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Statistical Compilation

The Characteristics of Multiple Reporting of Cases based on Article 23 of the Mental Health and Welfare Act in Kawasaki City and the Needs for Community Life Support

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Abstract

【Purpose】The purpose of this study was to clarify the characteristics of subjects who had been subjected to two or more police's reports based on Article 23 of the Mental Health and Welfare Act in three years, and to consider measures for enabling them to lead a stable life in the community, taking into account perspectives other than mental health care.

【Method】We analyzed the data of 748 anonymized police's reports (actual number of persons, 668) sent to Kawasaki City Mental Health and Welfare Center between April 1,2015 and March 31,2018. Those reported twice or more (multiple group) and those reported only once (single group) in the 3-year period were compared. This study was

approved by the Research Ethics and Conflict of Interest Conference of the Kawasaki City Mental Health and Welfare Center, and the Kawasaki City Information Disclosure Management Council.

【Result】The actual number of persons and the total number of reports in the multiple group were 63 (9.4%) and 143 (19.1%), respectively. Examinations for the necessity of involuntary admissions by the prefectural governor were performed for 98 (68.5%) of the reports. Comparing the multiple and single groups, a higher percentage of patients in the multiple group had a history of involuntary hospitalization by the prefectural governor (39.7%, $\chi 2=80.206$, $P< 0.001$) compared to the single group. As a result of the examinations, a primary diagnosis was also higher in F5 (Behavioural syndromes associated with physiological disturbances and physical factors, 2.0%), F6 (Disorders of adult personality and behaviour, 16.3%), and F7 (Mental retardation, 8.2%) as coded in the International Classification of Diseases Tenth Revision (ICD-10) ($\chi 2=24.467$, $P=0.018$). On the other hand, there was no statistical difference in the frequency of involuntary admissions by the prefectural governor including those ordered urgently (Article 29-2). In addition, the multiple group presented a higher frequency of "decisions not to perform examination" ($\chi 2=6.902$, $P=0.032$), "no need for hospitalization or medical treatment" ($\chi 2=12.661$, $P=0.013$), and "direct discharge from involuntary hospitalization by the prefectural governor without transferring to another form of admission" (-32.8%, $\chi 2=-9.703$, $P=0.021$), compared to the single group.

【Discussion】The multiple group had a high proportion of non-psychotic mental disorders and low proportion of hospitalization. As one of the background factors, their behaviors may have an aspect of reaction to an adverse living environment and/or life event. However, the proportions of involuntary hospitalization ordered by prefectural governor, including those ordered urgently, in both groups were almost the same. If we consider the report as a crisis call, it seems to be necessary to have a perspective of community life support corresponding to the subjects' problems of daily life.

【Conclusion】Although the multiple group had a lower proportion of psychotic disorders than the single group, they also need support. Therefore, it is necessary to consider how to support them from a viewpoint other than psychiatric care.

Keywords: police's report based on Article 23, Mental Health and Welfare Act, involuntary hospitalization ordered by the prefectural governor, non-psychotic mental disorders, community life support

Introduction

In 2004, Japan's mental health and welfare policy shifted from a focus on hospitalization to that on community life, and is currently working to establish a realistic process for "building a comprehensive community care system that also addresses mental disorders" 6)7). In this context, the reporting system of the "Act on Mental Health and Welfare of Persons with Mental Disorders Disabilities" (hereinafter referred to as "Mental Health and Welfare Act") plays a role of crisis intervention from psychiatry in response to crises in community life. The number of reports as shown in the Report on Public Health Administration and Service 4) has been increasing every year, doubling in the past 10 years, and although there has been a slight downward trend recently, the rate of increase over the past 5 years has been 45%. In terms of the type of report, the increase in the number of Article 23 reports (police reports (hereafter, Article 23 reporting)) of the Mental Health and Welfare Law was marked, and the growth in the total number of reports reflected the increase in the number of Article 23 reports.

Each type of report has its own characteristics 16)17)26). In particular, in the case of Article 23 reports, regardless of whether involuntary hospitalization is required, some form of medical and welfare support was reported as necessary 23)24). In addition, a comparison of nationwide surveys of cases reported under Article 23 between FY2000 and FY2010 shows an increase in the number of cases that did not require examinations for involuntary admissions, an increase in emergency involuntary hospitalizations, and a shortening of the duration of involuntary hospitalization, indicating a significant shift of involuntary hospitalization under Article 23 to emergency psychiatric care 16). Furthermore, it has been reported that those who are judged to require involuntary hospitalization as a result of a report are more difficult to treat, more economically impoverished, less likely to have family members or other supporters, more likely to cause trouble in the neighborhood, and more likely to require administrative intervention than those who are hospitalized for medical care and protection 19). In addition, in a survey of users of emergency psychiatric treatment, including those involuntarily hospitalized, there was a report that focused on cases of repeated hospitalization, and it was stated that even in such cases, the threat of self-harm or harming others does not occur suddenly, but is the result of various

difficulties in daily life that increase over time, such as problems in relationships with family members and background problems that lead to repeated acts of violence 18).

