 時間のサービスを提供することになっているが、週平均労働時間は 26.18 時間で、サービス提供者のうち 6 割程度が時間外労働をしていることが分かった。職位別にみると、サービス管理者は、週平均 5.16 時間の時間外労働をし

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ている一方、お年寄りケアヘルパーは、週平均 3.51 時間の時間外労働をしていることが分かり、サービスの管理者の週平均超過勤務時間が長いことが明らかになった。

一人暮らしの高齢者ケアサービスの給与基準の場合、サービス管理者は、月 120 万ウォン、お年寄りケアヘルパーは月 60 万ウォンだが、サービス提供者の大半は、労働時間を考慮すると、給与水準が低いと認識している。無給・有給休暇を規定しているが、休暇を利用できないサービス提供者も 1 / 5 程度に達している。このようなサービス提供者の時間外労働、低い給与水準、不十分な福利厚生制度などは、サービス提供者の仕事の満足度を低下させ、さらには、転職率を高める結果を招くことになり、一人暮らしの高齢者にとっては関係喪失を経験することになるか、またはサービスの質を低下させる要因として作用する可能性が高い。

お年寄りケアヘルパーのサービス態度を評価するため、お年寄りケアヘルパーを対象に仕事の事前準備、高齢者の関心とニーズの反映、最善のサービスの提供など、10 項目を 5 点満点で調査した結果、すべての項目で 9 割以上のお年寄りケアヘルパーと一人暮らしの高齢者が肯定的に評価していた。

＜表４＞お年寄りケアヘルパーの業務態度に関する評価　（単位：%）

業務態度	まったくそうでない	そうでない	まあまあだ	そうである	非常にそうである	計
その日の業務を徹底的に準備する	-	0.2	1.6	51.0	47.1	100.0
高齢者の関心やニーズを最大限反映する	-	0.1	0.9	42.6	56.3	100.0
高齢者に最善のサービスを提供しようと努力する	-	0.1	0.6	31.9	67.4	100.0
高齢者のプライバシーや自己決定権を守る	0.2	0.1	0.8	24.2	74.7	100.0
高齢者との約束を守る	0.1	0.1	0.2	21.8	77.9	100.0
仕事中に知り得た高齢者の秘密を守る	-	0.1	0.2	15.3	84.4	100.0
難しいことでは上司と相談して処理する	0.1	0.2	0.8	31.7	67.3	100.0
仕事の内容を記録し、定期的に報告する	-	0.2	0.8	28.6	70.4	100.0
高齢者と家族・友人などとの連携に勤める	-	0.6	3.4	47.1	48.8	100.0
機関の使命、政策、規制を受け入れ、守る	0.1	0.2	0.7	30.9	68.2	100.0

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本研究では、お年よりヘルパーが提供するサービスの品質（quality of service）を確実性、アクセシビリティ、コミュニケーション、キャパシティー、コンプライアンスなど 15 項目（Martin、1993）で評価した結果、すべての項目で、最低 93%以上が肯定的に評価していた。そして、本研究でお年よりヘルパーのサービス品質を評価した点数は、最低 15 点から最高 75 点となり、中間のスコアは 45 点であるが、平均 67.64 点であることが明らかになり、サービスの質が非常に高い水準であることがが分かった。このような結果から、サービス提供者は、低い給料と不十分な福利厚生制度にもかかわらず、一人暮らしの高齢者へのサービス提供に当たっては、人間に役立つ奉仕専門職が備えるべき態度を十分持っていて、一人暮らしの高齢者に質の高いサービスを提供していることが分かった。

＜表５＞お年寄りケアヘルパーのサービス品質評価　（単位：%）

サービスの品質	まったくそうでない	そうでない	まあまあだ	そうである	非常にそうである	計
高齢者が必要とするとき簡単に連絡できる	0.1	0.3	1.6	42.7	55.3	100.0
高齢者に向けて親切で丁寧である	-	-	0.2	25.7	74.0	100.0
高齢者が分かりやすい言葉で対話し支援する	-	-	0.3	25.7	73.9	100.0
サービスの提供に必要な知識と技術を備えている	0.1	0.3	6.4	60.4	32.8	100.0
サービス提供の過程で規則に従う	-	0.1	1.1	37.1	61.8	100.0
サービス提供する際高齢者を人間的に尊重する	-	-	0.4	21.9	77.7	100.0
すべてのサービスを高齢者にもれなく提供する	0.1	1.0	6.0	51.5	41.4	100.0
サービスが高齢者の生活に大きく役立つ	-	0.2	3.8	46.7	49.3	100.0
高齢者の特性とニーズに合ったサービスを提供する	-	0.7	6.4	51.9	40.9	100.0
高齢者のプライドを守るために努力する	-	0.1	0.5	25.5	73.9	100.0
事前に計画されたサービスの提供に充実する	-	0.6	3.4	46.9	49.1	100.0
決まった時間内に高齢者にサービスを提供する	0.1	0.6	2.9	50.1	46.3	100.0
サービスを提供する際に、高齢者の安全を考える	-	0.1	0.8	29.0	70.2	100.0
高齢者が必要なときにサービスを提供する	0.2	1.3	5.4	51.6	41.5	100.0
サービスに必要な資源の動員するために努力する	0.1	0.5	3.6	46.7	49.0	100.0

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3. 算出評価

一人暮らしの高齢者ケアサービスでは、安全確認サービス、生活教育サービス、サービスの連携を必須サービスとして規定している。各サービス別の算出（outcome）を評価すると、その結果は以下の通りである。

1)安全確認サービス

一人暮らしの高齢者ケアサービスの安全性確認サービスの算出結果を見ると、直接安全確認が 668 万 2,545 件、間接安全確認が 11,568,500 件、危機対応など他の安全確認サービスが 56 万 1,898 件と、算出基準より約 332.8%を超過達成しており、2008 年度に比べても、安全確認件数が 358 万 7,391 件増え、前年比 123.5%増加している。このような結果から安全確認サービスの算出結果は、非常に優秀であると評価される。

＜表 6 ＞年度別安全確認サービスの実績　（単位：件、%）

年度		直接 安全確認(A)	間接 安全確認(B)	その他(C)	総 安全確認(D)
2007 年*	件数	2,270,184	2,677,511	-	4,947,695
2008 年	件数	5,863,721	9,064,174	297,707	15,225,602
2009 年	件数	6,682,545	11,568,500	561,898	18,812,993
	前年比 増減率(%)	113.9	127.6	188.7	123.5

*2007 年は、事業開始の初年度で、7～12 月の実績

2)生活教育サービス

2009 年の一人暮らしの高齢者ケアサービスの生活教育サービスの算出結果を見ると、59 万 1,857 回の生活教育サービスを提供し、算出基準より 104.7%を超過達成し、2008 年度に比べても、生活教育サービスの件数が 33 万 6,678 回増え、前年比 116.3%増を示している。このような結果から生活教育サービスの算出結果は、優秀であると評価される。生活教育サービスを社会福祉共同募金会が配分している事業の予算基準の中の講師費の最下等級としてお年寄りケアヘルパーと同様の資格を持つ実践的な実技・実習の補助要員の講師費である 1 時間当たり 5 万ウォン（社会福祉共同募金会、2009.7.）を適用して経済的価値に換算してみると、2009 年生活教育サービスの経済的価値は 295 億 9,285 万ウォンで、実技・実習の補助要員がもらう講師費の 5 割のみを適用した場合も、147 億 9,642 万ウォンに上っている。このような生活教育サービスの経済的価値は、一人暮らしの高齢者ケアサービスの予算の最低 32.9%、最大 65.9%を占めており、目に見えない経済的価値の創出も非常に大きいといえる。

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＜表７＞生活教育サービスの実績　（単位：回、人、%）

年度		教育会期（回）	参加人数（人）
2007 年*		156,310	688,739
2008 年		464,188	2,060,901
2009 年	回数	591,857	2,397,579
	前年比増減率(%)	127.5	116.3

*2007 年は、事業開始の初年度で、7～12 月の実績

3)サービス連携

2009 年の一人暮らしの高齢者ケアサービスのサービス連携の算出結果をみると、312 万 4,815 件と、算出基準より何と 552.8%を超過達成した。2008 年度に比べても、サービスの連携件数が 100 万 1,555 件増加し、前年比 147.2%のサービス連携件数の増加率を示しており、サービス連携の算出結果は、非常に優秀であると評価される。

このようなサービスの連携件数のうち、経済的価値に換算できない、ボランティアなどの連携件数を除いて、経済的価値に換算できる後援金品などの連携件数は、サービスの連携件数の 28.7%を占めている。経済的価値に換算できるサービスの連携の実績のみを当該年度 8 月の「物価情報」に基づいて金額に換算してみると、2009 年度のサービスの連携を通じて動員した民間の資源は、計 403 億 1,504 万ウォンと、2009 年の高齢者ケアサービスに投入された予算総額の 89.8%に相当しており、コストパフォーマンスも非常に高いといえる。このようなサービス連携の算出結果の評価をもとにすると、一人暮らしの高齢者ケアサービスの算出は非常に優秀であると評価できる。

＜表８＞サービス連携の実績　（単位：件、千ウォン、%）

年度		総 連携実績（件）	連携金額に換算できない実績(件)**	連携金額に換算できる実績(件)	サービス連携額 (千ウォン)***
2007 年*		448,304	216,328	231,976	4,802,064+α
2008 年		2,123,260	1,231,789	891,471	23,419,795+α
2009 年	件数	3,124,815	1,913,830	1,210,985	40,315,046+α
	前年比 増減率(%)	147.2	155.3	135.8	172.1

*2007 年は、事業開始の初年度で、7～12 月の実績
**経済的価値に換算できないボランティアの連携、仕事の連携、他のサービスの連携など
***経済的価値に換算できるサービス連携の実績のみを当該年度の物価基準で換算した金額
資料：韓国物価情報編集部（2007～8)。総合物価情報。

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4) サービスのコスト-効率性の評価

<表９>サービス単位コスト　（単位：百万ウォン、人、ウォン）

総事業予算 (百万ウォン, A)	サービス対象者 (人, B)	サービス提供者 (人, C)	総サービス実績 (件, D)	サービス単位コスト(ウォン)		
				サービス対象者 (B/A)	サービス提供者 (C/A)	1件のサービス当たり (D/A)
44,890	143,142	5,324	22,529,665	314,600	8,431,600	1,992

一人暮らしの高齢者ケアサービスは、公的財源を投入し、高齢者のニーズを満たすとともに問題の解決を支援するという点から消費的性質を持つ一方、投入された公的財源を活用し、民間の資源を開発・動員して活用する生産的性質を同時に持つ高齢者ケアサービスである。特に、他の高齢者ケアサービスでは見られないサービスの連携は、経済的価値に換算できる連携実績だけを計算しても、＜表 10＞で示しているように 2009 年に一人暮らしの高齢者ケアサービスに投入された公的財源の約 9 割に上る 403 億ウォンの経済的価値を生産した。そして生活教育サービスを行うお年寄りケアヘルパー講師の人件費を社会福祉共同募金会の講師費の最低基準の 5 割のみを適用しても 148 億ウォンに近い経済的価値を持つ。そのため、一人暮らしの高齢者ケアサービスの経済的価値生産額を最低水準に換算しても2009年に投入された公的財源の122.7%に達する金額を再生産することを考えると、一人暮らしの高齢者ケアサービスのコストパフォーマンスは非常に高いと評価することがてきる。

＜表１０＞サービスの経済的価値生産額　（単位：百万ウォン、%）

総事業予算 (A)	経済的価値生産額(百万ウォン)			予算比生産額 (%, B/A)
	生活教育サービス	サービス連携**	総生産額(B)	
44,890	14,796+α	40,315+α	44,890	14,796+α

*社会福祉共同募金会の実技・実習の補助要員講師費基準の 50%を適用

**2009 年 8 月の「物価情報」に基づき、経済的価値に換算できる連携実績のみ含む

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4. 成果評価

一人暮らしの高齢者ケアサービスの成果は、最終的にサービスを利用した一人暮らしの高齢者の生活に肯定的な変化が現れることで裏付けられる。サービスを利用した後、生活が変化した程度を評価した結果をみると、一人暮らしの高齢者ケアサービスが生活全般において肯定的な影響を与えたと評価できる。それを＜表 11＞の項目別にみると、一人暮らしの高齢者ケアサービスを利用した後、孤独感が減少したと回答した高齢者が約 92%、事故や緊急事態などの危機的状況に対する不安感が減ったと回答した高齢者が約 83%だった。また、生活教育を通じて、老後の生活に必要な知識や情報を習得することができたと答えた高齢者が 78%程度に達していた。お年寄りケアヘルパーが高齢者の福祉に関連する情報を提供するとともに、サービスのお申し込みや地域の資源を連携するため、以前より豊かな福祉サービスを受けることができたと回答した高齢者が 73%程度であった。また、一人で生活しながら、欠食をしていることが多かったが、お年寄りケアヘルパーが訪問するようになってからお弁当、おかずを提供される、または直接調理をしてもらえることが多く、栄養管理に役立ったと回答した高齢者が 67%程度に達している。そして、一人暮らしの高齢者ケアサービスの利用後、家族・友人・隣人との交流が増えたと答えた人が約 5 割だった。

＜表 11＞サービス利用後の高齢者の生活変化

サービス利用後の変化	平均	標準偏差	そうでない	半々	そうである	計(人)
孤独感の減少	2.91	.33	1.2	6.5	92.3	100.0(2,240)
危機的状況に対する不安感の減少	2.81	.44	1.8	15.8	82.5	100.0(2,240)
老後の生活に必要な知識の習得	2.75	.49	2.8	19.6	77.6	100.0(2,240)
経済的支援	2.05	.83	32.2	30.4	37.5	100.0(2,240)
セーフティーネットとの交流増加	2.37	.71	13.2	36.5	50.4	100.0(2,240)
病気の治療や介護の支援	2.26	.75	18.4	37.3	44.3	100.0(2,240)
栄養の供給を促進	2.58	.65	9.2	23.8	67.0	100.0(2,240)
住居環境の改善	2.09	.81	28.8	33.6	37.6	100.0(2,240)
福利厚生の増加	2.67	.58	5.7	21.8	72.5	100.0(2,240)
生活の満足度の増加	2.78	.48	2.7	16.4	80.9	100.0(2,240)

ただし、一人暮らしの高齢者ケアサービスの利用後、病気の治療や介護に多くの支援を受けたと答えた高齢者が約 44%、経済的支援が増えた、居住環境が改善されたと答えた高齢者がそれぞれ 28%程度であることが分かった。このように、経済・健康・住居環境などの改善においてサービスの効果が低くかったのは、お年寄りケアヘルパーのサー

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ビスが不十分だったというよりは、事業のサービスの予算が全くないなかで、地域社会の民間資源とサービスを連携するだけでは高齢者の生活上のニーズを満たすには限界があるというほかない。

Ⅴ. 結論：一人暮らしの高齢者ケアサービスの発展に向けた政策的課題

韓国の一人暮らしの高齢者ケアサービスの歴史は非常に短いが、最初にその有効性および成果を評価した結果から分かるようにサービスの有効性と成果は非常に高いことが分かる。しかし、一人暮らしの高齢者ケアサービスは、様々な問題を抱えており、今後、より望ましい方向に政策を改善・発展させるためには、次のような政策的課題を推進しなければならない。

第一に、一人暮らしの高齢者ケアサービスの法的根拠を明確化・具体化する必要がある。現行の法律では一人暮らしの高齢者ケアサービスにおける法的根拠は老人福祉法第27 条の 2、「一人暮らし高齢者に対する支援」だが、詳細な措置を規定した施行規則が用意されていない。このように法的根拠の不十分であるため、同様の高齢者ケアサービスとの統合が求められており、一人暮らしの高齢者ケアサービスではなく、中高年層のための社会的雇用創出事業とみなされ、政策の改善に必要な財政を確保するには様々な問題がある。そのため、一人暮らしの高齢者ケアサービスの詳細な施行規則を設け、サービスの体系化を図り、一人暮らしの高齢者関連サービスとの連携と役割分担に関する明確な基準を提示しなければならない。

第二に、一人暮らしの高齢者に向けた社会サービスとしての性格と目的を明確にする必要がある。一人暮らしの高齢者ケアサービスは、「一人暮らしの高齢者のための社会的セーフティーネットの強化と一人暮らしの高齢者の生活の質の向上」を目的としているが、中高年層の社会的雇用の創出という隠された目的（hidden goal）が存在する。そのため、一人暮らしの高齢者ケアサービスの目的が逆転する場合がある。つまり、目的が手段となって手段が目的になることで、一人暮らしの高齢者ケアサービスが目指す目的の達成に限界を露呈し、政策の改善のための財政確保やサービスを提供する人材に対する待遇の改善などに問題が発生している。そのため、一人暮らしの高齢者ケアサービスの社会的雇用創出という目的を完全に排して、一人暮らしの高齢者の生活の質の向上という目的を追求する純粋な社会サービスとしての性格を明らかにする必要がある。

第三に、サービス提供者の労働条件の改善や能力の強化が求められる。一人暮らしの高齢者ケアサービスの提供者に支給される給与は、最低生計費をやや上回る水準であり、

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彼らの業務負担は非常に重いのが実情だ。このように、サービス提供者への劣悪な給与と福利厚生の水準は、サービスの質の低下に直結する。したがって、今後、サービス提供者の正規雇用に向けたの努力、給与の引き上げといった労働条件の改善がなされてこそ質の高いサービスを持続的に提供することができる。また、現在は一定時間の教育だけを受ければお年寄りケアヘルパーの資格基準を取ることができるが、その資格基準を最低療養保護士 2 級以上に上方修正し、生活教育サービスに関する補修教育を集中的に強化することで、サービス提供者の力量を強化する必要がある。

第四に、一人暮らしの高齢者に向けたケース管理サービスの体系を整える必要がある。一人暮らしの高齢者ケアサービスは、ケース管理の方法を基本サービスの方法として採用しているが、ずさんな現況調査や安全確認サービス体系の不備、不十分な生活教育サービス、事業費策定の遅れなどの問題により、個別オーダーメード型のケース管理サービスの提供に限界を見せている。このような問題を改善するためには、現況調査の完了と継続的な更新、地域内の長を中心とする安全確認システムの構築、お年寄りケアヘルパーの生活教育能力の強化、人件費と運営費に加え生活教育サービスと連携業務などに投入できる基本的な事業費の編成、家事や介護サービスなどの付加サービスにおけるバウチャーの適用など、様々な改善に向けた努力を傾注しなければならない。

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ORIGINAL ARTICLE 6

The Current Situation and Tasks of Hospital Schools for Students with Health Impairment in South Korea

Chang-Wan HAN[1)] , Eun-Ae LEE[2)] , Atsushi TANAKA[3)]

1) The Center for Research and Development of Higher Education, Saga University
Graduate School of Economics and Management、 Tohoku University
Department of Internal Medicine and Rehabilitation Science, Tohoku University Graduate School of Medicine
#1308, 5-1-1, Nabesima Saga, 849-8501 Japan
Graduate School of Medicine, Saga University
hancw917@gmail.com

2) Faculty of Culture & Education, Saga University
eunae929@gmail.com

3) Faculty of Education, University of the Ryukyus
atanaka@edu.u-ryukyu.ac.jp

ABSTRACT

As some of 「Special Education Promotion Law」 was amended in 2005, the term, 'health impairment', has been added to the types of disabilities requiring special education and education services have been provided for the children with health impairment, namely with chronic diseases or weakness. As hospital schools have been expanded in the whole country, more students with health impairment could be officially provided with education services. Now it is the time to secure the higher-quality of education for students with health impairment by establishing the support system that is ready to be applied for the management of hospital school.

