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Special Feature Article

How to Cooperate in a Medical Examination for Involuntary Hospitalization: Cooperation from Report to Hospitalization

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Abstract

The involuntary hospitalization system involves various problems. In the present study we aimed to investigate two topics: the possibility of cooperation with the judiciary, and the possibility of cooperation for the purposes of involuntary hospitalization through physical evaluation such as medical examination.

There is a fundamental difference in purpose between medical judgment, such as a medical examination, for involuntary hospitalization and judicial judgment. While the former consists of "assessment of mental disorder" and "necessity of medical care and protection for the risk of self-harm and other harm", the latter is concerned with whether to prosecute by verifying whether the patient committed a crime. Thus, there are large differences in the amount of information and the amount of time required to make judgments. Thus, cooperation between medical care staff and judiciary in the medical examination for involuntary hospitalization is difficult because of these different processes. However, in "gray-area cases", it is necessary to discuss how to achieve cooperation between medical care staff and the judiciary.

Medical examination for involuntary hospitalization requires the exclusion of mental symptoms such as those caused by physical disease and COVID-19 infection. As we must examine physical evaluation in a limited time period, we need to clarify the purpose of physical evaluation. In addition, the timing of physical evaluation depends on the

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medical care system and cooperation with the medical institution where the patient is planning to be hospitalized. However, it is not easy to find a medical institution to perform physical evaluation; therefore, it is necessary to establish a network for cooperation on physical complication medical care. In the future, it may be necessary to build such a system to receive hospitalizations at designated hospitals.

Keywords: medical examination for involuntary hospitalization, judiciary, gray-area cases, physical evaluation, cooperation

Introduction

In the medical examination for involuntary hospitalization, a designated psychiatrist for mental health "diagnoses" whether the individual has a mental disorder, and based on the risk of self-harm or harm to others, "assesses" the necessity of medical care and protection. However, many psychiatrists may have encountered cases in which this diagnosis and assessment are difficult. For example, even if it is determined that involuntary hospitalization is unnecessary for a person reported to the police due to harmful behavior, there may be concerns about incidents occurring afterward, making it difficult to reach a clear conclusion. Another example is when abnormal behavior accompanied by agitation is observed in the reported person; can psychiatric symptoms caused by physical diseases such as encephalitis or thyroid disorders truly be ruled solely through an interview, without conducting blood tests or imaging studies?

In reality, designated psychiatrists often have no choice but to conduct the medical examination for involuntary hospitalization under conditions with limited information and time. The key to conducting a medical examination for involuntary hospitalization in such a constrained way is cooperation. This paper discusses the possibility of cooperation between medical care services and the judiciary regarding harmful behavior, and the possibility of cooperation through physical evaluation in the medical examination for involuntary hospitalization.

I. Possibility of Cooperation Between Medical Care Services and the Judiciary Regarding Harmful Behavior

1. What Are Gray-area Cases?

A report by the review and recurrence prevention team on an incident at a disability support facility in

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Sagamihara City[5] describes cases in which it was difficult to determine whether the risk of harmful behavior was due to a mental disorder as so-called gray-area cases. However, no widely agreed-upon definition of such cases currently exists. From the perspective of forensic psychiatry, cases in which a mental disorder plays a partial role in a criminal act may fall under the category of gray-area cases. In my opinion, even cases that do not fall under harmful behavior subject to the Medical Treatment and Supervison Act (such as murder, injury, arson, robbery, forced sexual intercourse, and forced indecency), for example, cases involving repeated involuntary hospitalization due to harmful behavior, also constitute gray-area cases requiring close cooperation between medical care and the judiciary.

A survey[4] targeting designated psychiatrists for mental health revealed that about half of the designated psychiatrists felt pressured to judge a case as requiring involuntary hospitalization during the medical examination for involuntary hospitalization. Various reasons may underlie this, but some designated psychiatrists may feel that, in so-called gray-area cases where the involvement of a mental disorder in harmful behavior is unclear, they are implicitly expected by those around them to make decisions from a precautionary perspective. In such cases, even if a judgment of “involuntary hospitalization not required” is made, if a mechanism were in place to refer such individuals back to the judiciary, it may alleviate the pressure felt by the designated psychiatrists. Therefore, it is necessary to consider how medical care and the judiciary can cooperate in such so-called gray-area cases.