Considering all of the above, the recent Article 23 reporting is considered to have shifted from the function of responding to persons with problems in between justice and medical care when reporting by police officers under the Mental Health and Welfare Act was stipulated in Article 24 (the period of much discussion was from 1980 to 2002) 20)21) to a pathway for urgent medical care access for persons who manifest difficulties in daily living in the form of self-harm or harming others. In addition, with changes in the functions of Article 23 reporting, it is considered that the problems and needs behind the reporting are becoming more diverse. Therefore, it is necessary to understand the characteristics of the cases and their daily needs from various angles based on the recent cases of Article 23 reporting. Especially in cases where there are multiple emergency and crisis calls, immediate action is needed to ensure the proper operation of the support system.

The purpose of this study was to clarify the characteristics of the former group and examine how to support them by focusing on the difference between those who were reported twice or more and those who were reported only once in three years based on Article 23 in Kawasaki City.

Details of the involuntary hospitalization system in Kawasaki City are described in a separate paper 25), and Article 23 reporting is handled as part of the psychiatric emergency medical care system implemented jointly by Kanagawa Prefecture and three designated cities within the prefecture. Figure 1 shows the number of police reports in Kawasaki City. During the daytime, all reports are received and investigated through the public health center (ward office), and during the night-time and holidays, all cases are handled by the Kanagawa Mental Health and Welfare Center's police report reception desk, which is responsible for determining the necessity of involuntary hospitalization and transporting the patient to the hospital 24 hours a day. When it is decided to examine the patient to determine whether or not he/she needs to be involuntarily hospitalized, the core hospital or one of the rotating hospitals will accept the patient, and if it is determined that the patient needs to be hospitalized, they will be admitted to the hospital concerned.

If it is determined that no compulsory measures are required, the procedure as an involuntary hospitalization system is terminated, but medical measures such

as hospitalization for medical care and protection may be proposed based on the opinion of the designated mental health physician who conducted the examination. In addition, even if the examination to determine the necessity of involuntary hospitalization is not conducted, Kawasaki City may propose support for the reported subject as consultation and support services based on Article 47 of the Mental Health and Welfare Law 8).

I. Subjects and Methods

Among the databases collected as part of the monitoring of the operational status of involuntary hospitalization, anonymized data of 748 cases reported to the Kawasaki City Mental Health and Welfare Center under Article 23 during the 3-year period from April 1, 2015 to March 31, 2018 were used as a resource. The data were obtained from the report receipt form, measure diagnosis form, and measure symptom disappearance report, and the items were as follows: ID of the person reported by the police (the same ID was assigned when the same name and date of birth matched), date of report receipt, time of receipt, age, sex, police station with jurisdiction, residential district, insurance type, measure examination performed or not, medical examination date, time of day, start and end time of examination, place of examination, receiving medical institution, action required or not after examination, medical response when action not required (hospitalization for medical care and protection, voluntary hospitalization, non-hospitalization treatment, medical treatment not required), date of hospitalization, diagnosis at the time of examination, physical complications, date of termination of action in case of involuntary hospitalization, diagnosis at the time of termination of action, etc. The past history of reports and hospitalizations of the subjects includes information on reports and hospitalizations made before this study.

The classification of self-harm or harming others was "Yes" if any of the following A (past behavior) or B (behavior that may occur in the future) was indicated in the "Serious problematic behavior" column of the medical report on involuntary hospitalization, including emergency examinations for involuntary hospitalization. As for harmful behavior to others, when any of the following, which generally correspond to the behaviors covered by the Medical Treatment and Supervision Act, are included: "1. murder," "2. arson," "3. robbery," "4. forced sexual intercourse, etc.," "5. indecent assault," and "6. injury," and as for self-harm behavior, "15. suicide attempt" and "16. self-

harm". Then, cases in which there were acts of harming others but no acts of self-harm were defined as the "harming others core group". Cases with self-harm behavior but no other harmful behavior were assigned to the "self-harm core group". Cases with both self-harm and harmful behavior to others were classified as the "self-harm/harming others group," while cases that did not fall into any of the three groups were classified as the "non-core group. It should be noted, however, that the acts of harm that are recognized as facts by the designated mental health physician do not strictly correspond to the acts that are the constitutive requirements for the crime of the same name under the Penal Code.