This study aims to understand health impairment and to analyze and examine the current situation and tasks of hospital schools. This study employed literature review as a study method centering on the analyses of precedent studies and statistics.

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In South Korea, the number of students with health impairment has increased from 1,024 in 2006 to 2,174 in 2010. There are total 30 special schools nationwide; 20 schools run by offices of education and 10 schools run based on the agreement between office of education and hospital or run by only hospital in 2010. 30 hospital schools are giving education services to 1,005 students per month by 50 teachers and staffs.

The management of hospital schools has presented several problems; the lack of teachers and assistive personnel considering the number of students with health impairment, the insufficient facilities and the regional bias of hospital schools; 10 schools among total 30 schools nationwide are being operated in Seoul. To solve these problems, special education teachers, assistant teachers and volunteers have to be supplied sufficiently and the facilities for education have to be expanded.

＜Key-words＞

health impairment, hospital school, special education

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Ⅰ. Introduction

The children and adolescents who have chronic diseases including pediatric cancers, kidney diseases and cardiac diseases have difficulties caused by long-term treatment, chemotherapy and pharmacotherapy; the limitation of physical change and body functions in daily life comparing with the same age group, psychological and emotional difficulties and the difficulties in school life and performance. As 1~4% of Survival rate of patients of pediatric cancer in 1930's has risen to about over 70% owing to the development of medical science for the last 70 years (Park Mi-Ju 2007), the focus of the education for students with health impairment has been moved from psychological approach to death from the way of living their life together with chronic diseases.

As students with health impairment are absent from school frequently and/or for a long time because of their diseases and its treatment process, they may not only struggle with school life by being kept back in the same class and feeling difficulty in studying, but also have psychological and emotional problems in the relationship between friends and teachers. To solve these problems and secure the right of learning for students with health impairment, special educational support is required.

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About 8,000 students drop out of and/or are temporarily absent from school because of diseases (MEST 2003) and 97% of those with health impairment have trouble with the re-adaptation to school life due to the long term learning deficit and the blank of school life, even though they are recovered and return to school(Park Eun-Hye et al. 2005).

To solve the psychological and emotional problems of students with health impairment, foreign countries such as the U.S.A, Japan, Germany and Swiss have already considered the students with health problems as the person subject of special education. In Japan, the Enforcement Rules of Act on Elementary Education in 1947 mentioned that sick and weak children require special protective care and in the Act on School Education, the Article 75, clearly states that children with health impairment become the persons subject of special support class in elementary, middle and high schools. In South Korea, by partially amending the 「Special Education Promotion Law」, children who have chronic diseases or weakness were included to the persons subject of the special education with the name of 'health impairment' and began to be given educational services and also the 「Enforcement Decree of the Act on the Special Education for Disabled Persons, Etc.」, which was enacted in 2007, prescribes that children with health impairment have to be given special educational support by selecting them as the persons subject of special education.

The methods to provide educational supports for students with health impairment include hospital school, the support for students to return to school, itinerant education, supports within school, and educational supports by using mass media such as cyber home learning system or video lesson (Park Eun-Hye et al. 2005).

Hospital schools enable in-patient students to be provided with tailored education services that help them keep up with the education courses of general schools. In Japan, U.K., Italy and Canada as well as the U.S.A., these kinds of hospital schools are generally run in the pediatric ward. In Japan, a hospital school is installed in a hospital as a branch school of close general school of the hospital and provides education based on the local school curriculum for students with chronic disease who need long-term treatments and daily living management (Thkahashi YoKo 2006).

In South Korea, Seoul National University Hospital began to run a hospital school in 1999 and Severance Hospital also started to set up a small scale of children's hospital school in 2000, even when students with health impairment had not been included to the persons subject to special education in 2005. Hospital schools that belong to office of education and run by dispatched special education teachers have been installed in Gyeongsang National University Hospital and Pusan National

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University Hospital in 2004. Four hospital schools in 2005 and 10 in 2006 have been established; total 30 hospital schools are providing education for 1,005 students per month on average in 2010.

As hospital schools have been expanded in the whole country, more students with health impairment could be officially provided with education services. Now it is the time to secure the higher-quality of education for students with health impairment by establishing the substantial support system that is ready to be applied for the management of hospital school. Therefore, this study aims to understand health impairment and to analyze and examine the current situation and tasks of hospital schools. This study employed literature review as a study method centering on the analyses of precedent studies and statistics.

Ⅱ. Theoretical Background

1) The Definition of Health Impairment

As the sense of value and systems of eras has changed, the concept of disability has also changed. Recently "International Classification of Functioning, Disability and Health (ICF)" by WHO has affected the concept of disability to change from physical disabilities to functional disability in social policy context (WHO 2001; Hwang Soo-Kyeong 2004) and the persons subject to special education tend to be expanded.

Along with the international tendency, in 2005, as the Special Education Promotion Law was partially amended, students with 'health impairment', which the fields of medicine, nursing, health studies and pedagogy have concerned about, became the persons subject to special education.

In South Korea, children with health impairment who need medical and life care for over 6 months because of chronic chest disease, cardiac disorder and kidney disease are classified into the persons subject to special education. Ahn Byung-Jub et al. (1994) analyzed the current situation of children with health impairment and emphasized that the education of hospital schools has to be connected to that of the schools that students are originally affiliated with in order to help them readapt to school life.

Korea Institute for Special Education defines students with health impairment as the students who need special supports for studying and daily living, for they require continuous medical treatments e.g., long-term hospitalization or outpatient care due to the chronic disease or weakness and for the first time, added students with health impairment to the persons subject to special education (Chung Dong-Young et al.

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2001).

As persons with chronic diseases or children with chronic disease and weakness have been included to persons with 'health impairment' by the amendment of the Special Education Promotion Law in 2005, the concept of children with health impairment has been established and the tailored education support and services to meet their need have been able to be provided.

Moreover, 'Act on Special Education for Disabled Persons, Etc' defines a person with health impairment as the person who needs continuous education services for school life and school performance as well as continuous medical support such as long-term hospitalization or out-patient care for over three months because of chronic diseases including mental and physical disorder, kidney disorder and liver disorder.

Japan employs the term, frailty linked to disease and physical frailty, as the similar term of health impairment. Japan Ministry of Education, Culture, Sports, Science and Technology defines frailty linked to disease as the condition that needs continuous medical and life regulation due to chronic disease and physical frailty as the condition that needs continuous life regulation due to the state easily to be sick (Ministry of Education, Culture, Sports, Science and Technology: Japan, 2006).

Social Security Act in the U.S.A. prescribes children with health impairment as the ones who need special health-related care, for they have developmental disorder, mental retardation and learning disorder or have chronic disease e.g., asthma or diabetes or have emotional and behavioral disorders e.g., ADHD.

Individuals with Disabilities Education Act (IDEA) of the U.S.A. defines other health impairment as the insufficient state of physical power and arousal due to chronic disease or serious health-related conditions including asthma, ADHD, diabetes, epilepsy, cardiac disease, tuberculosis, rheumatism, nephritis, hemophilia, lead toxicity, leukemia, etc. (OECD 2004).

2) Characteristics of Students with Health Impairment

Most of students with health impairment present the difficulties in cognitive and socio-emotional adaptation due to the diseases themselves, long-term absence, long-term hospitalization and changes of the function of family members (Brown & Madan-Swain 1993). Therefore, it requires that the characteristics of diseases of student with health impairment are needed to be understood and the cognitive, social, emotional and physical characteristics of students with health impairment may be presented differently due to the treatment processes of their diseases and other various experiences.

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① Pediatric Cancer

Pediatric cancers include malignant tumors such as leukemia and brain tumor and among them, leukemia is the one that occurs most frequently. Leukemia develops the cognitive, social-emotional and behavioral problems for short- or long-term period due to the treatment process (Brown & Madan-Swain 1993). In addition, physical change including the weight change, hair loss, oral ulcer and others in the process of treatment, which make patients hurt pride and lowered social adaptability. Especially it is reported that children with leukemia show the difficulty in quantitative description, fine motor skill, vision and movement (Park Eun-Hye et al., 2004) and their abilities of attention, concentration, ordering, memory and understanding seem to go down (MEST 2006).

② Childhood Asthma

Childhood asthma is the bronchial asthma and bronchitis to give rise to respiratory distress and makes patients absent from school frequently and difficult to learn new information, for they feel bad and hard to concentrate on, even though they attend class (Bender 1999). Asthma itself is not the cause to lower learning ability, but the medication for asthma bring about depression, fear and short-term memory impairment and in result, decreases the ability of understanding (Park Eun-Hye et al., 2004).

③ Children Diabetes

Diabetes is the chronic disease occurred by the decrease of synthesis and secretion of insulin in the pancreas. Diabetes doesn't have perfect cure and may cause complications such as retinosis, nephrosis and nerve leisions.

Diabetes requires strict self-management; blood-sugar test and insulin injection several times a day to keep proper blood-sugar, regular meals based on the balanced nutrition level and daily and steady exercise. Therefore, there is possibility that diabetes makes patients' life shrunken greatly. Childhood diabetes occurs in the physically and mentally immature period; patients feel burden mentally, for they have to manage the disease for the rest of their life and struggle with depression and stress due to the side effects and complications, if they fail to manage it.

Moreover, they feel difficult in peer relationship and school life comprehensively; they don't have enough place or time to exercise, to do blood-sugar test and to get injection and cannot have direct support of parents in the school; when they are excluded from school events, for example, school excursion, they feel isolated.

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④ Cardiac Disorder

Cardiac Disorder is the term to include the dysfunctions of heart caused by myocardial infarction, valvular disease of heart and angina pectoris. Most of children cardiac disorders occur innately; in result, normal physical development is disturbed and frequent respiratory diseases cause vulnerable health condition; and the difficulties in commuting to school, passive relationship with friends and performing school activities are raised (MEST 2006).

⑤ Kidney Disorder

This is the disorder that is caused by the dysfunctions of kidney that controls the proper quantity of water and electrolytes by getting rid of waste matters in body; it makes patients difficult in daily living activities and includes chronic renal failure that requires permanent hemodialysis or renal transplantation. Childhood kidney disorder causes poor growth by bring about poor appetite, lack of calories and chronic anemia and the physical immaturity gives children mental burden greatly (Jo Byeong-Su, 1998).

Most of students with health impairment experience more severe fear and depression than other students of the same age without disorders, even though the degrees and kinds of difficulties are different from the kind of diseases. Students with health impairment have psychological, social and cognitive difficulties such as physical changes caused by disease, passive relationship with people, maladjustment to school or society rather than difficulties from diseases themselves. Moreover, the medication for treatment causes psychological, social and emotional problems such as depression raised by steroid for a short-term and emotional fluctuation of fear or sadness.

3) Definition and Roles of Hospital School

Hospital schools have been established to meet the needs of students with health impairment. The hospital school is the school that is installed within hospital for students who cannot attend school due to the long-term hospitalization and outpatient treatment (Kim Eun-Joo 2006). Hospital schools provide the opportunity to continue to get education for students with health impairment that are given long-term treatment and carry out various programs to help them return to school after treatment. Therefore, they help students continue school life by establishing educational environment and getting dispatched teachers to teach them while they get treatment from hospital. In addition, as well as education, they aim to improve

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the treatment effects based on the psychological and emotional stability of students with health impairment by helping them maintain the relationship with students of the same age.

Likewise, hospital schools provide the opportunity to be promoted to next grade and various educational benefits free of charge by securing the educational opportunity for students with health impairment, minimizing the burden from learning deficit, helping them maintain the relationship with students of the same age and securing attendance days. Moreover, teachers can teach students with health impairment without stopping and simultaneously have medical supports for the emergent situation while they are teaching (Choi Yong-Jae 2009).

In South Korea, based on the Act that prescribes the provision of education to the persons subject to special education by dispatching teachers to the facilities or hospitals, hospital schools have been established in the type of special classes and special education teachers have been dispatched (MEST 2006). Most of hospital schools are run as the type of branch class by one special teacher who is dispatched from general school. Even though hospital school are composed of only one class, they are called as not hospital class, but hospital school, for several classes and several grades study together and the positions of students and their parents are considered (Kim Eun-Joo 2006).

4) The Necessity of Educational Support for Students with Health Impairment

Students with health impairment experiences various difficulties caused by chronic diseases as well as the physical pains (Kim Eun-Joo 2008). Especially as students with health impairment are absent from school frequently and/or for a long time because of their diseases and its treatment process, they struggle with school life feeling social and emotional difficulties in the relationship with friends or teachers and difficulties in academic retardation or academic performance.

Students with health impairment feel difficult in being kept in the same class, as they cannot enter advanced school or be promoted to higher grade together with friends of the same age due to the long-term or frequent absence (Kim Eun-Joo 2008).

The attendance of students with health impairment is affected by some factors: the attitude for the diseases, the response to the learning deficit, significant adults surrounding children, e.g., teachers and parents, doctor's attitude, educational level of parents, the children's ability for physical activities, the children's health condition and available resources of school to meet the needs related to health and learning

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(Kim Eun-Joo 2008).

Even though there are somewhat differences according to the symptoms of diseases, the common symptom in therapeutic process of chronic diseases is fatigue, which makes students difficult to study; students with health impairment have difficulties in secondary outcomes of medication as well as the disease, itself (Sexson & Madan-Swain 1993).

Not only declines of Physical conditions and cognitive ability, changes of emotional state, limited physical movement and increase of absence, but also the short knowledge of the disease, the misunderstanding and the attitude changes of friends and teachers are the main problems to disturb the class activities of students with health impairment. Side effects of therapeutic process of chronic diseases bring about negative responses from friends or teachers: frequent absence, difficulty in learning caused by side effects from chemotherapy or radiation therapy, loss or increase of weight, hair loss, etc. Those problems make students with health impairment lost confidence, decrease participation of school life, induce them to be excluded from school activities and give rise to psychological and social anxiety in the relationship with friends or teachers.

Therefore, solutions to overcome difficulties including being kept in the same class and feeling difficult in studying and adapting themselves to school life have to be found.

Ⅲ. Education for Students with Health Impairment

1) Current Situation of Students with Health Impairment

Students with health impairment take outpatient care attending general school or choose hospitalization for a long-term treatment attending hospital school or attend special school for a long-term treatment (Choi Yong-Jae 2009).

As persons with Health impairment were included to the persons subject to special education in 2005, the official statistics on health impairment has been managed since 2006 and the number of students with health impairment for the last five years is shown in Table 1.

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<Table 1> Number of Students with Health Impairment

Year	Special Schools	General Schools		Total
		Special Classes	General Classes	
2006	46	619	359	1,024(1.6)
2007	40	509	593	1,142(1.7)
2008	17	490	1,130	1,637(2.3)
2009	16	538	1,391	1,945(2.6)
2010	24	496	1,654*	2,174(2.7)

Source: 「2010 Workshop on the Management of Nationwide Hospital Schools」 Ministry of Education, science and Technology

**Special Education Support Center: two (2) persons are included*

( ): proportion of children with health impairment to total number of person subject for special education

As noticed in the Table 1, since 2006 when the research on students with health impairment has been carried out, the number of students with health impairment has increased every year. In 2010, the students with health impairment were 24 in special schools, 496 in special classes and 1,654 in general classes and total of students with health impairment is 2,174, which is the 2.7% of 79,711 of the persons subject to special education. The number of students with health impairment has increased in general classes rather than in special schools.

2) Current Situation of Hospital Schools

In South Korea, based on the Act that prescribes the provision of education to the persons subject to special education by dispatching teachers to the facilities or hospitals, hospital schools have been established in the type of special classes and special education teachers have been dispatched.

In South Korea, Seoul National University Hospital had opened a hospital school in July, 1999 as it was authorized as an official school, and then, Severance Hospital and Gyeongsang National University Hospital opened in 2004, In 2004 the Korean Association for Children with Leukemia & Cancer opened a shelter that performs the functions of hospital school by connecting with Pusan National University Hospital. In March, 2005, two university hospitals in Busan Metropolitan City founded hospital schools for pediatric cancer patients as the part of the policy of alternative

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education in Korea.

<Table 2> Current Situation of Hospital Schools

Number of Schools	Number of Students by month	Number of Teachers and Staff	Name of Hospitals	
			Hospital Schools run by Offices of Education (20)	Hospital Schools run based on the Agreement between Offices of Education and Hospital or run by Hospital alone (10)
30	1,005	50	Gyeongsang National University Hospital, Pusan National University Hospital, Inje University Pusan Paik Hospital, Dong-a Medical Center, Bugok National Hospital, National Cancer Center, Daegu Yeungnam University Medical Center, Daedong Hospital, Gachon University Gil Hospital, Inha University Hospital, Ulsan University Hospital, Chungnam National University Hospital, Chonnam National University Hwasun Hospital, Dankook University Hospital, GangNeung Asan Hospital, Kangwon National University Hospital, Chungbuk National University	Seoul National University Hospital, Severance Hospital, Hanyang University Medical Center, Asan Medical Center, Samsung Medical Center, Seoul National Hospital, Seoul Metropolitan Children's Hospital, Korea Institute of Radiological and Medical Science, Seoul St. Mary's Hospital, Kyung Hee University Medical Center

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			Hospital, Chonbuk National University Hospital, Kyungpook National University Hospital, Pusan National University Yangsan Hospital	

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

As shown on Table 2, in South Korea, total 30 hospital schools have offered education to 1,005 students per month on average; 10 hospital schools run based on the agreement with office of education to provide administrative and financial support for hospitals; 20 hospital schools operated as the classes belong to office of education or general schools.

For the first semester (March to July) in 2010, 50 teachers in nationwide 30 hospital schools are teaching 1,005 students a month on average and among them, 930 students had health impairment.

As for the average period that students with health impairment attended, less than one month were most frequent and then, 6 months to 1 year and one month to three months were ranked next in descending order (MEST, 2010).