2. What Constitutes a Crime

When a police officer determines, based on abnormal behavior or surrounding circumstances, that there is a risk of self-harm or harmful behavior due to a mental disorder, a police report is filed in accordance with Article 23 of the Act on Mental Health and Welfare for the Mentally Disabled. Once this report is made, the case is not referred to the public prosecutor, and judicial intervention does not occur. However, when the police apprehend the individual and refer them to the public prosecutor as a suspect, it is treated as a criminal case for the first time.

In the course of the investigation, the public prosecutor examines three elements that constitute the requirements for a crime: “applicability of statutory elements,” “illegality,” and “responsibility.” If it is determined that the act in question “meets the statutory

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elements, is unlawful, and the individual is responsible," then the act is considered a crime. For reference, the process of judicial and medical responses following the occurrence of harmful behavior is shown in Figure 1.

3. The Role of Psychiatric Evaluation

Mental functioning is a key factor in determining "responsibility," which is one of the elements required to establish a crime. Therefore, when a mental disorder is suspected to have influenced the criminal act, a psychiatric evaluation may be conducted. Psychiatric evaluations are broadly categorized into "pre-indictment evaluations" and "trial evaluations," with pre-indictment evaluations further divided into "full evaluations" and "brief evaluations."

Each type of evaluation is conducted by specialists such as psychiatrists; however, formally, the evaluator is not permitted to directly assess the presence or absence of criminal responsibility. Based on the results of the psychiatric evaluation, the public prosecutor comprehensively examines whether a crime has actually been committed and prosecution is necessary, and then decides whether to indict.

4. The Process of Brief Evaluation

This paper focuses on the medical examination for involuntary hospitalization, which is promptly conducted following a report; therefore, particular attention is given to brief evaluations, which are carried out relatively early after the alleged criminal act.

Although procedures may vary by region, the general process of a brief evaluation is as follows. The evaluator, upon receiving a request from the public prosecutor, is provided in advance with materials related to the case. For example, investigation reports and, if the individual has a history of treatment, medical records are supplied. In some cases, a head CT or intelligence test may be conducted beforehand; however, physical evaluation is generally not feasible.

During the suspect's detention period, the evaluator conducts an interview lasting several hours to a full day. Subsequently, the evaluator conveys their findings orally regarding psychiatric symptoms and their possible influence on the criminal act to the public prosecutor and submits a written report. The written evaluation often includes the presence or absence of mental disorder at the times of the offense and evaluation, the mechanism of its influence on the act if a mental disorder is present, and whether a report to the public prosecutor under the Act on Mental Health and Welfare for the Mentally Disabled is necessary.

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5. Medical and Judicial Judgments in the Medical Examination for Involuntary Hospitalization

A comparative examination of medical judgment in the medical examination for involuntary hospitalization and judicial judgment regarding harmful behavior is presented (Table 1).

1) Timing of Psychiatric Evaluation

The timing of psychiatric evaluation differs between the medical examination for involuntary hospitalization and psychiatric evaluation. The medical examination for involuntary hospitalization is conducted promptly following prescribed procedures and assesses the mental state at a point relatively close to the time of the offense. In contrast, a brief psychiatric evaluation is conducted during the detention period. Specifically, a decision on referral is made within 48 hours of arrest, and if detention is approved within the next 24 hours, the suspect may be detained for up to 20 days. Thus, the evaluation takes place 2 to 23 days after the offense, by which time psychiatric symptoms have often already subsided. Thus, in such evaluations, the presence and degree of mental disorder at the time of the offense must be inferred based on the suspect's recollections and documents, such as statements prepared after the offense.

2) What Constitutes Medical Judgment in the Medical Examination for Involuntary Hospitalization

In the medical examination for involuntary hospitalization, the designated psychiatrist for mental health must determine whether "the individual has a mental disorder" and whether "there is a risk of self-harm or harmful behavior requiring medical care and protection." Therefore, medical judgment in the medical examination for involuntary hospitalization refers to assessment of the need for prompt medical intervention. A preliminary investigation is conducted to determine the necessity of the examination, during which a range of information is collected. However, the amount and quality of information may vary depending on factors such as the start time of the investigation or presence of family members. Moreover, due to time constraints, it is not uncommon for the examination to proceed without sufficient information.