In this study, among the subjects who were reported based on Article 23, those who were reported more than once within 3 years were classified as the "multiple group" and those who were reported only once were classified as the "single group", and the two groups were compared. The data of 748 cases were used for the comparison of differences in responses, while the data of recent reports were used for the comparison of case characteristics to remove duplicates, resulting in a 2-group comparison of 668 subjects. Statistical analysis was performed using SPSS ver. 26 for both cross-tabulations and tests. The significance level of the test was set at 5%.

This study was referred to the Research Ethics and Conflict of Interest Conference of the Kawasaki City Mental Health and Welfare Center and approved by the Kawasaki City Information Disclosure Management Council.

II. Results

1. Number of reports from multiple and single groups

There was a total of 748 reports during the 3-year period (actual number of subjects: 668), of which 143 (19.1% of the total number of reports) were from multiple groups.

The actual number of subjects in the multiple group was 63, which corresponded to 9.4% of the total of 668 subjects. The sex was: male, 31; and female, 32. The number of times reported was 2 times for 49 persons, 3 times for 12 persons, 4 times for 1 person, and 5 times for 1 person each.

2. Comparison of pre-survey results between groups and reasons for not conducting examinations for involuntary hospitalization

1) Comparison of pre-survey results between groups

Comparing the results of the pre-survey of 143 cases in the multiple group and 605 cases in the single group, a higher percentage of patients in the

multiple group did not receive examinations for involuntary hospitalization (29.4%, $\chi 2 = 6.902$, $P = 0.032$).

2) Reasons for not conducting examinations for involuntary hospitalization

Failure to conduct an examination was observed in 186 cases, accounting for 24.9% of the total number of reports. Of these, 45 cases were reported in the multiple group, corresponding to 31.5% of the 143 cases reported in the multiple group. Reasons for not performing the examination for involuntary hospitalization are shown in Table 1. In the multiple group, the proportion of those who were found to be intoxicated by alcohol or drugs at the time of self-harm or harmful behavior to others was higher in the pre-survey, and the number of reports withdrawn by police officers tended to be higher than that in the single group.

3) Results of medical examinations for each report and outcome after removal of involuntary hospitalization (Table 2)

There was no significant difference in the proportion of patients who were judged to require urgent involuntary hospitalization or involuntary hospitalization in the examination between the multiple and single groups. Regarding the responses taken after the decision that no measures were required, the proportion of cases of hospitalization for medical care and protection was low (7.0%), and the proportion of cases taken outside of hospitalization was high (20.9%, $\chi 2=12.661$, $P=0.013$) in the multiple group. In the case of involuntary hospitalization, many cases were directly discharged after the measure was lifted (32.8%, $\chi 2=9.703$, $P=0.021$). No significant difference was found in the category of self-harm or harmful behavior to others.

4) Case characteristics of the multiple and single groups (Table 3)

The multiple group had a higher rate of cases with a history of involuntary hospitalization than the single group (39.7%, $\chi 2=80.206$, $P<0.001$). The diagnoses of F5 (behavioral syndromes associated with physiological disturbances and physical factors, 2.0%), F6 (disorders of adult personality and behavior, 16.3%), and F7 (intellectual disability, 8.2%) were more common than in the single group ($\chi 2 = 24.467$, $P = 0.018$).

We could not identify any differences in age groups other than a significant difference in the group with an unknown age group. However, age was younger in the multiple group ($t=3.981$, $P<0.001$).

III. Discussion

1. Multiple group cases and re-reporting accounted for 20% of the total number of

reports. Comparing all calls and responses (748 cases) into multiple and single groups, the proportions of emergency involuntary hospitalization and involuntary hospitalization were almost the same. On the other hand, a higher proportion of cases in the multiple group did not receive the examination for involuntary hospitalization. The medical response after the medical examination determined that involuntary hospitalization measures were not necessary, a higher proportion of cases were treated outside of hospitalization. In contrast, the single group was more likely to be hospitalized for medical care and protection. In the multiple group, more than 50% of cases did not result in involuntary hospitalization, but 40% of cases with a history of involuntary hospitalization resulted in a second report. In addition, the difference between the two groups was also observed in the response after the termination of involuntary hospitalization, with a higher proportion of patients in the multiple group being discharged directly and a higher proportion in the single group continued to be hospitalized with a change in the form of hospitalization. In the psychiatric diagnoses at the time of the examination for involuntary hospitalization, a higher percentage of F5 to F7 was found in the multiple group than in the single group.