<Table 3> Number of Students and Teachers and Staff by Hospital School

Region	Name of Hospital	Monthly Average Number of Students to Use Hospital School	Number of Students with Health Impairment	Number of Special Education Teachers(In Case of Seoul, Qualification and Number of Teachers or Staff)	Number of Assistants
Seoul	Kyung Hee University Medical Center	7	1	Social Worker 4	30
	Seoul National Hospital	86	61	Therapeutic Teacher 3	50

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Region	Name of Hospital	Monthly Average Number of Students to Use Hospital School	Number of Students with Health Impairment	Number of Special Education Teachers(In Case of Seoul, Qualification and Number of Teachers or Staff)	Number of Assistants
	Samsung Medical Center	63	66	Level 2, Teacher's License for Middle School, 1	-
	Seoul National University Hospital	80	267	Lifelong Educator 1	111
	Seoul St. Mary's Hospital	87	57	Medical Social Worker 1	-
	Seoul Metropolitan Children's Hospital	6	0	Special Education Teacher for Elementary Students 1	- -
	Seoul Asan Medical Center	29	61	Medical Social Worker 1	
	Severance Hospital	115	68	Level 1, Teacher's License for Elementary School 1 Level 2, Teacher's License for Middle School 1	-
	Korea Institute of Radiological and Medical Science	20	22	Teacher's License for Elementary, Middle and High School 11	8
	Hanyang University Medical Center	52	28	Staff of Hospital 1	-
Busan	Pusan National University	15	16	1	1

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Region	Name of Hospital	Monthly Average Number of Students to Use Hospital School	Number of Students with Health Impairment	Number of Special Education Teachers(In Case of Seoul, Qualification and Number of Teachers or Staff)	Number of Assistants
	Hospital				
	Dong-a Medical Center	17	2	1	-
	Inje University Pusan Paik Hospital	28	39	1	1
Daegu	Daedong Hospital	15	5	1	-
	Daegu Yeungnam University Medical Center	12	34	1	-
	Kyungpook National University Hospital	28	24	1	-
Incheon	Inha University Hospital	35	2	1	-
	Gachon University Gil Hospital	15	1	1	-
Daejeon	Chungnam National University Hospital	8	17	1	1
Ulsan	Ulsan University Hospital (Dasom Hospital School)	51	42	2	3
Gyeonggi	National Cancer	15	12	2	-

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Region	Name of Hospital	Monthly Average Number of Students to Use Hospital School	Number of Students with Health Impairment	Number of Special Education Teachers(In Case of Seoul, Qualification and Number of Teachers or Staff)	Number of Assistants
	Center				
Gangwon	Kangwon National University Hospital	65	6	1	1
	GangNeung Asan Hospital	88	12	1	1
Chungbuk	Chungbuk National University Hospital	7	8	1	-
Chungnam	Dankook University Hospital	5	5	1	1
Jeonbuk	Chonbuk National University Hospital	12	10	1	1
Jeonnam	Chonnam National University Hwasun Hospital	16	36	2	1
Gyeongnam	Gyeongsang National University Hospital	4	4	1	-
	Bugok National Hospital	8	8	1	1

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Region	Name of Hospital	Monthly Average Number of Students to Use Hospital School	Number of Students with Health Impairment	Number of Special Education Teachers(In Case of Seoul, Qualification and Number of Teachers or Staff)	Number of Assistants
	Pusan National University Yangsan Hospital	16	16	2	-
Total	30	1,005	930	50	211

Source: 「2010 Annual Report on Special Education」, Ministry of Education, Science and Technology

3) Current Situation of Education Support System and Curriculum of Hospital Schools

Various education delivering systems need to be built for the educational support for students with health impairment in order to secure the equal opportunity based on their physical state (Park Eun-Hye et al., 2005).

Educational support for student with health impairment needs to be given to secure the opportunity for education and the basic right to learning and to help them adapted to school life by providing individualized learning support and balanced psychological and emotional supports. In addition, various services have to be given to improve the treatment effect by planting the hope and courage for life (MEST 2006).

In South Korea, the educational supports for students with health impairment have been carried out through the cyber home learning system, itinerant education and U-learning support and psychological and emotional supports for them have been carried out through communication media such as telephone and e-mail and education programs to improve the perception for health impairment (See Figure 1).

Hospital schools have run the curriculum aiming to increase the synergy effects of treatment through the psychological and emotional stability by minimizing the difficulties of students who have learning deficit and absence with the result of long term treatment based on the continuity of studying and peer relationship.

Hospital schools have focused to the establishment of tailored educational

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planning, the management of attendance based on efficient education management, active visitations of friends and teachers, the provision of counseling for out-patient students and the offering of supports for educational, psychological and emotional adaptation (Hospital School of Korea 2011).

The education curriculum of hospital schools are largely divided into learning activity, special activities and diverse events. Learning activities are comprised of education activity and discretionary activity; education activity for main subjects, which are Korean, Mathematics, social studies and sciences for elementary school students and Korean, Mathematics and English for middle and high school students, is provided to meet the needs of each student through various methods by considering the characteristics of hospital school and the health condition and learning ability of students; discretionary activity includes various programs for psychological stability, emotional cultivation and increase of sociality.

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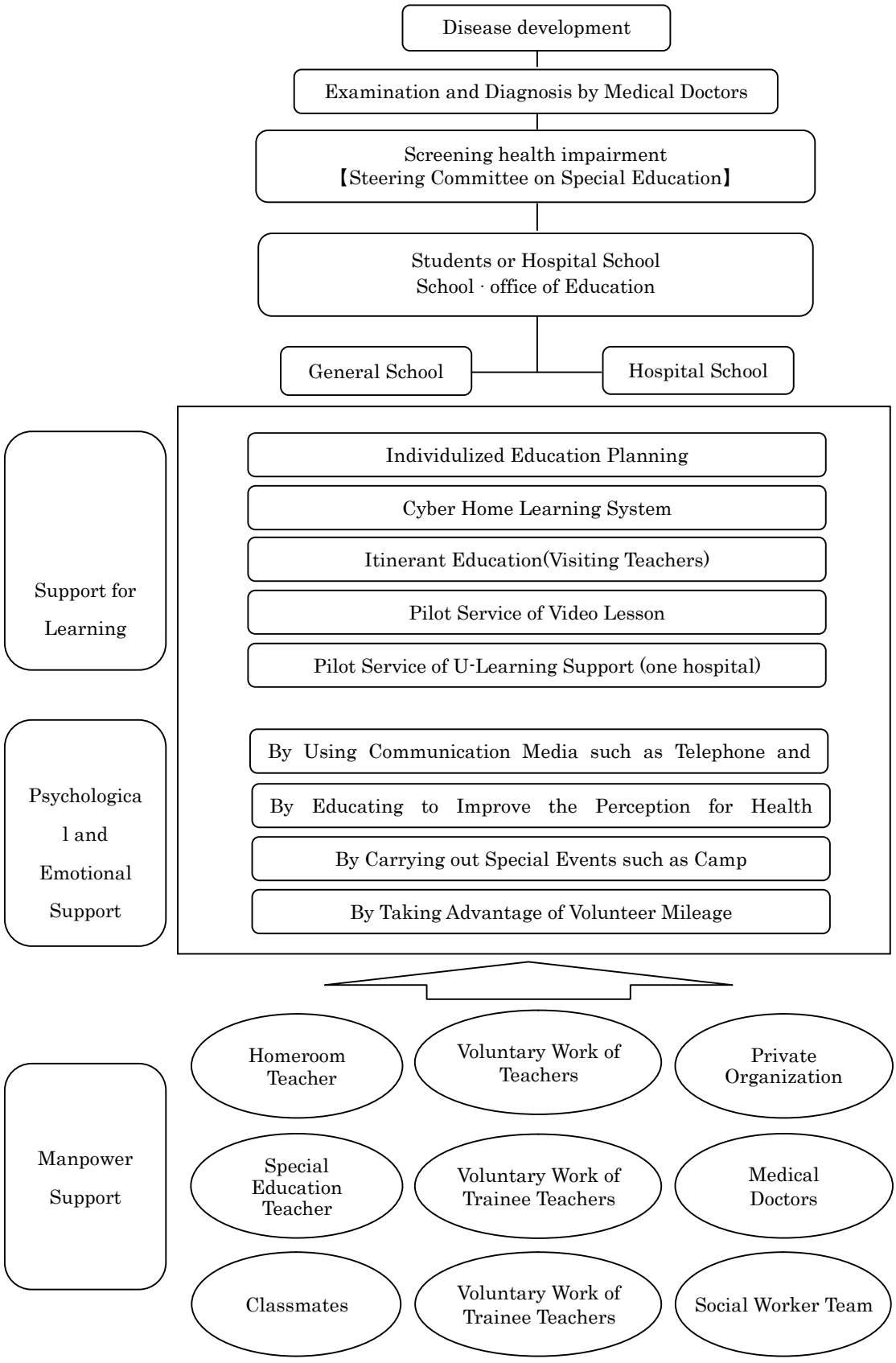

<Figure 1> Model of Educational Support for Students with Health Impairment

Source: Hospital School of Korea (2011)

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Special activities consist of various programs including folding paper into various figures, art, watching movies, storytelling, art therapy, music therapy and play therapy that are carried out by professionals and volunteers. These activities help students with health impairment adapted psychologically and emotionally and lessen depression and mental stress caused by diseases.

As for events, various events including Children's Day, experiential learning, drawing contest, book report contest have been performed.

The classes of hospital school are scheduled as one (1) or over one hour a day for elementary school students and two (2) or over two hours a day for middle and high school students. Students with health impairment are registered to the schools that they are originally affiliated with and the classes are carried out by hospital schools. Attendance of hospital school is considered as official attendance based on the verification of the principal.

If possible, students with health impairment are recommended to take the academic achievement test at school that they are affiliated with, but if impossible due to the health related problems, they may take the test at hospital based on the discussion between teachers of hospital school and school that students are affiliated with. In addition, if the test cannot be taken, the principal of school may decide the result of the test based on the 'rules of academic achievement management' of the school.

Ⅳ. Discussion

As the sense of value and systems of eras has changed, the concept of disability has also changed. As the Special Education Promotion Law was partially amended in 2005, the term, 'health impairment', has been added to the scopes of disabilities, which includes children with chronic diseases or weakness to the persons subject to special education.

As students with health impairment are absent from school frequently and/or for a long time because of their diseases and its treatment process, they struggle with school life by being kept back in the same class and feeling difficulty in studying and the relationship with peers. To solve those problems, hospital schools have been established.

In South Korea, total 30 hospital schools have offered education to 1,005 students per month on average; 10 hospital schools run based on the agreement with office of education to provide administrative and financial support for hospitals; 20 hospital

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schools run by office of education or general schools as the classes.

Hospital schools aim to increase the synergic effects of treatment through the psychological and emotional stability by minimizing the difficulties of students who have learning deficit and absence with the result of long term treatment based on the continuity of studying and peer relationship. Therefore, hospital schools play roles to establish tailored educational planning, to manage attendance based on efficient education management system, to make peers and teachers visit patient actively, to provide counseling for out-patient students and to offer supports for educational, psychological and emotional adaptation.

In hospital schools, students are provided education to meet the needs of individual students through various methods centering on key subjects, considering the health condition and learning ability of students.

In South Korea where legally recognized health impairment, established hospital schools and built support system and operational policies, the education students with health impairment by hospital schools have tasks to be improved:

First, the number of hospital schools is absolutely insufficient, as there are only 30 hospital schools for 2,174 students with health impairment in 2010. Hospital schools need to be expanded enough to meet educational needs of student with health impairment.

Second, the distribution of 30 hospital schools shows regional imbalance, which make students with health impairment take advantage of hospital schools; while 13 schools in Seoul and Gyeonggi areas and 7 in Busan and Gyeongnam are situated, 3 schools in Daejeon and Chungcheong areas, 3 in Daegu, 2 in Gangwon area and 2 in Jeolla area are established and Gyeongbuk area except Daegu and Jeju area doesn't have any schools. To solve the regional imbalance of hospital school distribution, enough number of hospital schools needs to be established based on the research on the regional demand.

Third, as most of the hospital schools are run by one special teacher who is dispatched, it is practically difficult to deal with all students whose grades and learning ability are different at the same time. The placement of special education teachers needs to be carried out based on the actual demands.

Fourth, because hospital schools except several ones in Seoul don't have any assistant for education and special education teachers have to take responsibility for all students alone, the efficiency of class management has fallen. The methods to expand manpower support, for example, to make parents of students with health impairment participate in class as teaching assistants, have to be found.

Finally the inclusive education programs to understand students with health

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impairment and to help their psychological and emotional treatment need to be developed by connecting the school that they are affiliated with and inducing the student of the same age to work as volunteers.

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ORIGINAL ARTICLE 7

Causes of Transition from Institution to Group Home for the Persons with Intellectual Disability, Analyzed with the ICF

Atsushi TANAKA [1)] , Toru HOSOKAWA [2)] , Masumi INAGAKI [3)]

1) Faculty of Education, University of the Ryukyus
＃〒903-0213 Senbaru 1, Nakagami-gun, Nishihara-cho, Okinawa
atanaka@edu.u-ryukyu.ac.jp
2) Graduate School of Education, Tohoku University
hosokawa@m.tohoku.ac.jp
3) Of Developmental Disorders, National Institute of Mental Health, National Center of Neurology and Psychiatry, Tokyo, Japan

ABSTRACT

The Ministry of Health, Labor and Welfare has formed a scientific research study group to clarify factors inhibiting social participation of persons with mental retardation, and to develop methods to improve such participation. The group conducted the present survey with the aim of identifying the causes preventing such participation at present, and clarifying the types of measures needed to resolve these issues. To enable future international comparisons with some of the results, they were rated using the common international language in the International Classification of Functioning, Disability and Health (ICF). Surveys were sent to the chief staff of 506 institutions (welfare facilities for mentally retarded) nationwide in Japan, and valid responses were received from 224. Each institution was asked to recall one member each from among those transited or residing in institutions, and rate them on each of the ICF levels. The factors producing differences in the career path treatments for transition to community life and institutional residence were then analyzed. The transited group of members had a mean score of no higher than 2 for any item evaluated by the ICF criteria. The institutionalized group, on the other hand, had this score on 1 body function item and 12 activity and social participation items.

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Transition, Group home, WHO, ICF
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Ⅰ. Introduction

The popularization of normalization is changing policy toward the intellectually disabled, with the emphasis shifting from institutional placement to community life. In Japan, however, most people with intellectual disabilities who are employed by a company live with their parents. There are many people with intellectual disabilities unable to live by themselves, making them dependant upon their parents for daily life.

In Europe and America the development of group homes, which serve as a basis for transition to community life, has spread rapidly. The development of such facilities lags in Japan, however. There is an unequivocal shortage of support and societal resources for people with intellectual disabilities living in communities. We are then left to wonder if anything else is preventing the transition from institutions to community life.

A nationwide investigation was conducted by a welfare, labor and science group entitled "Research for the promotion of social participation in persons with intellectual disability by identifying and resolving obstructive factors." The two objectives of the study were as follows.

(1) To identify the factors which prevent such participation by people with intellectual disabilities.
(2) To clarify the types of measures needed to resolve these issues.

To enable future international comparisons with some of the results, graduates were rated using the common international language in the International Classification of Functioning, Disability and Health (ICF). ICF belongs to the “family” of international classifications developed by the WHO for application to various aspects of health. The WHO family of international classifications provides a framework to code a wide range of information about health and uses a standardized common language permitting communication about health and health care across the world in various disciplines and sciences. ICF is a multipurpose classification designed to serve various disciplines and different sectors (WHO, 2001).

The components of functioning and disability in Part 1 of ICF are interpreted by

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means of four separate but related constructs. These constructs are operationalized by using qualifiers. Body functions and structures can be interpreted by means of changes in physiological systems or in anatomical structures. For the Activities and Participation component, two constructs are available: capacity and performance2). The definitions of ICF components are given in Table 1. Badley (2008) described that A key area left open in the ICF was the distinction between activity and participation.

ICF has two parts, each with two components. Each component can be expressed in both positive and negative terms. Each component consists of various domains and, within each domain, categories, which are the units of classification. Health and health-related states of an individual may be recorded by selecting the appropriate category code or codes and then adding qualifiers, which are numeric codes that specify the extent or the magnitude of the functioning or disability in that category, or the extent to which an environmental factor is a facilitator or barrier (WHO, 2001).

Bruyere, Van Looy, Peterson (2005) reviews the literature since the ICF's endorsement, focusing on those articles that discuss (a) what the ICF means and how it can be used. Research and clinical implementation efforts suggest that the ICF is a useful and meaningful public health tool (Peterson, 2005). Jette, Norweg, & Haley (2008) reviewed the strengths and weaknesses of two different approaches to assessing ICF concepts: coding versus quantitative scales. They concluded ICF codes provided a useful approach for classifying easy-to-interpret health-related information on individuals that can be incorporated into administrative records and databases.

Schneidert, Hurst, Miller, & Ustun (2003) provides a framework for understanding the impact of environmental factors on functioning when a person has a health condition. They said the ICF was a classification that allows a comprehensive and detailed description of a person's experience of disability, including the environmental barriers and facilitators that have an impact on a person's functioning. Howard, Nieuwenhuijsen, & Saleeby (2008) discussed how the ICF could be useful in enhancing social change through health promotion and health education for all people, in particular those with disabilities and chronic conditions. Excepting the reports mentioned above, there are many ones affirm the ICF in clinical experience (Maeda, Kita, Miyawaki, et. al., 2005; Slebus, Sluiter, Kuijer, et. al., 2007; Mullis, Barber, Lewis, et. al., 2007; Gabl , Krappinger, Arora, et. al., 2007; Osteras, Brage, Garratt, et. al., 2007; Starrost, Geyh, Trautwein et. al., 2008; Mittrach, Grill, Walchner-Bonjean et. al., 2008; Paul, Leitner, Vacariu et. al., 2008;

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Jonsson, Ekholm, & Schult, 2008; Martin, Burtner, Poole et. al., 2008; Soberg, Finset, Roise et. al., 2008; Coster & Khetani, 2008; Wright, Rosenbaum, Goldsmith et. al., 2008; Okawa, Ueda, Shuto et. al., 2008).

<Table 1> The definitions of ICF components

In the context of health: Body functions are the physiological functions of body systems (including psychological functions). Body structures are anatomical parts of the body such as organs, limbs and their components. Impairments are problems in body functions or structures such as a significant deviation or loss. Activity is the execution of a task or action by an individual. Participation is involvement in a life situation. Activity limitations are difficulties an individual may have in executing activities. Participation restrictions are problems an individual may experience in involvement in life situations. Environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives.

WHO (2001)

In this investigation, the transition from institutions to community life was considered to be a concrete form of participation. Each institution was asked to recall one user with intellectual disabilities each from among those sifted to group homes or residing in institutions, and to rate them in accordance with each ICF criterion. From comparison, the factors behind these differences in career path handling (i.e., transition to community life and institutionalization) were then analyzed.

Ⅱ. Methods

1. Subjects

Replies to the survey investigation were requested from the chief staff of 506 institutions (welfare facilities for mentally retarded) nationwide in Japan. Although the director at each institution was in charge of filling out the return questionnaire

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in principle, it was presumed that other teachers were also allowed to do so in cases requiring detailed evaluation.

2. Procedure

1) Investigation method (Mail survey)

The survey questionnaire recipients were asked to mail back the completed stamped, self-addressed reply forms using the previously enclosed return envelope.

2) Contents of questionnaire

A stamped, self-addressed return envelope containing the request letter and a set of survey forms was mailed out to the chief staff at each institution. The questionnaire survey items covered the group home's conditioning, system, ICF comparison, and opinion.

Here we present the results of the ICF comparison. One member each from the institution was to be chosen for the following categories: "Member transit to a group home" and "Member entering institution for more than 3 years". The respondent was to select members whose informations were sufficient to rate them on each of the ICF levels. They were to remember how the member of their choice seemed as, and then to evaluate him according to the ICF criteria. A member transit to a group home was called A, and a member entering institution for more than 3 years was called B.

They were to be evaluated by each of the main 3 ICF factors of body functions, activity and participation, and environment. However, since body structure was difficult for an on-site teacher to distinguish clearly from psychosomatic function, it was included in the body function analysis.

The ICF uses two ways to score activities and participation; performance and capacity. The scoring (evaluation) of capacity is defined as the level of an individual's ability to execute a task or given action at a given time. Since evaluation involves the past in the present survey investigation and the person doing the evaluation does not do so in a uniform manner, the evaluation in a uniform or standard environment is virtually impossible. For this reason we decided to use only performance as a criterion to evaluate activity and participation. Moreover, the evaluation of activity and participation was to be made in detail by further subdividing the "education" factor into 3 categories; "informal education," "school education," and "vocational training."

"Relationship and support" in the environmental factors was also to be evaluated in detail using further classifications because one's relationships and the type of support provided key information for devising measures to address certain issues.

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Specific examples of the above criteria items were provided in each case in the questionnaire. Use of only ICF expressions would be presumably difficult to understand and thus make it difficult for the respondent to reply. The respective standards used by the ICF to rate difficulty, etc. were adopted for the evaluation criteria. Among the environment factors, the "facilitation level" was evaluated for "Member transit to a group home", and the "hindrance level" was evaluated for "Member entering institution for more than 3 years".

Ⅲ. Analysis

After checking the original forms of the returned questionnaires, Excel was used to finally sort out the raw data from valid replies. SPSS was used for the statistical analysis.

Ⅳ. Result feedback

The plan is to e-mail a summary of the survey results to any person requesting it.

1. Results and Discussion

1) Response Rate

Some 224 valid replies were obtained from the survey questionnaires sent out to the chief staff of 506 institutions nationwide in Japan. This amounts to a response rate of 44.3%.

2) ICF comparison of transit to group home and residing in institutions members

(1) Severity of body function and functional impairment

Figure 1 presents a comparison of body functions between those who transit to group homes (A) and those who reside in institutions (B). The severity was significantly greater in the transit group than the residing group on all items using t-test. In both groups "mental functions" were highest, followed by "voice and speech functions." Both groups evidenced virtually the same tendencies for all items evaluated. According to the ICF evaluation criteria, a score of 2 was defined as a moderate degree of functional impairment, and only the "mental functions" item of the residing group exceeded this level.

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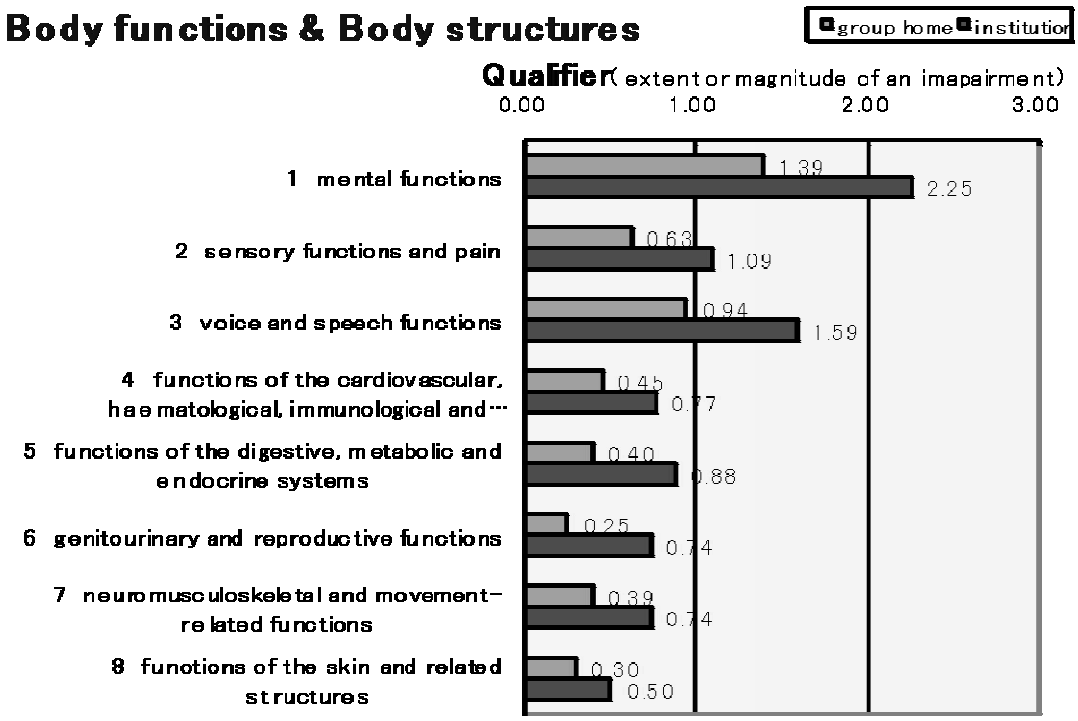
<Fig 1> Impairment of body functions



(2) Degree of difficulty associated with activities and participation

Figure 2 shows a comparison of the transited (A) and institutionalized (B) groups in terms of their activities and social participation. Members (B) residing in institutions scored significantly higher than transited members (A) on every item based on the t-test results. In the residing group, scores were higher in the order of "vocational training," "economic life," "community life," "interpersonal interaction and relationships," and "school education".

According to the ICF criteria, a score of 1 indicates mild difficulty while a score of 2 denotes moderate difficulty. The mean score of the institutionalized group proved to be over 2 in 12 of the 14 evaluation items. The transit group, on the other hand, had a mean score of more than 1 on only one item, "informal education." This suggested that the "activation and social participation" item is very important as a factor distinguishing the two groups here.

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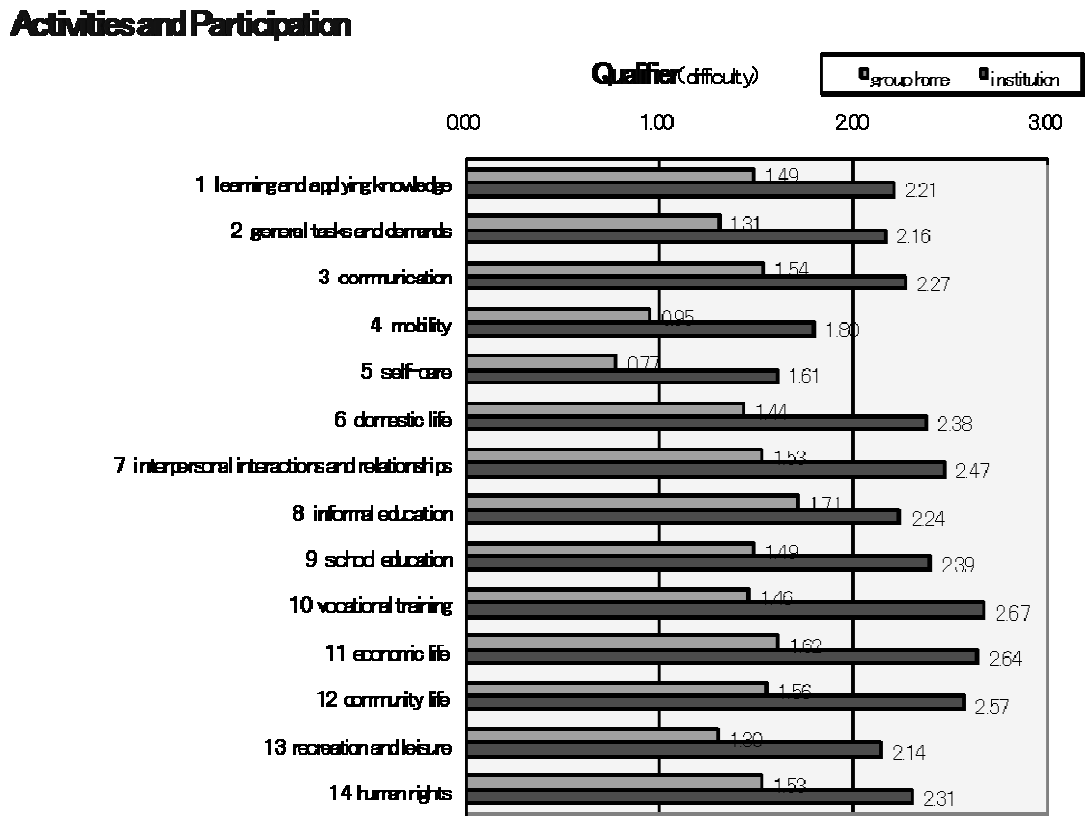
<Fig 2> The degree of difficulty of activities and participation



(3) Facilitation and impairment levels

Figure 3 shows the facilitation level as an environmental factor in the transited group (A) of members. For those in this group, it was clear that the facilitation level was highest for "support and relationships; personal care providers and personal assistants," reflecting the importance of teachers.

Figure 4 shows the hindrance level as an environmental factor in the institutionalized group (B). The highest hindrance levels were for "support and relationships; immediate family" in the institutionalized group. It was clear that the reasons they were forced to enter institutions was the little support from their families.

The ICF evaluation criteria define a score of 1 as a mild facilitation/hindrance factor, and a score of 2 as a moderate facilitation/hindrance factor. Neither group had a mean score of more than 2.

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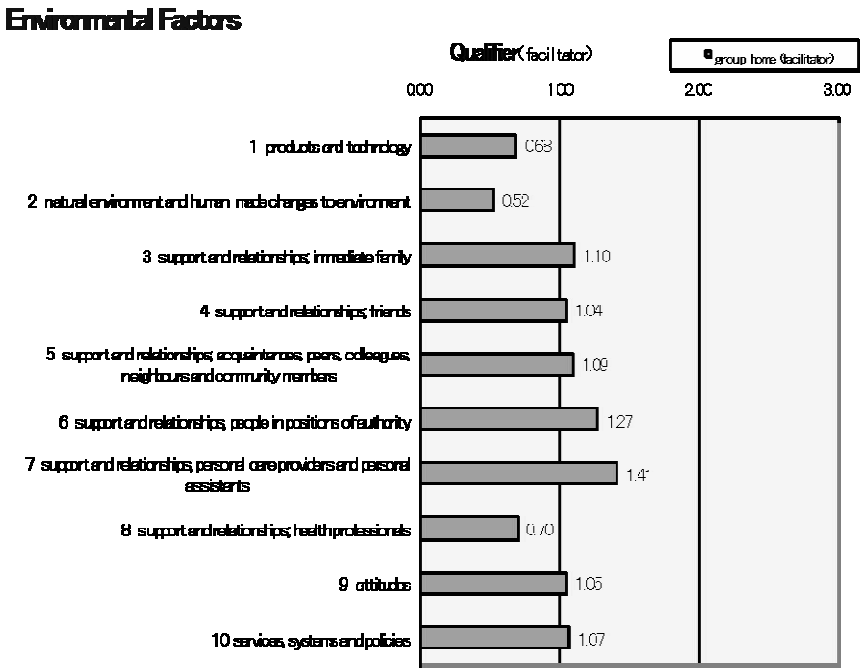
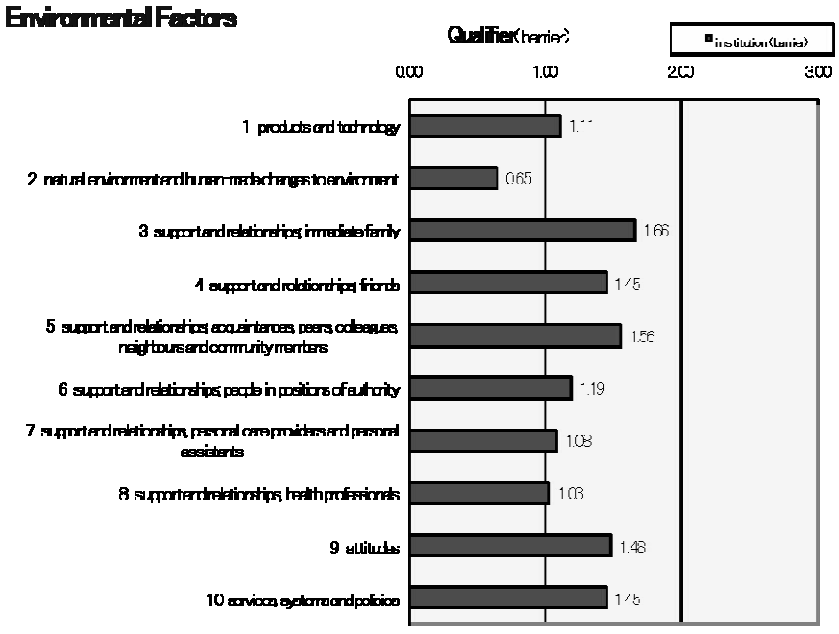
<Fig 3> The degree of facilitator of the environmental factor of an employment group (the A)



<Fig 4> The degree of barrier of the environmental factors of the institution group (the B)



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(4) Overall comparison

The transit group had a mean score of no higher than 2 for any item evaluated by the ICF criteria. The institutionalized group, on the other hand, had this score on 1 body function item and 12 activity and social participation items. It was suggested that these 13 items were important factors for distinguishing between the transited and institutionalized members in terms of career path approaches. We plan to conduct further analyses using detailed statistical processing.

2. Additional remark

This research was performed as a welfare, labor and science research group project entitled: "Research for promotion of the social participation in persons with intellectual disability by identifying and resolving obstructive factors" (representative: Masumi Inagaki) in Japan. We are deeply grateful to the professors of the research group, and to the institution staffs who cooperated in our investigation.

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原著論文 8

特別支援教育を担う教員におけるメンタルヘルスの現状 ―教員に対するGHQ28の分析結果から―

The Present Condition of Mental Health in Teachers that engaged in Special Needs Education — From the Analysis of GHQ28 for Teachers—

森　浩平[1)]（Kouhei MORI）　田中　敦士[2)]（Atsushi TANAKA）

1）琉球大学大学院　教育学研究科
〒903-0213　沖縄県中頭郡西原町千原１　琉球大学教育学部特別支援教育講座
ktv_m_kohei@yahoo.co.jp
2）琉球大学　教育学部
〒903-0213　沖縄県中頭郡西原町千原１　琉球大学教育学部特別支援教育講座
atanaka@edu.u-ryukyu.ac.jp

ABSTRACT

本研究では、特別支援教育に携わる教員におけるメンタルヘルスの現状を明らかにすることを目的とする。特別支援学校教諭免許状を未取得で特別支援教育に携わる教員に対するGHQ28の分析結果から、特別支援教育に携わる教員の約70%が精神健康になんらかの問題があることが明らかとなった。また、男女差と精神健康度、教職経験年数と精神健康度には関連性がないことが示唆された。

The purpose of this research is to disclose the present condition of mental health in teachers that engaged in special needs education. From the analysis result of GHQ28 of teachers that engaged in special needs education who doesn't have the special needs education license, it shows that approximately 70% of teachers engaged in special needs education had some kind of problems with mental health especially. In addition, it was suggested that there was no relationship in gender gap and a mental

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health degree, years of teaching experience and a mental health degree.