These results suggest that in the multiple group, the problematic behavior at the time of the report of F5-7 non-psychotic patients was self-harm or harming others as a reaction to their living environment or life events, and they were less likely to undergo an examination for involuntary hospitalization or be treated outside of hospitalization. In particular, with regard to F6, it has been pointed out that there is a tendency to avoid involuntary hospitalization due to a lack of familiarity with it 14)15), which has traditionally been assumed to involve a state of hallucination and delusion and psychomotor excitement in the psychosphere 14). In the case of F7 diagnosis, there are: limited socialization, impulsivity, low learning ability, low self-esteem, and a lack of educational and occupational skills, characteristics that predispose to problematic behaviors such as aggressive behavior 1)2)11). Therefore, it is considered that self-harm or harming others is easily diagnosed as a reaction to the living environment or events in the patient's life, and that the patient is likely to be decided not to require an examination for involuntary hospitalization or be treated outside of hospitalization.

On the other hand, since some patients in the single group actually have a

diagnosis placing them in the non-psychotic group, the characteristics of those in the non-psychotic group may not be the only factor that causes them to be in the multiple group. Sugiyama et al. 19) reported that the problems faced by those involuntarily hospitalized include: (1) intractable psychiatric symptoms, (2) economic deprivation, and (3) lack of cooperation or absence of family members and other support persons. In some cases, economic problems (problems related to employment) and problems related to family members and other supporters may not necessarily be solved by mental health and welfare support alone.

Based on the above, it can be inferred that the lack of treatment for unstable mental symptoms that lead to self-harm and harming others, as well as unresolved problems that cannot be resolved by mental health and welfare support alone, may be a factor in the re-reporting of cases in the multiple group. Therefore, it is desirable to assess the need for support to stabilize the life situation that triggered mental health problems upon reporting. At the same time, it is necessary to consider the establishment of a system to strengthen the health system that does not use reporting as an emergency means of accessing medical care for the support provision system that has been lacking.

2. Examination of the circumstances involved in Article 23 reporting and factors leading to reporting again

In the previous section, we examined the factors that lead to re-reporting based on the characteristics of the multiple group, but we would also like to take into account the factors that lead to re-reporting in the context of Article 23 reporting.

The number of Article 23 reports (Figure 2) began to increase noticeably around 2011, and this increase after 2012 was thought to be due to the enforcement in April 2012 of the mandatory effort provision for the development of emergency medical systems by prefectures. The growth of awareness due to the development of psychiatric emergency services has been pointed out as a factor influencing the increase in Article 23 reporting 10). In addition, the police have strengthened their counseling system for crimes, accidents, children, women, and the elderly, paying attention to their feelings and circumstances, which is believed to have led to an increase in the number of Article 23 reports and a diversification of the target population 16)22)27). In fact, according to the "White Paper on Police in 2013, "3) the number of consultations concerning crimes and accidents increased by about 70,000 cases annually, from 1,398,989 cases in 2010 to 1,461,049 cases in 2011

and 1,553,189 cases in 2012.

On the other hand, the current reporting system remains as it was before the Vision for the Reform of Mental Health and Welfare (2004) was issued. When a report is made and a preliminary investigation confirms the need for an examination for involuntary hospitalization, the patient is examined by a designated mental health physician (Article 27 of the Mental Health and Welfare Act), but there is no provision for support for those who are judged not to require an examination for involuntary hospitalization or who do not require involuntary hospitalization 13). The psychiatric emergency medical care system in Kanagawa Prefecture proposes hospitalization for medical care and protection, voluntary hospitalization, or treatment outside of hospitalization (outpatient treatment required) based on the fact that consent as a medical response after measures is no longer necessary, but this is a part of the system that is performed outside the scope of the involuntary hospitalization system. In other words, in principle, support other than involuntary inpatient care is not planned for those who have fallen into a state of crisis in their community life and have issued a crisis call in the form of Article 23 reporting. Such a support system may have been sufficient in the era of inpatient-centered medical care when the reporting system was established, but it may be insufficient today, when the number of reports has increased while the duration of hospitalization has become shorter and community life has become the focus, and it is more likely to lead to re-reporting.

An overview of the changes in the number of people with mental illness over the past 20 years (Figure 3) 5) shows that the number of people with mental illness has doubled. Taking into account the ambiguity of the diagnosis and prevalence of minor illnesses 9)12), the number of people with organic mental disorders (excluding dementia) and endogenous psychosis, which are so-called psychotic disorders, has remained almost constant, suggesting that the number of people with non-psychotic mental disorders has increased. In other words, these are people who are more likely to benefit from pharmacotherapy and psychosocial treatment while leading their daily lives, rather than from hospitalization and treatment centered on pharmacotherapy. In today's society, which is moving from hospitalization-centered medical care to community life-centered care, it is considered necessary to take a viewpoint of life support in accordance with the problems of the subjects, and it is hoped that the reporting system will be positioned as part of the enhancement

of community psychiatric care in consideration of the "construction of a comprehensive community care system that also responds to mental disorders".