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teacher, special needs education, mental health, GHQ28
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Ⅰ. 問題と目的

１．教員のメンタルヘルス悪化の問題

文部科学省の教育職員に関する統計調査（2010）によると、全国の公立小・中・高校、特別支援学校などの教員約 92 万人のうち、病気休職者が 8627 名、精神疾患による休職者は 5458 名で、休職者の約 63%が精神疾患という事態に陥っている。精神疾患に陥る教員は年々増え続け、教員のストレスは増加の一途を辿っている。石川・中野（2001）が小・中学校・高等学校に所属する教員を対象におこなった調査では、日常の仕事の中でストレスを「非常に感じる」あるいは「感じる」と答えた教員が半数以上を超えている。このような調査から、子どもの成長を支える教員たちが、今、自分自身の危機に曝されていると言える（田上・山本・田中，2004)。かつて国際労働機関（ILO）が指摘したように「教員たちは戦場並みのストレスに晒されている」と言っても過言ではない（赤岡・谷口，2009)。

このような深刻な状況の中にあり、多くの教員のストレス改善のための研究が増え、教員のバーンアウト（燃え尽き症候群）に目を向けようといった動きが強まっている。こうした中で提唱された「教員バーンアウト」は特に教員に限定した概念で、「教員が、理想を抱き真面目に仕事に専心する中で、学校のさまざまなストレスに晒された結果、自分でも気づかぬうちに消耗し極度の疲弊をきたすに到った状態」と定義されている（田上・山本・田中，2004)。

うつ病の症状を訴える教員の割合は、一般企業の労働者の約 2.5 倍にのぼる（文部科学省，2010）ことから、教員のメンタルヘルスについて継続して調査や研究を行い、現状を把握することが必要といえる。

２．教員のメンタルヘルス悪化の要因

社会に溢れている様々なストレッサー（ストレスを引き起こす刺激）とメンタルヘルスの関係について、様々な観点から分析した研究が数多く存在する。

これまでの心理社会的ストレス研究の先駆けとなったのは、「社会再適応評価尺度（Social Readjustment Rating Scale)」を作成し、個人のストレス量を査定することを試みた Holmes&Rahe（1967）の研究である。彼らは、生活上の変化をもたらす何らか

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の出来事を経験した場合、社会的に再適応する際に必要とされる労力をその出来事のストレス量として数値化し、その数値の合計が高いほど、将来病気に罹患する可能性が高いことを指摘した（岡安・片柳・嶋田ら，1993)。

教員のストレスの要因を高木・田中（2003）は職務自体・職場環境・個人的（家庭内）の 3 つの要因が影響しており、バーンアウトとの関連性があることを指摘している。このうち職場環境の影響によるストレッサーに関しては、役割葛藤・同僚との関係・組織風土・評価懸念の 4 因子 25 項目に分類がされている。

沖縄県内の教員の悩みについての実態については、を教職員の勤務の実態や意識に関する分析委員会（2008）が、沖縄県の公立小・中・高校、特別支援学校に在籍する本務職員 12,760 人を対象にした調査を実施した。その結果、「日頃、悩んでいること」について、「特になし」（29.4%）が最も多く、次いで「教員としての適性」（24.4%)、「子育て」（9.8%)、「自分の病気」（6.7%）の順であった。「教員としての適性」に悩んでいる教員の割合が約 4 分の 1 を占め、他の悩みに比べて特に多い結果となっている。

UNESCO(1966）による「教員の地位に関する勧告」では、教員の仕事を専門職として定義している。さらに、「厳しい継続的な研究を経て獲得される専門的知識及び特別な技術を要求する公共的業務」と規定し、障害児教育教員の「専門性」は、複雑な教育的ニーズを抱えた障害児の増加を踏まえ、通常教育教員との専門性の差異は量的な差異とともに質的な差異も包含している（清水，2003)。

特殊教育から特別支援教育へと大きな転換が図られ、障害種の拡大や重度・重複化に伴う一人一人のニーズに応じた適切な指導・支援の要求水準の引き上げや、学校と福祉・医療・保健・労働機関等との連携など特別支援教育を担う教員に求められる専門性は非常に高まっている。こうした現状の中で特別支援教育に携わる教員のストレスも飛躍的に高まり、問題も年々深刻化している。

3．目的

本稿では、特別支援教育に携わる教員のメンタルヘルスについて、男女差、教職経験年数との関連を分析し、教員の精神健康度の現状を明らかにすることを目的とする。

Ⅱ．方法

1．調査対象

特別支援学校教諭免許状未所得で、障害のある幼児・児童・生徒の指導を担当している教員 103 名を対象に質問紙調査を実施した。

2．手続き

2009 年 8 月 5 日の沖縄県教育職員免許法認定講習の休憩時において、調査の趣旨説明

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を行いプライバシーの配慮をしたうえで調査票を 103 名へ配布、同日中に 94 名から回収を行った。

3．調査内容

今回分析対象とした質問紙調査の内容は以下の通りである。

（1）フェイスシート

回答者の基本属性

・年齢

・性別

・教職経験年数

フェイスシートでは、回答者の基本属性として性別・年齢・教職経験年数についてたずね、それぞれにおいてバーンアウトにどのように関連しているのかを明らかにした。

（2）精神健康度 GHQ28（中川・大坊、1985、4 因子、28 項目）

ゴールドバーグ（Goldberg,D.P.）が神経症、心身症を中心とする非器質性、非精神病性の疾患の病状把握、スクリーニング・テストとして 60 項目からなる質問紙を英国で開発した。因子分析の結果をもとに 28 項目版、30 項目版などの短縮版も作成されている。本調査では、GHQ28 項目版を使用する。信頼性・妥当性の吟味がよくなされており、実施・採点の簡便性、判別効率、適用範囲の広さなどから精神科、内科、学校、企業などで広く用いられている。28 項目から成り、4 件法で回答を求め、「0－0－1－1 得点法」で得点化する。精神健康度は、0～28 点の得点で精神健康状態が判断される。精神健康度得点が 0 点に近づくにつれて精神健康状態は良好であり、6 点以上の得点になると、精神健康状態が悪いとされる。さらに、28 点に近づくにつれて神経症者として診断される。

Ⅲ. 結果

1．フェイスシート

（1）回収率

本研究における調査のアンケート回収率は 103 名中、有効回答数は 94 名で、回収率は 91.3%であった。内訳は、男性 27 名（28.7%）、女性 65 名（69.1%）、不明 2 名（2.1%）であった。

（2）回答者の年齢

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回答者の年齢については、「35 歳以上 40 歳未満」と回答した人が一番多く、27 名（28.7%）であった。次いで、「40 歳以上 45 歳未満」が 23 名（24.5%）、「30 歳以上 35 歳未満」が 16 名（17.0%）、「45 歳以上 50 歳未満」が 12 名（12.8%）、「50 歳以上 55 歳未満」が 6 名（6.4%）、「25 歳以上 30 歳未満」が 5 名（5.3%）、「55 歳以上」が 2 名（2.1%）、「25 歳未満」が 0 名（0.0%）、不明は 3 名（3.2%）であった。

（3）回答者の通算教職経験年数

回答者の通算教職経験年数の平均は 14.7 年（SD 6.6 年）であった。最大は 29 年、最小は 2 年 4 ヵ月であった。

通算教職経験年数が 1 年から 10 年未満の教員を「若手教員群」、10 年以上 20 年未満の教員を「中堅教員群」、20 年以上の教員を「ベテラン教員群」とした結果、「若手教員群」は 25 名（27.5%）、「中堅教員群」は 38 名（41.8%）、「ベテラン教員群」は 28 名（30.8%）となった。

2．GHQ（精神健康度）得点

（1）基礎統計量

GHQ（精神健康度）は 0 ~28 点の得点で精神健康状態が判断される。6 点以上になると精神健康状態が悪いとされる。今回の結果、平均値 8.95±5.88 点、最低点は 0 点、最高点は 25 点であった。

（2）男女差の検討

男女差の検討を行うために、GHQ（精神健康度）得点について t 検定を行った。表 1 に男女別の各平均点等を示す。その結果、GHQ(t(92)=1.31,n.s.)について男女の得点差は有意ではなかった。

表 1　　男女別の平均値と SD および t 検定の結果

	男性（n ＝27）		女性（n ＝65）			
	平均	SD	平均	SD	t 値	
GHQ	7.70	6.51	9.48	5.66	1.31	n.s.

（3）GHQ 得点

GHQ が 0～5 点の教員は 50 名（34.2%）、6 点以上の得点を示した教員は 96 名（65.8%）であった（図 1）。約 3 名に 2 名はメンタルヘルスに何らかの問題を抱えていることが明らかとなった。

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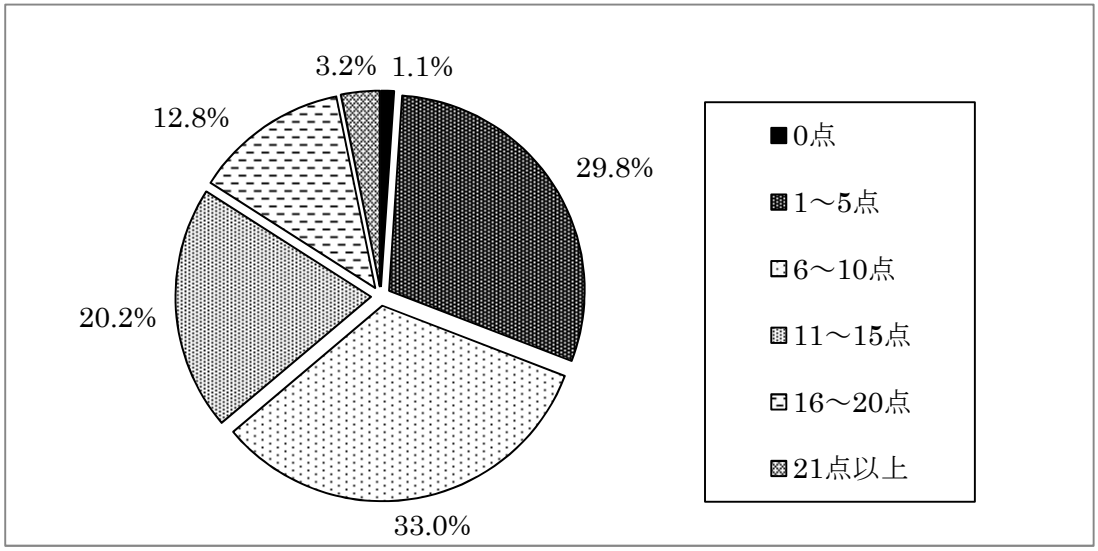

図１　　GHQ 得点（ｎ＝94）

（４）通算教職経験年数の比較

通算教職経験年数の 3 つのグループ「若手教員群」「中堅教員群」「ベテラン教員群」を独立変数、「ＧＨＱ（精神健康度）」を従属変数とした分散分析を行った。表 2 に 3 群の各平均点等を示す。その結果、ＧＨＱに有意な群間はみられなかった。

表 2　　3 群の GHQ（精神健康度）平均点

	若手教員群	中堅教員群	ベテラン教員群	*F*	主効果(*p*)
GHQ 平均点	7.24±5.22	10.16±6.58	8.61±5.36	1.91	n.s.
n	25	38	28		

Ⅳ. 考察

1. GHQ（精神健康度）得点

特別支援教育に携わる教員の GHQ（精神健康度）得点の平均は 8.95 点で、6 点以上（精神健康に何らかの問題あり）とされる教員は全体の 69.1%であった。これらより、教員のメンタルヘルスの悪化は学校組織の運営だけでなく、児童生徒にまで悪影響が及ぶものと考えられ、早急なメンタルヘルス対策が必要だということを示唆している。

文部科学省は 2006 年に義務教育の構造改革を進めるため、「新教育開発プログラム」という調査研究を始めた（東京都教職員互助会・ウェルリンク，2008）。その中で社団法人東京都教職員互助会が「教職員に対するメンタルヘルス対策の効果検証及び新規メンタルヘルス対策の構築とその効果検証」を実施した。全国の教育委員会への「メンタ

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ルヘルス対策に関する意見調書」と全国７つの都道府県の公立小中学校の教員 1600 人を対象にアンケート調査の結果、メンタルヘルス対策が「必要である」（19.9%）の合計は 98.5%に及び、ほぼ全員が必要性を認めている。その一方で、「十分に取り組んでいる」は 0.8%に過ぎず、「まあ取り組んでいる」と合計しても２割に満たなかった。さらに、現状のメンタルヘルスの効果が「あがっている」は 0.4%、「まあ効果があがっている」と合計しても 23.4%に過ぎないという結果であった。特別支援教育に携わる教員のメンタルヘルスがこれほど深刻な状況にあるにも関わらず、メンタルヘルス対策の充実とその効果については満足のいく結果はあらわれていない。

教員に対するメンタルヘルス対策の充実がはかられ、なおかつその効果的な対策について今後検証する必要がある。

２．男女差、教職経験年数とメンタルヘルスの関連

GHQ（精神健康度）得点について、男女間に有意な得点差はみられなかった。また、通算教職経験年数の３つのグループ「若手教員群」「中堅教員群」「ベテラン教員群」による有意な得点差はみられなかった。これらより、性別、教職経験年数によるメンタルヘルス悪化へのリスクは同等にあるものと考えられた。しかし、ストレスの要因まで同質のものを受けているとは限らない。若手教員は慣れない業務に悪戦苦闘し、ベテラン教員は責任のある仕事を任され、その重圧に耐えられなくなるなど、それぞれにメンタルヘルスに影響を与えるストレッサーについては今回の結果では推察ができない。特別支援教育において教員のメンタルヘルスを規定する要因について、今後実証的に検証していくことが必要であろう。

付　　記

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ORIGINAL ARTICLE 9

自然災害時の支援機能としての地域包括支援センターに関する研究

Research of Support Function of General Support Center at the Time of Disaster

北川　慶子 1) (Keiko KITAGAWA)　永家　忠司 2) (Tadashi NAGAIE)

1）佐賀大学文化教育学部
〒840-0027　佐賀県佐賀市本庄町本庄 1 番地
kitagake@cc.saga-u.ac.jp
2）佐賀大学工学系研究科
f0319@cc.saga-u.ac.jp

ABSTRACT

東日本大震災は、被災者支援の福祉機関として地域包括支援センター（包括センターとする）の支援役割を重視している。我々は、全国 4,209 包括センターに対し、質問紙調査（2010 年 12 月から 2011 年 2 月末まで）を実施した。質問紙による調査の内容は、被災と防災・減災に関する具体的な質問内容は、被災経験・被災の心配や不安・災害時要援護者への支援準備・災害に備えた名簿作成や連絡体制・備蓄・避難訓練・地域との連携等 47 項目である。

調査の結果、包括センターの職員の防災意識は「やや低い」51.6%、「やや高い」27.2%、「低い」14.9%、「高い」6.4%である。被災経験がある包括センターは約 1 割ほどであったが、被災経験を有する包括センターが、防災意識の「やや高い」が最も多い。平均値も2.84で被災経験がない(2.24)ところよりも防災意識が高いことが明らかになった。

包括センターでは、これまでに、被災者に対する直接的支援は実施されており、包括センター内の連絡体制も整備されていた。しかし、地域の災害時要援護者（高齢者）情報の把握、消防、医療・保健・福祉等関係施設等との連携など、包括センターに最も求められる機能は、被災者と支援を繋ぐ機関としては明らかに準備不足であった。

The massive earthquake and tsunami had hit the north-east area in Japan on March 11, 2011, inflicted unparalleled damages including more than 23,000 deaths

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and missing. Further, 4 months after the disaster (as of June 11, 2011), about 84,000 are leading refuge life. In protracted refuge life, specially, circumstances of older adults are difficult. There are many challenges requiring complex and exact supports such as increase of older adults in need of nursing care, Lack of appropriate nursing and insufficient facilities for older adults in need of nursing care. True value of local general support centers (referred to as support center) is evaluated now.

In 2006, Cabinet Office prepared "Guideline for Evacuation Support for Disaster Victims in Need of Care at the Time of Disaster." The guideline clearly shows that general support center should be used for continuing social welfare service and relationship with related such social welfare organizations and local government.

We studied support functions and relief operations by of support center at the time of disaster and post-disaster support functions by nationwide research. Questionnaire survey was performed toward 4,209 support centers in Japan (from December, 2010 to the end of February, 2011). The purpose was to research the disaster prevention and reduction of disaster victims. Specifically the questionnaire included experience of disaster, worry and anxiety of disaster, support preparation for victims in disaster, list making in preparation to disaster, communication system, stock, disaster drill and cooperation within the community.

With regard to awareness of disaster prevention of the support center staffs, the questionnaire showed "slightly low (2 points)," 51.6%; "slightly high (3 points)," 27.2%; "low (1 point)," 14.9%; "high (4 points)," 6.4%. The number of "slightly high (3 points) was most frequently observed in staffs at local comprehension support centers that had experience of disaster. Average of score of them was 2.84 showing higher awareness of disaster compared to centers without experience of disaster (2.24).

Direct support to victims was performed and the Communication system within the support centers was established. However, lack of preparation as organization to connect victims to support such as understanding of alder adults in the community and combination with related facilities like fire department, medical care facilities, healthcare center and welfare facilities that was highly requested for local support center was illuminated.

＜Key-words＞

Higashi-Nihon Earthquake and Tsunami Disaster　General Support Center　Vulnerable Older Adult Evacuation Center

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Ⅰ. はじめに

2011 年 3 月 11 日に発生した東日本大震災では、犠牲者が死亡者（15,733 人）・行方不明（4,462 人）と約 20,000 人を数え、負傷者数は、5,924 人という未曾有の被害をもたらした。1)　震災から 4 ヶ月（2011 年 8 月 11 日現在）経過しても約 93,000 人が避難生活を続け、その後仮設住宅の建設が進んだものの、8 月 15 日現在、目標の 88%、4 万 5,800 戸にとどまっている。被災者の避難先は全国に広がっており、8 万 7,063 人が避難生活を送っている。その内訳は、内閣府によると 1 万 2,905 人が公民館や諸学校などの避難所で生活し、旅館ホテルなどいわゆる見做し仮設住宅に 1 万 9,918 人、親族・知人宅に 1 万 8,874 人、公営住宅・仮設住宅への入居者は 3 万 5,366 人となっている。2) このように避難生活は長期化し、特に高齢者等要援護者の生活状況は厳しく、二次的な被災ともいうべき、新たな要介護状態に移行する高齢者や避難生活の中での介護問題、要介護高齢者の受入れ施設不足等の課題が徐々に増加し始め、複合的で的確な支援を必要となってきている。厚生労働省老健局振興課は、東日本大震災における地域包括支援センターへの職員派遣及び設置運営基準の弾力的な取り扱いについて（依頼）」の通知を各都道府県の所管局あて、支援の長期化に伴い、職員を被災地に派遣し、被災要援護者の安否確認，課題の把握，必要なサービスへの連結・支援を実施するよう継続支援を要請している。3)

本論においては、東日本大震災発生直前の防災・減災に関する地域包括支援センター全国調査の結果分析から、包括センターの被災者支援に対する意識は必ずしも高くはなかったものの、大震災発生後には被災者に対する支援の中心的な役割を果たしている包括センターの災害時における機能の背景となる防災意識について考察する。

Ⅱ. 本研究の目的

我々は、2007 年より、社会福祉分野、救急医・災害医療分野そして、自然災害防災分野の異分野融合による災害時要援護者のための地域防災研究を開始した。災害時要援護者が居住している全国の介護保険施設に対し、2007-2008 年にかけて、施設の防災・減災意識調査を、2009 年-2010 年には全国の障害者自立支援施設に対する同様の調査を実施した。そして、自然災害の被災地現地調査の中から、包括センターは地域の要援護者に対する支援の中心的機関であること、要援護者は包括センターを利用することにより円滑な生活復帰が可能になっていることなどが明らかになったため、2010 年-2011 年にかけて全国の包括センターに対する同様調査を実施した。すなわち 2 つの調査は支援を必要とする施設に対する調査、1 つの調査は支援を行う機関の調査という要支援者側・支援者側に対する全国調査を行ったのである。

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さて、3 月 11 日に発生した東日本大震災は、犠牲者（死亡者・行方不明）が 23,000 人を超える未曾有の被害をもたらした。さらに、震災から 3 ヶ月（2011 年 6 月 11 日現在）経過しても約 93,000 人が避難生活を続けている。長期化する避難生活において、特に高齢者を巡る状況は厳しく、新たな要介護高齢者の増加や介護問題、要介護高齢者の受入れ皿の不足等、複合的で的確な支援を必要とする課題が山積しており、まさに地域包括支援センター（以下、包括センターと略する）の役割が問われている。

2006 年に内閣府が策定した「災害時要援護者の避難支援ガイドライン」では、災害時の福祉サービスの継続や関係機関等との連携において包括センターを活用することが明記されている。包括センターはその機能と役割から地域の要援護高齢者情報を把握しているはずであり、災害時に要援護高齢者と医療・福祉・介護関連諸機関とを繋ぐ基幹の機能を果たすこととされている。実際に東日本大震災後、厚生労働省から地域包括支援センターを中心に要援護高齢者等の安否確認、課題の把握、必要なサービスへの連結・支援を実施するよう事務連絡が出されている。また、我々の被災地現地調査によっても、過去の災害において包括センターの主導により、介護サービスの継続的提供に繋がる支援が展開された例があり、被災者支援における包括センターの役割の重要性と効果が実証されている。

災害時要援護者の避難支援ガイドラインに包括センターの役割が明記されて以来、大規模災害が発生しなかったこともあってか、事例も少なくまた包括センターの災害時における支援や防災・減災の現状に関する研究は少なかった。我々の全国の包括センターに対する防災･減災調査は、わが国で初めて実施したものであり、しかも調査終了が 2011 年 2 月 28 日（投函締切）という、震災の直前であった。なお、震災後、現在（2011 年 8 月）になっても数は少ないが回答票が郵送されてきている。

本論では、所期の締め切りまでに届いた回答票につき分析し、防災意識を中心とし災害時の包括センターの支援機能を検証する。

Ⅲ. 研究対象･調査方法

本論の対象は全国の包括センターである。47 都道府県 4,209 の包括センターに対し、「全国の地域包括支援センターにおける災害時支援と防災･減災に関する調査」を質問紙調査票により郵送で実施した。なお、調査の回答者は、包括センターが 3 専門職によって構成され、いずれも災害時には被災者支援を行う要務を負う人たちであるため、社会福祉士、保健師、介護支援専門員 3 者の協議により回答するか機関全体の防災と災害時支援に関する調査であるためにセンター長のいずれかとすること文書で依頼した。被災と防災・減災に関する具体的な質問内容と、被災経験・被災の心配や不安・災害時要援護者への支援準備・災害に備えた名簿作成や連絡体制・備蓄・避難訓練、地域との被災者支援連携等で 55 項目であった。調査期間は 2010 年 12 月から 2011 年 2 月末まで 3

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か月の留め置き法とした。

Ⅳ. 調査結果

（1）地域包括支援センターと災害時対応

地域包括支援センターは、2006 年の介護保険法の改正に伴い創設された機関であり、地域の高齢者のための支援機関として中学校区を一つの単位として設置されているため、地域における災害時要援護者支援に対する主要な支援役割を有する。2007 年日本社会福祉士会（「福祉関係者のための災害対応マニュアル研究会」）は、地域包括支援センター用として、「災害時の対応チェックリスト」を作成した。これは、災害時に具体的な対応、要援護者が避難生活等で生活困難に直面することへの対応を図ることを目指したものである。

東日本大震災の発生による膨大な数の災害時要援護者への支援が必要とされるようになって、ようやく地域包括支援センターの役割に注目され始めた。しかし、2006 年に内閣府が策定した「災害時要援護者の避難支援ガイドライン」においても、災害時の福祉サービスの継続や関係機関等との連携において包括センターを活用するということがすでに明記されていた。

過去の災害においても地域包括支援センターの主導により，介護サービスの継続的提供に繋がる支援が展開された例があり被災者支援における地域包括支援センターの役割の重要性と効果が実証されている 4)　災害時における地域包括支援センターの役割に関する研究は，被災後の高齢者の見守りを通した孤独死防止や生活支援についての報告等はあるが 4，5)、全国規模の地域包括支援センターにおける災害時の要援護高齢者の支援準備や防災の現状に関する研究はない。我々は、全国の地域包括支援センターに対する防災・減災調査を実施した。

（2）調査票の回答状況

本調査の回収率 31.8%（回収数 1339 票）であった。全回答に占める設置主体の割合は「社会福祉法人」が 45.3%と最も多く、次いで「市町村直営」35.9%であった。(表 1)

地域包括支援センターは、介護保険により地域包括ケアを目指し、地域高齢者の心身の健康の保持および生活の安定に必要な支援を行うことにより、保健医療の向上および福祉の増進のため、地域におけるほ支援事業を一体的に実施する中核的機関として市町が責任主体として設置することと規定されている。ただし、市町村又は市町村から委託を受けた法人（在宅介護支援センターの設置者、社会福祉法人、医療法人、公益法人、ＮＰＯ法人その他市町村が適当と認める法人）とされ、市町村直営および市町村による委託とに 2 区分される。5)

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表１　設置主体

	1	2	3	4	5	6	7	8
回答数	市町村直営	在宅介護支援センター設置者	社会福祉法人	医療法人	公益法人	NPO法人	その他	未記入
1340	475	10	599	147	15	9	68	17
100	35.4	0.7	44.7	11.0	1.1	0.7	5.1	1.3

表２　専門職種

	1	2	3	4	5
合計人数	保健師	介護支援専門員	社会福祉士	看護師	社会福祉主事
7112	1512	2662	1847	907	185
100.0	21.3	37.4	26	12.7	2.6

包括センターの具体的な包括的支援事業としては、①介護予防ケアマネジメント、②総合相談・支援、③権利擁護、④包括的・継続的ケアマネジメント支援が主たる事業である。それを担う専門３職（社会福祉士、保健師、主任介護支援専門員）は必置であり、1 号保険者数によって配置基準を設けている。（表 2）ただし、地域により 3 職の確保が困難である場合も想定し、小規模市町村には例外基準があり、それは、指定介護予防支援事業所の配置基準として定められている、社会福祉士、保健師、介護支援専門員および高齢者保健福祉に関する相談業務等に 3 年以上従事した経験のある社会福祉主事、経験のある看護師とされているところから、それを準用している包括センターがある。

表３　地域包括支援センター職員配置基準

	保健師等	社会福祉士等	主任介護保険支援専門員等
1 号被保険者数			
3,000-6,000 人	1	1	1

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（3）地域包括支援センターの防災・災害時対応

職員の防災意識は「やや低い」51.6%、「やや高い」27.2%、「低い」14.9%、「高い」

6.4%となり、被災経験別では被災経験有りは「やや高い」が最も多く、平均値も 2.84 で被災経験無し（2.24）よりも防災意識が高かった。

職員の防災意識は、「低い」、「やや低い」で 66.4%である。総じて包括センター職員の防災意識は低調といえよう。防災意識に関連する要因としては、設置主体、過去の被災経験、被災の心配や不安、防火訓練・防災訓練の有無、地域包括支援センターが避難所生活支援に果たす役割への認識との有意な関連が認められた。

回答のあった包括センターの設置主体別では、直営が防災意識が高いという傾向が見られた。地域包括支援センターは、その機能・役割は同様であっても、設置主体の有する機能が異なれば、必然的に、設置母体の業務の特性にも影響されるため、防災意識に、このような結果として反映されてきたようである。すなわち、直営型の場合は、行政機関の一部であり、防災・災害情報等の共有化や、災害時の所掌事務など関連行政部署との強い連携があるため、防災や災害対応においては大きな強みとなる。

また、防災意識には、過去の被災経験の有無が極めて強く関連していることが認められた。実際に被災経験がなくても過去に災害があった地域や将来的に災害が発生すると予測されている地域においては防災意識が高まる 6）ことから、被災の心配や不安が影響したものととらえることができよう。

防火訓練、防災訓練は社会福祉施設および自治体の役場等の施設において年 2 回の実施が義務づけられている。しかし、本調査では防火訓練の回数を 0 回と回答している包括センターが多く見られた。これは、自治体や法人のサブセンターやサテライト型の少人数のセンターでは、自治体や法人が実施する訓練に参加しているため、単独での訓練は行わず、したがって 0 回と回答したのではないかと推察される。7）（表 4）。

表４　職員の防災意識

	高い	やや高い	やや低い	低い	合計値	平均値	検定
設置主体（直営）	39(8.5)	143(31.2)	224(48.9)	52(11.4)	1085	2.37	**
設置主体（委託）	44(5.3)	208(25.0)	441(52.9)	140(16.8)	1822	2.19	
被災経験有	5(15.6)	18(53.6)	8(25.0)	1(3.1)	91	2.84	***
被災経験無	75(6.0)	332(26.6)	654(52.5)	185(14.8)	2789	2.24	
被災の心配有	57(6.7)	286(31.7)	420(49.6)	101(11.9)	1973	2.32	***
被災の心配無	25(5.7)	84(19.0)	242(54.9)	90(20.4)	926	2.10	
防火訓練（1 回以上あり）	60(7.3)	250(30.2)	415(50.2)	102(12.3)	1922	2.32	***
防火訓練（0 回）	14(3.9)	73(20.4)	196(54.9)	74(20.7)	741	2.08	
防災訓練（1 回以上あり）	49(9.0)	180(33.0)	265(48.5)	52(9.5)	1318	2.41	***
防災訓練（0 回）	22(3.7)	122(20.6)	329(55.5)	120(20.2)	1232	2.08	
避難所生活支援の役割ある	73(6.9)	314(29.8)	524(49.7)	143(13.6)	2425	2.30	***
避難所生活支援の役割ない	6(3.2)	27(14.3)	112(59.3)	44(23.3)	373	1.97	

検定はｔ検定による　　***P＜.001　**P<.01　　欠損値あり（無回答および不明は除いた）

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表 5　被災経験者別防災意識

	被災経験有		被災経験無	
	(n=32)		(n=1246)	
	度数	(%)	度数	(%)
高い	5	15.6	75	6.0
やや高い	18	56.3	332	26.6
やや低い	8	25.0	654	52.5
低い	1	3.1	185	14.8
スコア合計値	91		2789	
平均スコア	2.84		2.24	

注：スコアは「高い」を 4 点、「やや高い」を 3 点、
「やや低い」を 2 点、「低い」を 1 点とした。

被災者支援を経験した包括センターの支援実績は、「被災者の避難先の確認」85.9%、「被災者の体調管理」79.2%、「被災者の自宅訪問」69.7%、「被災者の福祉ニーズの把握」61.0%、「関係者間のカンファレンス」43.2%、「ボランティア・社会福祉協議会等へのニーズ情報提供」26.0%であった。また、災害時要援護者への支援準備は、「要援護高齢者名簿作成」(28.0%)、「要援護高齢者の状況把握」39.7%、「災害時連絡先名簿作成」22.5%、「職員の情報連絡体制の整備」88.5%であった（表 6)。

表 6　災害時要援護者への支援準備

	援護高齢者名簿作成		要援護高齢者の状況把握		災害時連絡先名簿（関係機関）作成		職員の情報連絡体制の整備	
	(n=1341)		(n=1284)		(n=1284)		(n=1323)	
	度数	(%)	度数	(%)	度数	(%)	度数	(%)
している	368	28.0	510	39.7	289	22.5	1171	88.5
していない	946	72.0	774	60.3	995	77.5	152	11.5

注：無回答は除外したため回答合計が異なることが示唆される。

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被災者支援では直接的支援は比較的実施されており、包括センター内の連絡体制も整備されていることが伺える。他方、地域の要援護高齢者情報の把握や消防、医療・保健・

福祉等関連諸施設・機関との連携等、包括センターに最も期待し求められている被災者と支援を繋ぐ差配（マネジメント）機関としての準備不足が明らかになった。このような現状の背景には、被災経験の有る包括センター職員の防災意識は高い傾向にあったものの全体的には低いという結果があり、防災意識の低さが被災者支援の準備不足の一因となっている。

包括センターにおける防災や被災者支援の準備に関する現状からみると、国や自治体及び関係諸機関が包括支援センターに求める災害時の被災者支援機能に十分対応し得るかどうかは課題である。それは、災害時に要援護者に対する避難所として機能できる地域内の介護保険施設を利用する場合、避難先の施設の立地が安全であるかどうか、包括センター職員が要援護者支援をする場合、そのアクセスはどうかといったことを十分考えているかどうかも災害時は大きな支援機能の課題である。

施設と包括センターは近距離ではない。このことは、直営のみならず、介護保険施設に委託されている包括センターであれば、母体の介護保険施設に避難した要援護者への対応は、施設利用者と同等に可能であるが、地域の包括センターであるために、地域に所在する他の施設への避難要援護者への対応、自治体とのアクセスなど時間空間的な課題は大きい。

Ⅴ. まとめ

従来、自治体が指定する避難所の多くは、小中学校や公民館などの公共施設であったが、災害種別や被災の規模、被災者の状態に応じた適切な避難所を地域住民の身近な場所に設置しておく必要がある。われわれの 2007 年から 2009 年における全国介護保険施設の防災・減災調査と全国の障害者自立支援施設の防災・減災調査 8）においては、高齢者施設の 6 割、障害者自立支援施設の 5 割は災害時要援護者を受け入れると回答している、実際に東日本大震災の被災者についても岩手県、宮城県、福島県の社会福祉施設は積極的に被災者を受け入れている。このことからも社会福祉施設や児童福祉施設の要援護者を受け入れる施設として活用を図っていく必要がある。災害時要援護者の避難所のあり方として、災害時要援護者に特別な配慮がなされた避難所としての福祉避難所の指定が市町村によって進められているが、福祉避難所の取組は未だ十分であるとは言えない。このため、福祉避難所のより一層の普及方策を含め、避難所生活における災害時要援護者支援のあり方や避難所としての公共施設のあり方、避難所設置の時期のあり方について検討していかねばならない。さらに、被災後の包括センターの支援を受けることを想定し、双方の距離やアクセス等を考慮し、避難者に対する生活の質に留意した支援の円滑性を考慮しておく必要がある。（図 1、2、3）

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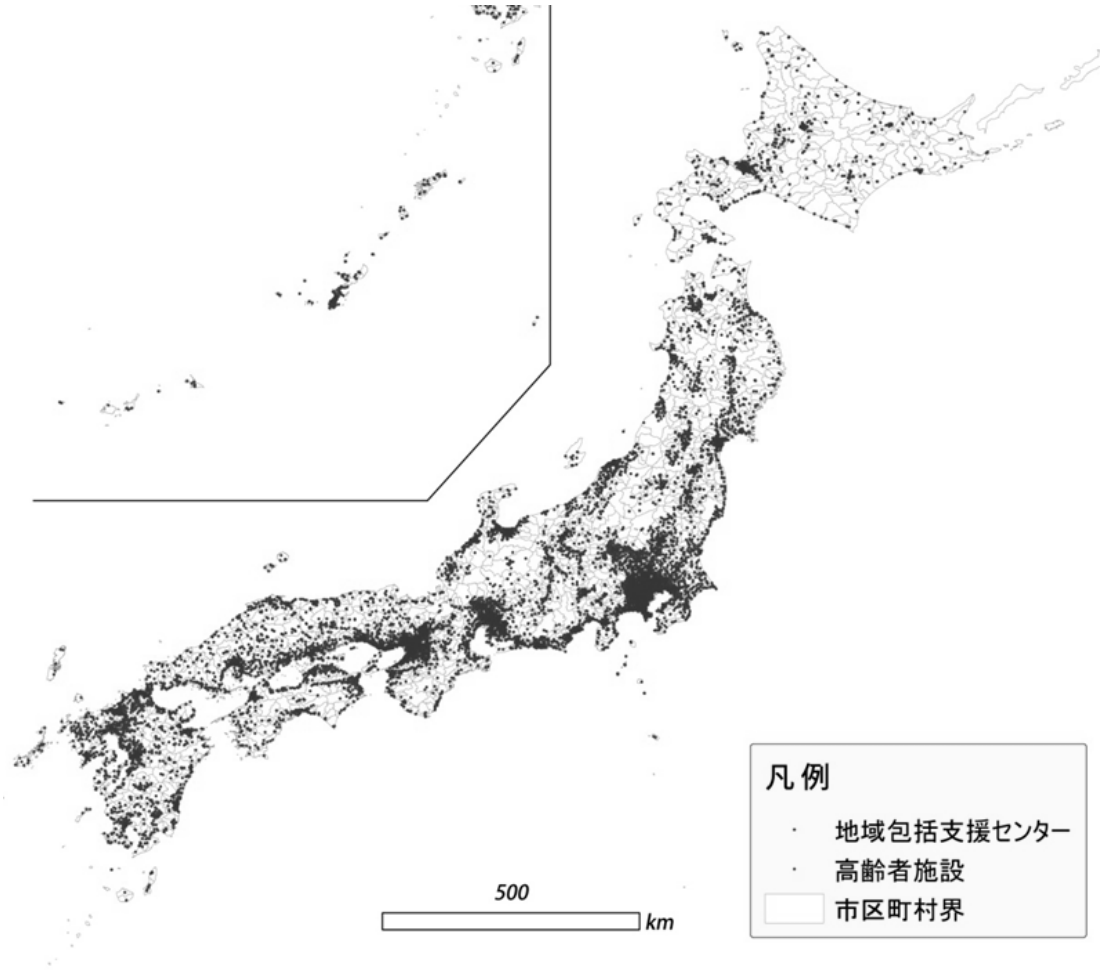

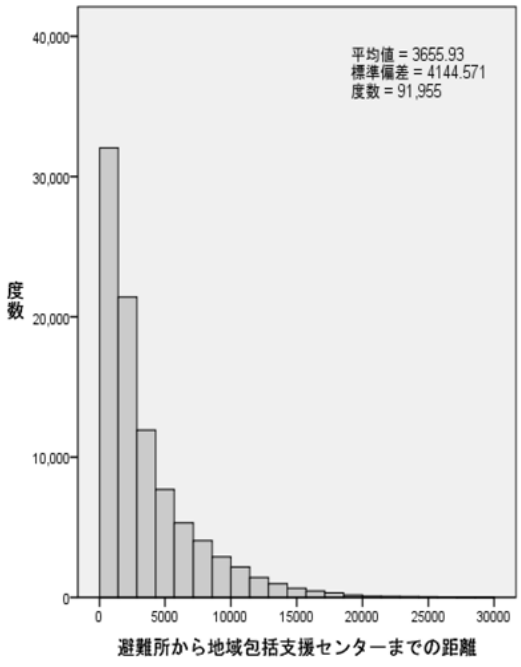

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短報

軽度認知症高齢者を対象とした認知症症状の進行抑制プログラムにおける利用者の変化に関する報告

Behavioral and cognitive change of elderly with mild dementia that participated in the "cooking" program

稲垣　宏樹 1)　(Hiroki INAGAKI)

1)　東京都健康長寿医療センター研究所　自立促進と介護予防研究チーム
〒173-0015　東京都板橋区栄町 35-2
inagaki@tmig.or.jp

ABSTRACT

認知症症状の進行抑制を目的として、軽度認知症高齢者に対し、料理プログラムを実施した。初年度の対象者は 10 名（男性 2 名、女性 8 名)、プログラム参加時点での平均年齢は 75.4 歳（SD8.5）であった。プログラム参加前後に、6 カ月間のインターバルで認知機能検査（HDS-R）を実施した。得点はほとんど変化していなかった（1 回目 18.7±7.0、2 回目 18.2 点±7.9)。その一方、行動面では、多くの参加者で、プログラム中または日常生活場面で、改善が示された。翌年度は、参加期間の異なる対象者が混在していたが、期間の長短に関わらず、多くの参加者で、前年度同様、行動面での改善傾向が示された。ただし、本研究は研究方法上の限界があり、プログラムの有効性は慎重に判断されなければならない。

In aim to inhibit the progression of dementia, we provided "cooking" programs for the elderly with mild dementia. At first year, the participants were 10 persons (2 male and 8 female), and mean age was 75.4 years old (SD8.5). Their cognitive performance were assessed twice using HDS-R on 6 month interval. In the results, cognitive performance did not change (mean score were 18.7±7.0 and 18.2±7.9, respectively). But, almost of participants showed some improvement of behavior on the program and daily living. At 2nd year, some subjects were continued to participate from 1st year, and the others participated newly. Regardless of the length of participation, many participants showed a improvement of some aspects of behavior. However, this study has limitations on the methods, effect of program must

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be interpreted carefully.