The above findings suggest that it may be important to assess the need for lifestyle support for subjects in the multiple group, focusing on the characteristics of their disabilities and the complex difficulties they have living in the community that are behind their psychiatric symptoms, and to establish a system that enables them to receive support while continuing to live in the community. In reality, it is difficult to determine whether a subject will become a "multiple group" member in the future at the time of initial reporting, but it is desirable to attempt an assessment of the need for life support, focusing on those with F5-7 disabilities, those who did not receive an examination for involuntary hospitalization, those for whom a decision was made to respond outside hospitalization, and those who were directly discharged after termination of measures. In this case, it is important to include the characteristics of the subjects and perspective of life support that cannot be solved solely by the mental health and welfare support system, and it is considered necessary to switch to the construction or development of a health care system that will not lead to reporting in the future.

3. Limitations of this study

This study was conducted in an ordinance-designated city. Because of regional differences in the operation of the reporting system, the results of this study cannot be immediately generalized to other regions. For the future, it will be necessary to conduct a detailed analysis of the cases not requiring medical examination or involuntary hospitalization, including the circumstances that led to the reporting of such cases.

Conclusion

The purpose of this study was to understand the characteristics of subjects who had been reported on twice or more in three years based on Article 23, and examine measures to enable them to lead a stable life in the community. The results showed that "decisions not to perform examination," "out of hospitalization or no medical care required," and "direct discharge after termination of involuntary hospitalization" were the most frequent responses for the multiple group. In terms of case characteristics, a high proportion of subjects had a history of involuntary hospitalization, and F5, F6, and F7 were the diagnoses at the time of the examination for involuntary hospitalization.

One of the reasons for the high rate of non-psychotic mental disorders in the multiple group and the high number of cases that were unlikely to be hospitalized may be that the self-harm or harming others that triggered the report was a reaction to the living environment or events in their lives. However, the rates of emergency involuntary hospitalization and involuntary hospitalization were almost the same in both groups. If the reporting is regarded as a crisis call, it may be considered necessary to adopt a viewpoint of community life support in line with the problems faced by the subject. Although the multiple group of Article 23 reporting had a lower proportion of psychotic disorders than the single group, there are a number of cases in which support is needed. It is necessary to examine how support should be provided, including perspectives other than psychiatric care, and in the future, to shift to strengthening the health system that does not lead to reporting.

Conflict of interest

The analysis of anonymized data was supported by the "Policy Research to Promote Community Life Support for Persons with Mental Disabilities" (Principal Investigator: Chiyo Fujii), which was subsidized by the Health, Labor and Welfare Administration, Research and Development Project, FY 2018. There are no conflicts of interest to disclose in relation to this paper.

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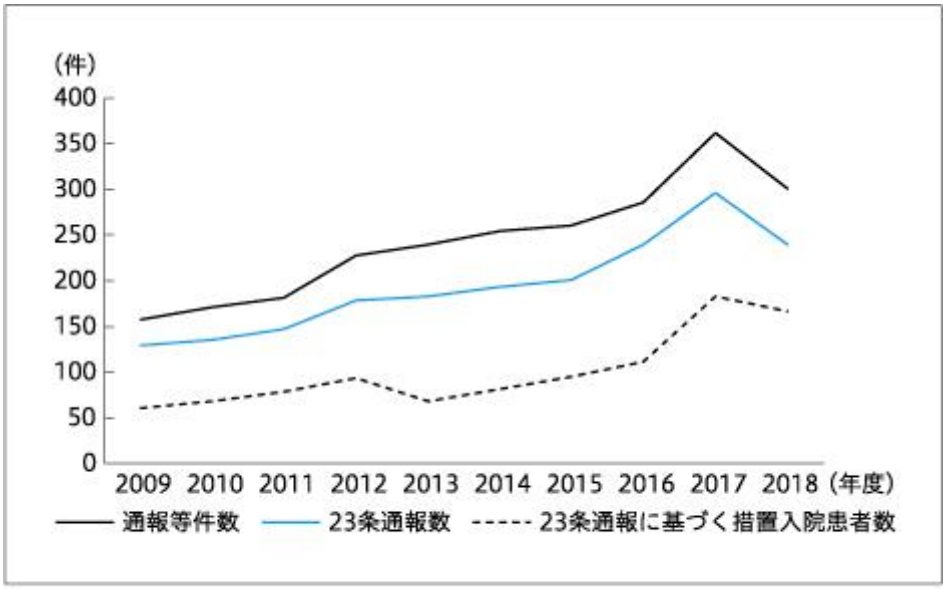

図 1　川崎市の通報等件数の推移
（文献 4 より著者作成）

Figure 1 Trends in the number of reports, etc., in Kawasaki City
(Compiled by the author based on Reference 4)

表 1　措置診察不実施（通報の取り下げを含む）の理由

理由	全体		複数群		単数群	
	n	%	n	%	n	%
精神疾患による症状がない	15	8.1	2	4.4	13	9.2
アルコール，薬物による酩酊状態である	20	10.8	8	17.8	12	8.5
精神症状が原因での自傷他害ではない	45	24.2	12	26.7	33	23.4
法に基づく自傷他害要件を満たさない	64	34.4	17	37.8	47	33.3
病状が安定している	7	3.8	2	4.4	5	3.6
家族の引き取り	6	3.2	0	0.0	6	4.3
身体的治療が必要なため	1	0.5	0	0.0	1	0.7
警察官による取り下げ	25	13.4	3	6.7	22	15.6
その他	3	1.6	1	2.2	2	1.4
合計	186	100.0	45	100.0	141	100.0

Table 1 Reasons for not performing examinations for involuntary hospitalization (including withdrawal of report)

表 2　複数群と単数群の通報ごとの特性とその後の処遇

項目		総数		複数群		単数群		χ^2	P
		n	%	n	%	n	%		
自傷他害の区分 (n＝562)	自傷コア群	29	5.2	5	5.1	24	5.2	2.139	0.544
	他害コア群	62	11.0	10	10.2	52	11.2		
	自傷・他害群	183	32.6	38	38.8	145	31.3		
	非コア群	288	51.2	45	45.9	243	52.4		
事前調査結果 (n＝748)	実施	562	75.1	98	68.5	464	76.7	6.902	0.032
	不実施	161	21.5	42	29.4	119	19.7		
	取り下げ	25	3.3	3	2.1	22	3.6		
緊急措置診察結果* (n＝189)	緊急措置	124	65.6	20	62.5	104	66.2	2.943	0.567
	医療保護	24	12.7	4	12.5	20	12.7		
	任意	3	1.6	0	0.0	3	1.9		
	入院外	33	17.5	8	25.0	25	15.9		
	医療不要	5	2.6	0	0.0	5	3.2		
措置診察結果* (n＝497)	措置	343	69.0	58	67.4	285	69.3	12.661	0.013
	医療保護	71	14.3	6	7.0	65	15.8		
	任意	6	1.2	2	2.3	4	1.0		
	入院外	74	14.9	18	20.9	56	13.6		
	医療不要	3	0.6	2	2.3	1	0.2		
措置解除後処遇 (n＝343)	医療保護	193	56.3	29	50.0	164	57.5	9.703	0.021
	任意	72	21.0	9	15.5	63	22.1		
	退院	77	22.4	19	32.8	58	20.3		
	死亡	1	0.3	1	1.7	0	0.0		

χ^2検定を行った
*緊急措置入院，措置入院以外は措置不要となった場合の対応であるが，本稿では対応の実態を明らかにするために同列に併記した．

Table 2 Characteristics and Subsequent Treatment of Multiple and Single Groups by Report
χ2 test was performed.
*The cases other than "emergency involuntary hospitalization" and "involuntary hospitalization" are responses when measures are no longer necessary, but in this paper, they are listed together in the same row to clarify the actual situation regarding the responses.