＜Key-words＞
軽度認知症高齢者、介入、料理プログラム、行動面の変化、認知機能の変化
elderly with mild dementia, intervention, cooking program, behavioral change, cognitive change
Asian J Human Services, 2011, 1: 131-141.

1. はじめに

我が国が高齢社会となって久しいが、社会の高齢化に合わせて、認知症高齢者の増加も懸念されている。粟田ら（2008）は、大塚の推計値（2001）と国立社会保障・人口問題研究所の将来推計人口（2007）を用いて、認知症高齢者数および有病率を推計した。その結果、認知症高齢者の数は 2015 年に 300 万人を超え、有病率も 2022 年に 10%を超えることが推計され、過去に予測されたよりも急速に増加する恐れのあることが示された。

こうした状況を背景として、いかに認知症にならないようにするか、また、いざ認知症になっても症状の進行を緩和するかといった認知症予防に関心が集まっている。介護予防対策の柱の一つに認知症の予防が掲げられたり、また数年前より脳機能の活性化を目指す活動やグッズの流行は、そうした関心の高まりを示したものであろう。

著者は、2003 年～2008 年にかけて、東京都内にあるデイケアホームと協力する形で、軽度認知症高齢者を主な対象とした認知症症状の進行抑制を目的としたプログラムを実施した。症状抑制のために目指したのは、以下の 2 点である。（1）利用者にとって居心地のいい場所を提供すること、（2）認知症初期に残存する能力、また認知症初期に低下する認知機能を積極的に使用し鍛えること。

（1）に関して、家庭に閉じこもることによって認知症のリスクは高まる（Fabrigoule, C.ら，1995 ; Scarmeans, N ら，2001 ; Verghese, J ら，2003 ; Fratiglioni, L ら, 2000）ことから、外出することが進行抑制の第一歩となる。このため、本プログラムでは、利用者が「居心地がいい」「楽しい」と思える場所を提供し、自主的にプログラムに参加したいという気持ちを高めることを目的のひとつとしている。（2）に関して、知的活動に参加している人のほうが、そうではない人に比べ認知症が発症するリスクが低いこと（Wilson, RS ら, 2002a ; Wilson, RS ら，2002b）、また積極的な予防的介入によって、認知能力に改善が見られたこと（Ball ら, 2003）が報告されている。本プログラムでは、利用者全員でその日の昼食を作るという活動を行った。このプログラムでは、献立の決定、実際の調理、配膳、後片付けまで利用者が中心になって行い、料理する過程を通して、認知症になっても残存している能力を積極的に活用し、また「自発性」「思考力」「計画性」「注意力」といった認知症初期に低下する認知機能を鍛えることで、機能低下を抑

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制することを目指している。同時に「自分にもこれだけのことができる」という自信、また満足感や達成感が得られるという心理的効果が期待できる。

しかし、軽度認知症高齢者を対象とした本プログラムのような活動は前例が少なく、試行錯誤で実施していたのが実状であった。より有効な実施方法を検討するためには、当プログラムの有効性、問題点を把握することが必要である。本稿では、まず初年度にプログラムの実践と並行して実施した認知機能検査と行動観察の２側面から当プログラム参加者の変化を記述し、当プログラムの進行抑制における有効性を検討した（報告１）。続いて、翌年度メンバーの入れ替えがあったことから、継続年数により参加者の行動に変化があったかどうかを、行動観察記録から記述し有効性を検討した（報告２）。

報告1　認知機能検査および行動観察による検討

Ⅰ．方法

１．対象

本プログラムに参加している軽度認知症高齢者 10 名（男性 2 名，女性 8 名）。プログラム参加時点での年齢は、平均 75.4 歳（SD8.5）で、最年少者は 58 歳、最高齢者は 88 歳だった。この 10 名に対して、認知機能検査、およびプログラム中の行動観察を行った。認知機能検査として、改訂長谷川式簡易知能評価スケール（加藤ら, 1991；以下, HDS-R）を用いた。HDS-R は、MMSE と並び、日本国内でよく使用されている認知症の簡易スクリーニング検査である（満点は 30 点）。

なお、この 10 名に加え認知的に問題のない高齢者 3 名と中等度以上の認知症高齢者 1 名が共にプログラムに参加していた。

２．プログラムの内容

本プログラムでは、「料理を作る」という活動を通し、認知症症状の進行抑制を目指した。活動に料理を選択した理由には、いくつか挙げられる。まず、ひとつは、料理が様々な認知機能が必要な活動であることである。例えば、煮物をしながら材料を切る等の複数の作業を同時に行なうのに必要な「注意分割能力」や、出来上がりの時間を考えながら、煮物を煮ている、その間に、別の料理の下ごしらえをするという、手順、段取りを考える力、つまり「計画力」も必要となる。これらは記憶障害と合わせ、認知症初期に衰えやすい能力とされている。また、二つ目の理由として、料理が日々毎日の生活にかかわる活動であるという点である。ただ認知機能を鍛えるだけの活動であるなら他にもあるが、生活と密着した活動を選択することで活動への動機づけがより高まることが期待できる。と同時に、生活機能（ADL）の改善につながる可能性も期待できる。三つ目の理由として、参加者の多くが女性で、しかも元主婦だった方が多く、料理という活動に馴染みが深かったこと、また、男性参加者に関しても、当初この活動に参加していた

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男性は料理経験者が多く、料理をするという作業に抵抗がなかったこと等が挙げられる。

本プログラムは、①メニュー確認、②調理、③配膳、④食事、⑤後片付け、⑥来週のメニュー決めの一連の流れで実施される。

まず実際の料理に入る前に、今日は何を作るかの「①メニュー確認」を行う。メニューは前の週に皆で話し合って決めて、それぞれの参加者がノートに書いておくが、そうした個々人のノートや、スタッフが大きな紙に書き写したメニュー表を見ながら、メニューや作り方を確認する。

メニューの確認が終わると、②実際の調理、それから、作った料理の③配膳を行う。料理が完成した時点で皆で④食事をして、お皿を下げたり洗い物をしたりといった⑤後片付けを行う。この行程では、特に参加者が中心になって作業が進むように、スタッフは声掛けと最低限のお手伝いしかしないように注意している。

その後、少し休憩を挟んで、⑥来週のメニューを決める話し合いを行う。メニュー決めでは、スタッフの一人が進行役（ファシリテータ）になって、話し合いを進める。ファシリテータ以外のスタッフは、輪の中に適度に散らばり、耳の悪い参加者や話し合いのスピードについていけない参加者の手助けをしたり、進行役のスタッフのフォローをしたりする。話し合いの中で、提案されたメニューや材料は、可能な限りノートに書いてもらうようにする。書くことが一人では難しい参加者には、スタッフが手助けをした。

プログラムは、大体午前 11 時頃から始まり、メニュー決めの話し合いが終わるのが午後３時～３時 30 分ころで、ほぼ日中の活動時間を全部を費やして、本プログラムを実施した。

Ⅱ. 結果

１．認知機能の変化

同一対象者に対して、2003 年 9 - 10 月と 2004 年 3 - 4 月の２回にわたり認知機能検査（HDS-R）を実施した。このうち、2 名が検査を拒否し、2 名がプログラムから脱落したため、2 回とも検査が実施できたのは 6 名だった。平均得点は１回目 18.7 点（SD7.0）、２回目 18.2 点（SD7.9）と検査を実施した約６ヶ月の間に認知機能にほとんど変化は見られなかった。

２．行動の変化

１年間の観察記録をもとに，各参加者の行動変化を示すエピソードを抜粋した。

１）デイ・サービスへの積極的参加：以下のエピソードは、利用者がデイ・サービスに積極的に参加していること、楽しんでいることを示している。

① 本人から「楽しい」と発言があった（または家族に話したといった報告があった）、スタッフから笑顔が増加したと報告された者が 7 名いた。

② プログラム参加中に他の利用者やスタッフに冗談を言うというエピソードが

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4 名で観察された。

③ スタッフや家族に親密な利用者がいると報告した者が 4 名、親密な利用者の名前を挙げた者が 3 名いた。

④ 帰宅後デイ・サービスでの様子を自分から家族に話すようになったことが 4 名の家族から報告された。

⑤ 欠席を繰り返したり毎参加日の朝に参加拒否を繰り返していた 2 名が、参加半年を経過した頃からほぼ欠席もなく、自分から出発の準備をして送迎車を待つようになったことが家族より報告された。

2）作業への自主的参加：以下のエピソードは、料理プログラムに自主的、意欲的に参加するようになった変化を示している。

① プログラム開始当初ほとんどの利用者（9 名）は作業に参加しないかスタッフが指示しなければ参加していなかったが、全員が自主的に作業に参加するようになった。例えば、自分から作業を引き受けるよう申し出る、必要な調理器具を探す、またはスタッフに要求する、張り出されているメニュー表を確認しながら作業を進める、など。

② 4 名の利用者で、作業中に、味付けや材料の切り方、盛り付けなどについて意見交換、質問、指示や試行錯誤が、利用者間で行われるようになった。これらは、プログラム期間中に作業の中心的役割を担うようになった 3 名の利用者を中心に行われていた。

③ 利用者の中で、特に調理技術が高くかつ身体的自立度の高い 3 名が、実際の作業場面でリーダー的役割を果たすようになった。このことによりプログラムの自主化が一層促進されることになった。

④ 4 名の利用者で、料理に関わるいくつかの活動が家庭でも見られるようになったことが家族から報告された。例えば、サラダや雑炊、みそ汁など比較的簡単なメニューの調理、食後に食器を下げる、食器を洗う、など。

⑤ 利用者全員での献立の決定や作業中において、積極的に自分のアイディアや意見、反論を言うというエピソードが 7 名で観察された。中には、オリジナルの料理や調理法を話し合いの中で思いつき提案するという者もみられた。

⑥ 作業を独りで抱え込み他者の協力を拒んでいた利用者 1 名が、他の利用者やスタッフに作業の応援を要請したり、他の利用者の作業を援助したりするようになった。

3）認知機能の変化：以下のエピソードは、限定的ではあるが認知機能（特にエピソード記憶）が向上したことを示していると考えられた。

① 5 名の利用者で、最近経験したこと、特に旅行や参加したイベントが報告されるようになった。

② 5 名の利用者で、スタッフや他の利用者の名前、顔を記憶している発言、行動が見られた。

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Ⅲ. 考察

当プログラムの実施により、利用者のほぼ全員で、何らかの肯定的な変化が見られた。当プログラムの中心的活動（料理）での自主的、積極的参加はもちろんのこと、デイ・サービスへの参加自体への積極性が高まったことは、当プログラムの目的のひとつである「居心地のいい場所の提供」が達成されていることを示している。また、プログラム内での調理の自主・自立化が進んだこと、積極的な提案・発言が増えたことは、プログラム参加により「自信・自尊心の向上」「生活意欲の向上」の現れであると考えられる。それに加え、家庭に帰ってからも調理をするというようにプログラムの効果が家庭にまで拡大したことは、当初期待していた以上の成果であった。もうひとつの目的である「認知症症状の進行抑制」に関しては、短期的には認知機能に低下は見られなかった。本当に進行抑制がされているのかを確認するには、今後も継続して追跡調査を行う必要がある。

本稿では、プログラム参加者の認知的・行動的変化についてのみの報告となったが、この間プログラムの進行方法や手順をマイナーチェンジし、また定期的に家族会を行い情報交換を密にしてきたことも利用者の変化の大きな要因になったことは間違いがない。そうした要因と利用者の変化を関連付けた分析を行うことが、より効果的なプログラムの実施方法の確立、マニュアル化に向けて必要である。

報告2　プログラム参加年数による行動変化の違い

Ⅰ. 方法

対象は、軽度認知症高齢者 21 名（男性 3 名，女性 15 名）である。21 名のうち、前年から継続して参加していたのは 10 名、本年度内に新規に参加した者が 11 名だった。

しかし、2004 年 9 月に実施事業所でグループホームが開設されたのにともない、デイ・サービス利用者のグループホームへの入所、および新規利用者の受け入れ、といった参加者の変動があった。これにより、利用者により参加期間に違いが生じることとなった。参加期間により参加者は、①通年群（２００４年４月～２００５年２月）7 名、②前期のみ群（２００４年４月～２００４年９月）10 名、③後期のみ群（２００４年１０月～２００５年２月）４名に分類された。

前年度からの継続参加者のうち、通年での参加者 7 名、前期のみ参加者は 3 名だった。この 3 名は、いずれもグループホームへ入所した。

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本年度からの新規参加者のうち、前期のみの参加者は７名、後期のみの参加者は４名だった。前期のみの参加者７名のうち、5 名は当事業所のグループホームへの入所予定者で、集団生活やスタッフに慣れるため一時的に参加したものであった。残りの 2 名は他施設に移った者であった。この 7 名は、当プログラムへの参加期間が短く（平均参加回数 4.7 回）、十分な観察記録が取れなかったため、分析からは除外した。最終的な観察対象者は 14 名であった。内訳を表に示した。

プログラムは，前年度と同様に行なった。

表　対象者の内訳

		参加期間による対象者の分類		
		①通年	②前期のみ	③後期のみ
期間		４月～２月	４月～９月	９月～２月
継続／新規		継続	継続	新規
人数		７名	３名	４名
平均年齢		75.3 歳	76.3 歳	79.0 歳
要介護度	支援	０名	１名	１名
	１～２	４名	２名	２名
	３以上	３名	０名	１名

Ⅱ. 結果

行動観察記録から、のべ 1779 エピソードを抜き出し、行動の内容を分類した。

１．通年参加者（前年度からの継続参加者）

１）作業（プログラム）への参加

スタッフの働きかけがなくても、または最小限の声かけで作業に従事していると思われるエピソードは７名で、のべ 242 エピソード観察された。

７名のうち４名で、作業への自主的・積極的な参加が、１年を通して観察された。いずれも前年から維持されていた。１名は、作業への参加が全体的に少ないものの、後半期には増加していた。２名については、前半期に比べ後半期で作業への参加が減少していた。１名は体調不良により参加が困難になった者、もう１名は体調不良の訴えにより欠席が多かった者である。

このことは、ほとんどの者で、前年度から参加意欲を維持していることを示している。

２）対人的行動

主に作業場面での、メニューや調理法の提案・意見・討論，他の利用者への指

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示・要求等である。これらは257エピソードが観察された。5名については、1年を通して増加しており、既に構築されたなじみの関係の中で、対人的交流がますます増加している様子がうかがえる。2名については欠席が多く、観察された対人的行動が少なかった。

また作業場面以外での対人的行動として、他の利用者との会話、冗談・軽口、援助行動といったポジティブな行動が53エピソード、また抗議・拒否といったネガティブな行動が44エピソード観察された。ポジティブな対人的行動は7名全員で観察された。このことは作業場面での対人的行動の増加と同様、プログラム内部での参加者間の人間関係が良好であることを示している。一方、ネガティブな対人的行動は2名の参加者で39エピソードを占めていた。この2名は、さらに爆発的な怒りをともなう場面や、状況や文脈から逸脱した行動が多く観察された。スタッフの介入によりトラブルに発展するケースはなかったが、この参加者の情動的側面での安定を図ることは今後の課題である。

3）記憶，認知機能

39エピソードが観察された。観察された内容は、エピソード記憶の欠落（昼食の内容が思い出せない等）、ものの置き忘れ、日付感覚の欠落、言語機能の障害（言葉が出てこない・書けない）といった、記憶障害、認知機能障害を示すエピソードが多かった。その一方で、印象的な出来事の記憶（旅行に行った、会合に行った、事故を目撃した等）や親しい人物の想起、エピソード記憶の維持（昼食のメニューを思い出す、前週のメニューの記憶）といった記憶機能の維持を示すエピソードが、同一の参加者において同時に観察された。

2．前期のみ参加者（前年度からの継続参加者）

1）作業（プログラム）への参加

前期のみ参加者3名においてのべ49エピソード観察された。この3名は、前年度から継続参加者であり、通年参加者と同様、作業への自主的・積極的な参加が観察期間を通じて観察された。

2）対人的行動

作業場面における対人的行動（38エピソード）は、2名で増加していた。またポジティブな対人的行動（21エピソード）は3名で観察期間を通じて観察された。通年参加者と同様、良好な人間関係が形成されていることを示している。しかし、その一方で、このうち1名が不安の訴えを増加させていた。不安の内容としては、「知らない人ばかりになった」「ものわすれが増えた」「わけがわからなくなることが増えた」という内容であり、この参加者の認知症が進行したことに加え、一時的に新規参加者が急増したことで、ひとつには本プログラムがこの参加者にとってなじみの場でなくなってしまったため、もうひとつには多人数での人間関係に対処しきれなかったためと思われる。

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3）記憶，認知機能

13 エピソードが観察され、いずれもエピソード記憶の欠落を示すものであった。

3．後期のみ参加者（本年度からの新規参加者）

1）作業（プログラム）への参加

後期のみ参加者 4 名において、113 エピソードが観察された。参加初日から、作業への抵抗が少なく、スムーズに作業に従事する姿が観察された。これには、ひとつにはスタッフが新規参加者に対するプログラム導入に熟達してきたこと、また、継続参加者という「お手本」がいたことが大きいと思われる。

2）対人的行動

作業場面における対人行動（90 エピソード）、ポジティブな対人行動（31 エピソード）は、観察期間を通じて 4 名全員で増加していた。また、参加当初、2 名の参加者で、プログラム途中で帰宅しようとする行動や「ここがどこかわからない」と不安を訴える行動が観察されたが、参加回数を重ねるごとに減少していった。これは、プログラムへの参加の積極性が高まったことを示しているとともに、デイ・サービス内で良好な人間関係が形成され安心できる場所となっていったことを示していると考えられる。さらに、2 名の参加者では帰宅後に料理をしようとする行動や家族に家事の手伝いを申し出るといった行動が、参加者の家族やホームヘルパーから報告された。当プログラム参加によって、生活に対する意欲が向上した結果であると考えられる。