表 3　複数群と単数群の事例特性

項目		総数 n＝668		複数群 n＝63		単数群 n＝605		χ^2 (t)	P
		n（平均）	%（標準偏差）	n（平均）	%（標準偏差）	n（平均）	%（標準偏差）		
年齢		41.9	16.7	37.3	12.6	42.3	17.0	3.981	0.001
年齢階級	10 代	37	5.5	4	6.3	33	5.5	20.312	0.009
	20 代	142	21.3	15	23.8	127	21.0		
	30 代	143	21.4	13	20.6	130	21.5		
	40 代	150	22.5	17	27.0	133	22.0		
	50 代	94	14.1	12	19.0	82	13.6		
	60 代	52	7.8	1	1.6	51	8.4		
	70 代	33	4.9	0	0.0	33	5.5		
	80 代以上	16	2.4	0	0.0	16	2.6		
	不明	1	0.1	1	1.6	0	0.0		
性別	男性	345	51.6	30	47.6	315	52.1	0.452	0.511
	女性	323	48.4	33	52.4	290	47.9		
保険区分	国民健康保険	258	38.6	30	47.6	228	37.7	6.302	0.390
	社会保険	161	24.1	10	15.9	151	25.0		
	生活保護	145	21.7	16	25.4	129	21.3		
	後期高齢者医療保険	16	2.4	0	0.0	16	2.6		
	その他	4	0.6	0	0.0	4	0.7		
	なし	3	0.4	0	0.0	3	0.5		
	不明	81	12.1	7	11.1	74	12.2		
家族状況	単身	181	27.1	22	34.9	159	26.3	0.290	0.514
	同居	412	61.7	35	55.6	377	62.3		
	施設入所	9	1.3	1	1.6	8	1.3		
	不明	66	9.9	5	7.9	61	10.1		
過去の通院歴	あり	467	69.9	50	79.4	417	68.9	3.212	0.201
	なし	124	18.6	7	11.1	117	19.3		
	不明	77	11.5	6	9.5	71	11.7		
治療経過	継続中	314	47.0	32	50.8	282	46.6	1.737	0.784
	断続	4	0.6	1	1.6	3	0.5		
	中断	104	15.6	9	14.3	95	15.7		
	終診	1	0.1	0	0.0	1	0.2		
	不明	245	36.7	21	33.3	224	37.0		
措置入院歴	あり	74	11.1	25	39.7	49	8.1	80.206	0.001
	なし	269	40.3	34	54.0	235	38.8		
	不明	325	48.7	4	6.3	321	53.1		
措置診察時診断 (n＝513)	F0	29	5.7	0	0.0	29	6.3	24.467	0.018
	F1	39	7.6	5	10.2	34	7.3		
	F2	247	48.1	20	40.8	227	48.9		
	F3	73	14.2	5	10.2	68	14.7		
	F4	41	8.0	4	8.2	37	8.0		
	F5	1	0.2	1	2.0	0	0.0		
	F6	42	8.2	8	16.3	34	7.3		
	F7	16	3.1	4	8.2	12	2.6		
	F8	16	3.1	2	4.1	14	3.0		
	F9	5	1.0	0	0.0	5	1.1		
	G4	1	0.2	0	0.0	1	0.2		
	精神疾患なし	3	0.6	0	0.0	3	0.6		

名義尺度は χ^2 検定，比率尺度は t 検定を行った．
複数群については，最新の通報時データを用いた．
措置診察時診断名は，診察を行った 513/668 名について措置診察時の診断を用いている．ただし，緊急措置診察のみを行った場合は，緊急措置診察時の診断を用いた．

Table 3 Case characteristics of multiple and single groups
The χ2 test was used for the nominal scale and the t-test for the ratio scale.
For multiple groups, the data at the time of the most recent report were used.

The diagnosis at the time of the examination for involuntary hospitalization was used for the 513/668 patients who were examined. In cases where only an examination for emergency involuntary hospitalization was performed, the diagnosis at the time of the examination for emergency involuntary hospitalization was used.