Ⅲ. 考察

プログラムの中心的活動（料理）での自主的、積極的参加が継続参加者で維持され、新規参加者で高まったことは、当プログラムの目的のひとつである「居心地のいい場所の提供」が達成されていることを示している。また、積極的な提案・発言、参加者間での対人的交流が増加したこと、また、家庭に帰ってからも調理をするというようにプログラムの効果が家庭にまで拡大したことは、プログラム参加により「自信・自尊心の向上」「生活意欲の向上」の現れであると考えられる。しかし、もうひとつの目的である「認知症症状の進行抑制」に関しては、低下を示すエピソード、維持を示すエピソードの双方が示され、当プログラムの効果は明確ではなかった。確認のためには、今後も継続して追跡調査を行う必要がある。

本稿では、プログラム全体での参加者の行動変化を中心に報告したが、個々の参加者の症状や身体的・心理的状況、また生活環境に配慮したケアもまた重要である。今後そうした要素をどのようにプログラムに導入するか、またスタッフの個々の参加者への対

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応をどのように反映させていくかが今後の課題である。

結　　論

軽度認知症高齢者を対象に、「料理」という活動を通して、症状の進行抑制を目的とした介入プログラムを実施した。認知機能における変化は概ね示されず効果は限定的であったが、行動面に関しては、プログラム中および日常生活において、一部症状の改善を示すと思われる変化が観察された。ただ、本研究は比較対照群も設けられておらず、ましてや RCT 法で実施されたわけではないので、プログラムの有効性は慎重に判断されなければならない。

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実践報告

韓国におけるパワーリハビリテーション研究会認定資格 IPR（Instructor of Power Rehabilitation）の創設について

The report of the certification of IPR (Instructor of Power Rehabilitation) for South Korea

片岡　芳樹[1)]　橋本　幸雄[1)]　秦　佳保林[1)]　水口　滋[1)]　尹　貞娥[2)]
（Yoshiki KATAOKA）（Yukio HASHIMOTO）（Kaori HATA）（Shigeru MIZUGUCHI）（Jeong-Ah YOON）

1）社会福祉法人梅の樹会フラワープラム，パワーリハビリテーション研究会関東支部
〒190-1231 東京都西多摩郡瑞穂町大字長岡長谷部 83 番地 1
hashimoto@flowerplum.jp
2）東北大学大学院　経済学研究科
jeongah628@gmail.com

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１．はじめに

パワーリハビリテーションとは老化や障害により動かさなくなった関節や筋肉を無理のないように、トレーニングマシンを楽しむ感覚で行うリハビリである。続けて行うことにより自立への回復・重症化の予防・介護負担の軽減などを目的としている。

IPR（Instructor of Power Rehabilitation）は、パワーリハビリテーションに関して、広く、正しく、安全な運用ができる知識や使い方などを専門家として適切にアドバイスできると認められる者に与える認定資格である。

日本同様、韓国においてもこのリハビリ手法が素晴らしい成果を上げるために、パワーリハビリテーションを正しく、安全に普及させる為、インストラクターとしての役割を担うことを期待し IPR を創設した。

２．パワーリハビリテーションについて

パワーリハビリテーションは、老化や器質的障害により低下した身体的・心理的活動性を回復させ、自立性の向上と QOL (Quality of Life）の高い生活への復帰を目指すリハビリテーションの新しい手法である。日本でリハビリの専門職の手によって開発された、マシントレーニングを中心とした運動プログラムであり、「老化に対するリハビリテ

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ーション」といえる。

パワーリハビリテーションの特徴は大きく三つ挙げられる。

第一、‘使われなくなった神経筋’の再活性化である。高齢者が「歩くのが遅くなった」など動作性が低下する原因は、「体のいたるところで使わない筋肉が増えてくる」事が原因である。高齢者が身動きが不自由になったり、寝たきりになる原因は、「筋力が弱くなった」「筋力が低下」ではなく、「使わない筋肉が増える」ことにある。パワーリハビリテーションは普段使っていない筋肉を動かしていく（再活動化）運動である。パワーリハビリテーションは、マシントレーニングを低負荷で行い、全身各部の使っていない筋を動かすことにより、「すたすたと歩けるようになった」というような動作性・体力の改善、「外出するようになった」といった心理的活動性の改善が得られる。また、パワーリハビリテーションが心臓に与える影響は、「入浴」よりも軽く運動によるリスクが少ないのも特徴である。

第二、動作性の改善である。パワーリハビリテーション理論に基づいて、マシントレーニングをすることで、肩甲骨を中心に引き寄せる筋肉の再活性化、背骨をまっすぐ伸ばす筋肉の再活性化、股関節をまっすぐ伸ばす筋肉の再活性化、膝をまっすぐ伸ばす筋肉の再活性化を図ることで、立ち上がる時の動作や歩くときの動作が改善される。

第三、行動変容の効果がある。パワーリハビリテーションは老化に対して、要介護化の本態である動作性の低下、体力の低下を改善し、最終的には行動全体が活発になることを目指している。 身体の動きが良くなった、疲れにくくなったという動作・体力の改善は、「自己認識・自己概念」に変化をもたらし、行動の変化も生まれる。また、パワーリハビリテーションのような軽い有酸素運動の時に、神経から放出される物質には、「うつの改善」など心理的効果もある。実際に、パワーリハビリテーション実施後に趣味であった社交ダンスや登山、絵画を再び行うようになったなど、数々の行動変容が報告されている。

３．日本におけるパワーリハビリテーションに関する資格研修の概要

日本国内の資格制度は、「実務者研修」「指導員研修」「上級指導員研修」と３段階に分かれており、受講者のキャリアと役割に応じて研修内容が区分されている。

（１）運動器の機能向上サービスに関連する実務者研修会

パワーリハビリテーションの基礎理論、プログラム、運営方法、マシントレーニングの基本的な設定方法を学ぶことができる（予防給付における当該の研修に相当します）。誰でも参加することができ、研修会修了者にはパワーリハビリテーション研究会発行の研修修了証が発行される。

（２）パワーリハビリテーション指導員研修会

「運動器の機能向上サービスに関連する実務者研修会」からのレベルアップ研修

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会である。主に高齢者、整形外科的疾患、脳血管障害、神経疾患等疾患別の運営方法、マシントレーニングの注意点・具体例等を学ぶことができる。受講資格としては、

① 高齢者筋トレ事業もしくは運動器の機能向上サービスに関連する研修会の修了証をもっていること（NPO 法人パワーリハビリテーション研究会発行）

② ６ヶ月以上のパワーリハの実務経験（３ヶ月以上の研究会推奨機器による実務経験を含む）

上記の二つの受講資格を有していない方は受講できない。

研修会修了者にはパワーリハビリテーション研究会発行の指導員研修会修了証が発行される。パワーリハビリテーション指導員の資格認定を希望する方は、研修会終了後申請が必要になる。

（３）パワーリハビリテーション上級指導員研修会

パワーリハビリテーション指導員から更にレベルアップするための研修会である。主に介護予防総論・高齢者リハビリテーション学、運営学（要支援者、要介護者等介護度別）、老人学（リスク管理や社会的背景等）、疾患学（骨関節疾患、呼吸器疾患、脳血管疾患）等、指導員研修よりも更に幅広く、より個別的・専門的な実践方法・運営方法を学ぶことができる。受講資格としては、

① パワーリハビリテーション指導員証を有していること

② パワーリハビリテーション指導員資格取得後、３年以上のパワーリハの実務経験

上記の二つの受講資格を有していない方は受講できない。

研修会修了者にはパワーリハビリテーション研究会発行の上級指導員研修会修了証が発行される。パワーリハビリテーション上級指導員の資格認定を希望する方は、研修会終了後申請が必要になる

今までの日本の資格制度の課題は、「実務対応力」であった。すでにパワーリハビリテーションが普及している日本においては、各法人や団体がそれぞれの事業所において、OJT（ On the Job Training ）や OFF-JT （Off the Job Training） を通じて実務力を養成している。それによって、法人間・事業所間とスタッフ間のスキルに大きな隔たりが見られている。

したがって、今回創設した IPR（Instructor of Power Rehabilitation）を韓国に適応する際には、この課題を是正する為、カリキュラムを作るにあたり、理論から実践まで幅広く実務に対応できるように構成した。

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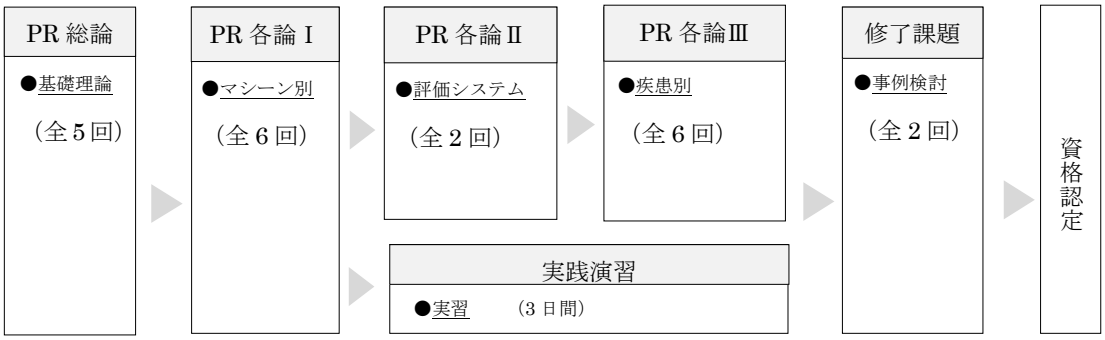
4．韓国における IPR 資格の講座内容

本講座はパワーリハビリテーションに関する知識のみならず実践的な運用方法までを習得する為、講義と実践演習を兼ねたプログラムとなっている。総論編では、パワーリハビリテーションの基礎理論、運営管理、マシントレーニングの設定方法を学び、各論編では、主に高齢者・整形外科的疾患・脳血管疾患・神経疾患等、疾患別の運用方法を学ぶ幅広いプログラムを構成している。最終的にはパワーリハビリテーションの理論を適切にアドバイスできる知識を習得しているかを判定する為、修了課題を作成して資格認定となる。

5．韓国における IPR 資格の講座カリキュラム

（1）講座フロー



（2）コントロールタワー

区分	講義名	学習内容
PR 総論	① 介護保険制度概論	韓国・日本の介護保険制度
	② パワーリハビリ基礎理論	基礎理論の学習
	③ 運営管理	トレーニングフロー、リスク管理 期間・負荷量の設定方法
	④ 評価学概要	評価項目、評価の位置づけ、効果判定
	⑤ マシーンオペレーション	専用マシーン6種類の取扱説明
PR 各論Ⅰ	【各論Ⅰ：マシーン別】	
	① チェストプレス	・各マシーンの特性 ・初期設定方法 ・操作時の注意点 ・動作時のチェックポイント （代償運動の見極め方）
	② ホリゾンタルレッグプレス	
	③ ヒップアブダクション	
	④ レッグエクステンション	
	⑤ トーソフレクション	
	⑥ ローイング	

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PR 各論Ⅱ	【各論Ⅱ：評価システム】 評価システム	10 項目の評価スケールの目的・実践
PR 各論Ⅲ	【各論Ⅲ：疾患別】 ① 老化（加齢・虚弱体質） ② 骨関節疾患 ③ 神経疾患 ④ 脳血管疾患 ⑤ 呼吸器疾患	・各疾患の特徴 ・各疾患におけるパワーリハビリテーションの目的 ・トレーニング原則と注意点 ・効果のメカニズム
修了課題	事例検討	実例をもとにレポートを作成
実践演習	実習	マシントレーニングから運営管理までを実践

6．韓国における IPR 資格の受講資格

受講資格	
① 学歴	イ 大学、短大を卒業した者で保健体育医療又は社会福祉に属する科目を履修した者 ロ 大学２年次以上の者で保健体育医療又は社会福祉に関する学部に在籍している者
② 資格	イ 保健体育医療に関する資格を有する者 ロ 運動指導に関する資格を有する者
③ 職歴	イ ３年以上運動指導に関する実務経験を有する者 ロ ３年以上高齢者福祉に関する実務経験を有する者

上記①～③のいずれかに該当する者

7．まとめ

NPO 法人パワーリハビリテーション研究会では、パワーリハビリテーションに関する幅広い知識を広く伝える能力を持った方を認定する為に資格認定制度を実施している。

IPR（Instructor of Power Rehabilitation）は、パワーリハビリテーションに関して、広く、正しく、安全な運用ができる知識や使い方などを専門家として適切にアドバイスできると認められる者に与えられる認定資格である。パワーリハビリテーションの普及などの為にインストラクターとしての役割を担えると期待される。

現在、日本国内において、2011 年 8 月から 9 月までの約 1 ヵ月のカリキュラムで第一期講座を実施している。また、今後の計画としては、韓国での資格講座の開催に向けて 2011 年 12 月に韓国人講師向け講座を開講する予定である。

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2) 介護予防・自立支援パワーリハビリテーション研究会「パワーリハビリテーション実践マニュアル」2009

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投稿規程

1. 投稿の内容について：本誌への投稿原稿は、ヒューマンサービスに関連する諸領域の進歩に寄与する学術論文とし、他誌に掲載されていないもの、もしくは掲載予定のないものに限る。

2. 倫理規定について：投稿原稿は、以下に沿ったものとする。
   ・ヒトを対象とした研究に当たっては、Helsinki 人権宣言に基づくこと。
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   ・個人情報保護に基づき、症例報告等では匿名化すること。
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〒198-0024
東京都青梅市新町 8-24-25
TEL ： 042-570-7205
FAX ： 042-576-7653
E-mail ： hancw917@gmail.com

執筆規程

1. 言語は英文または和文とする。

2. 論文は英文･和文を問わず、表題頁、著者頁、英文要旨、本文、文献、図説明文および図・表の順で構成されるものとする。投稿区分ごとに必要とされるものは下記の表に従うものとする。「著者頁」以外には著者を特定できる情報は入れないこと。

① 1頁目は表題頁とし、投稿区分、表題（和英）のみを記載するものとする。
② 2頁目は著者頁とし、筆頭著者および共著者の氏名（和英）、所属/住所（和英）、連絡先、住所、E-mail アドレス等を記載するものとする。
③ 3頁目は英文要旨頁とし、論文の要旨とKey words（和英）のみを記載するものとする。
Key words は日本語およびそれに対応する英語を記載するものとする。単語は原則として規定 5 に従い、名詞形で 5 語以内とする。
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投稿区分	表題	著者頁	英文要旨 Key words	本文 1 枚：1000 字程度	文献	表図 あわせて
原著	1 頁	1 頁	500 語以内	30 枚以内	40 個以内	10 個以内
短報	1 頁	1 頁	500 語以内	15 枚以内	20 個以内	4 個以内
症例報告 実践報告	1 頁	1 頁	—	15 枚以内	20 個以内	4 個以内
総説	1 頁	1 頁	500 語以内	30 枚以内	50 個以内	10 個以内
会員の声	1 頁	1 頁	—	2 枚以内	—	

4. 原稿枚数は上記の表の通りとする。

5. 原稿はひらがな･口語体･現代仮名遣い･常用漢字を使用することとする。

6. 数字は算用数字を用いることとする。
7. 数量は MKS（CGS）単位とし、mm、cm、m、ml、*l*、g、kg、cm^2 などを用いることとする。

8. 特定の機器・薬品名を本文中に記載するときは以下の規定に従うものとする。
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〈表記例〉MRI（Siemens 社製，Magnetom）

② 薬品名：一般名（商品名®）と表記する。
〈表記例〉塩酸エペリゾン（ミオナール®）

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〈表記例〉
1） 増田雅暢(2007)「韓国の介護保険の成立と今後の課題」週刊社会保障　Vol. 61, 36-43.

2） Song Tae-min, Lee Jung-sun(2010)「日本の少子化･高齢化現況と対策」保健福祉フォーラム, Vol. 50, 100-101.

3） Yamamoto Mikiko (2007) Community General Support Center and long-term care insurance system, Sogo Rehabilitation, Vol.35(4), 327-332.

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Proofreading by author(s) can be conducted only for the first proof and sentences, figure and tables must not be changed.

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2. Regardless of the English, Japanese language, the manuscript is composed in sequence with title page, author page, English title page, text, references, figures and tables. Refer to the following table when you needs information by parts. Except author's page, the information of author(s) must not be included.

   1) First page

   First page is a title page to provide category, title in English or Japanese.

   2) Second page

   Second page is an author's page to provide full names, institutional affiliation, complete contact information(postal/mail address, telephone and fax number and e-mail address) of all authors in English.

   3) Third page

   In English Abstract page, it should contain Abstract of manuscript and Keyword. Key word must be written in English. Words should be made of five or less than five nouns and should be written according to Rule 5.

   4) Text of manuscript is Besides of ①～③, the text of manuscript must be newly started as the first page numbered consecutively. The text of manuscript for original paper is the text of original material; for short, introduction, materials and methods, results and discussion; for case reports, introduction, case study and discussion. It is adjustable according to manuscript's contents.

   5) Figures and tables must be inserted to one per page. Figures must contain explanation.

3. For the manuscripts in Japanese, it must be written in horizontally on A4 size paper and completed within 1000 words per a page. For the manuscripts in English, it is also written in horizontally on A4 size paper. Both manuscripts should be written by word processor soft ware, formatting letter size as 10.5 points and strap-line should be 12 points. Formatting of line spacing and blank of papers are allowed to compose personally with author's convenience. There is no need to made abstract in manuscript in Japanese.
   Manuscript in English･Japanese （A4）

Category	Title· (page)	Author's Page	Cover page and Keywords in English	Text (Less than 1000 words per page)	References	Tables & Figures
Original paper	1	1	Less than 500 words	30page	Less than 40	Less than 10
Short paper	1	1	Less than 500 words	15page	Less than 20	Less than 4
Case report& Activity report	1	1	—	15page	Less than 20	Less than 4
Overview	1	1	Less than 500 words	30page	Less than 50	Less than 10
Comments	1	1	—	Less than 2page	-	-

4. As for the number of pages of manuscript, see the above table.

5. The manuscript in Japanese must be written in Hiragana, colloquial style and Chinese characters in common use.

6. For the numbers, Arabic numerals must be used.

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2) Song Tae-min, Lee Jung-sun(2010)「日本の少子化･高齢化現況と対策」保健福祉フォーラム, Vol. 50, 100-101.
3) Yamamoto Mikiko (2007) Community General Support Center and long-term care insurance system, Sogo Rehabilitation, Vol.35(4), 327-332.

Asian Journal of Human Services

査読結果報告書

[報告日：　　年　　月　　日]

査読対象論文

[No.　　]

査読結果

A　採択
B　条件付き採択（修正採択）
C　再投稿
D　不採択

コメント

Asian Society of Human Services

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一般社団法人ヒューマンサービス スマイル
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