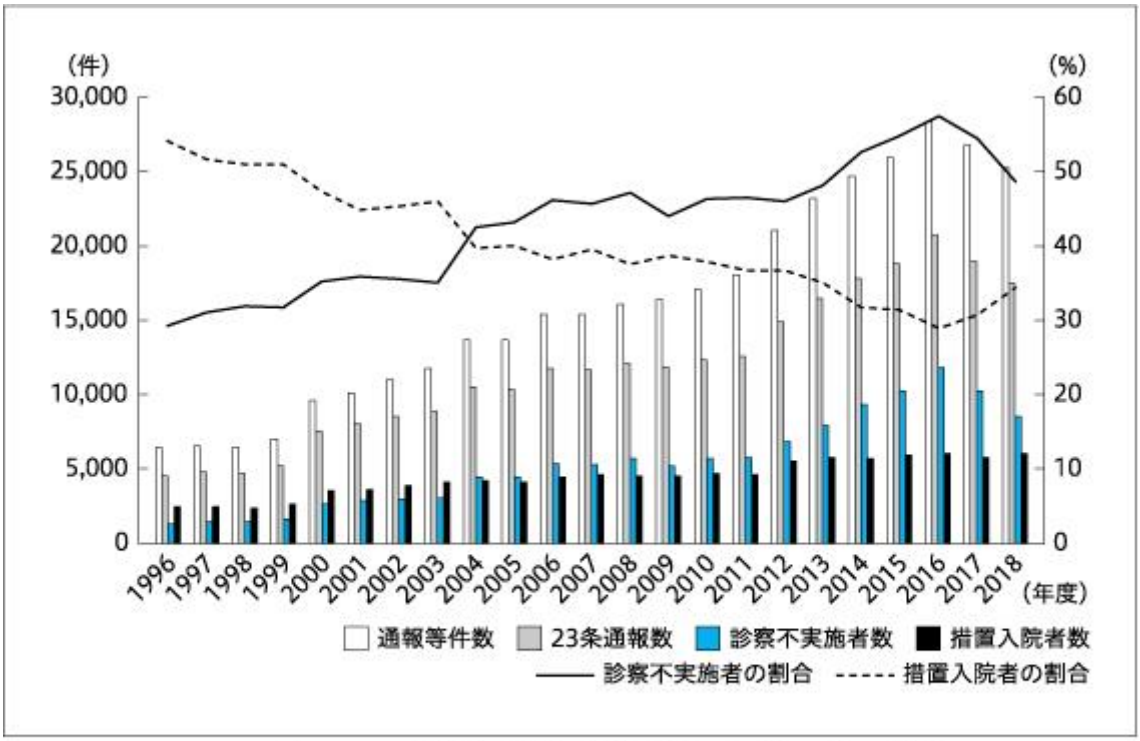

図 2　全国の 23 条通報と総通報等件数および処理数の推移
診察不実施数と措置入院者数，および 23 条に占める割合は，23 条通報に基づくものを表記した．（文献 4 より著者作成）

Figure 2 Trends in the number of Article 23 reports, total number of reports, and number of cases handled nationwide
The number of examinations for involuntary hospitalization not required, number of cases of involuntary hospitalization, and percentage of Article 23 reports are based on the Article 23 reports. (Compiled by the author from Reference 4)

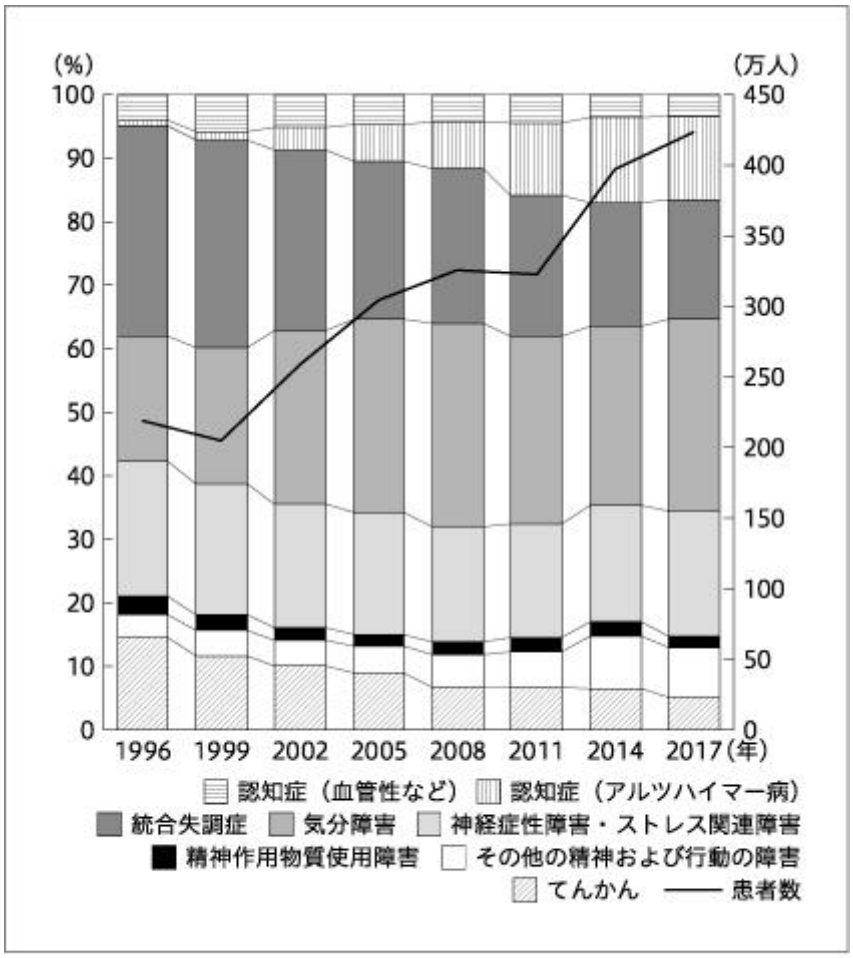

図 3　全国精神疾患の総患者に占める構成割合の推移
（文献 5 より著者作成）

Figure 3 Trends in the composition of each component of the total number of patients with psychiatric disorders nationwide
(Compiled by the author from Reference 5)