3) What Constitutes Judicial Judgment

The public prosecutor collects various information and verifies the

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elements necessary to establish a crime, then makes a judicial decision within the detention period regarding whether to prosecute. If it is determined that the influence of a mental disorder on the offense needs to be examined, a brief or other pre-indictment psychiatric evaluation is conducted. These materials may include a wide range of information such as statements from family members, victims, and third parties; medical records; and videos showing the suspect's behavior at the time of the offense or during interrogation. Information unfavorable to the prosecution may be excluded from the materials provided to the evaluator. In my opinion, a major difference from the medical examination for involuntary hospitalization is that, in pre-indictment evaluations, the specific circumstances of the offense are presented in detail, facilitating the assessment of psychiatric symptoms present at the time of the offense.

6. Possibilities for Cooperation Between Medical and Judicial Sectors

1) Possibilities for Cooperation in the Context of Medical Examination for Involuntary Hospitalization

As mentioned above, the process of medical decision-making in the context of medical examination for involuntary hospitalization differs from that of judicial decision-making. Moreover, while the judiciary is expected to make decisions with careful deliberation over time, medical examination for involuntary hospitalization requires prompt decision-making, resulting in a significant difference in the amount of time allocated for such judgments. These differences make cooperation with the judiciary during medical examination for involuntary hospitalization difficult. Therefore, establishing a system that allows for renewed consultation with the judiciary after hospitalization may prove beneficial.

2) Access from the Judiciary to Medical Care

Even if it is determined during medical examination for involuntary hospitalization that such hospitalization is not necessary, access to treatment itself may still be available through other forms of hospitalization. However, if a public prosecutor determines that treatment for mental disorder should be prioritized over prosecution, the only available options are to issue a "public prosecutor's report" or a "recommendation to seek medical consultation" after deciding not to prosecute. At this stage, the mental

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symptoms have often already stabilized, and in many cases where inpatient treatment is still necessary, the requirements for involuntary hospitalization are not met. There are many cases that fall under hospitalization for medical care and protection. Even when a public prosecutor's report is submitted, it is often determined during the preliminary investigation phase that medical examination for involuntary hospitalization is unnecessary, and dissatisfaction is sometimes expressed by prosecutors regarding the difficulty of accessing medical care. If inpatient treatment can be reliably secured, a recommendation to seek medical consultation is sufficient; however, in cases where that is not guaranteed, some prosecutors attempt to arrange hospitalization at psychiatric medical institutions in consultation with family members. From the standpoint of a court-appointed expert, improving access to medical care in non-prosecution cases where the criteria for involuntary hospitalization are not met but inpatient treatment is necessary remains an important issue to be addressed.

3) Gray-area Cases on the Judicial Side

When exchanging opinions with public prosecutors following a brief psychiatric evaluation, many prosecutors may seriously engage in discussions about what measures can be taken on the judicial side from the perspective of preventing recidivism. In particular, they frequently seek opinions on how to respond to harmful behavior stemming from personality disorders, intellectual disabilities, or borderline intellectual functioning, as well as to kleptomania. This indicates that gray-area cases also exist on the judicial side, and that there is overlap with the so-called gray-area cases recognized on the medical side. In such cases, the response to treatment is not always favorable, and continuous and persistent support is required. There are also cases involving repeated involuntary hospitalizations or recidivism, requiring coordinated efforts among psychiatric medical institutions, administrative bodies, and judicial agencies.

4) Possibilities for Cooperation with the Judiciary

The question of whether the person who has been reported should be led to recognize the reported act as a "disease" or "crime" in order to stop the behavior is considered to exist at

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the core of so-called gray-area cases. Personally, I believe that medical and judicial interventions should be appropriately applied depending on the nature of the act and mental state at the time. However, to achieve this, cooperation between medical and judicial sectors is essential. Since cooperation with the judiciary is difficult at the stage of medical examination for involuntary hospitalization, it is important to consider, moving forward, a "cooperation model" that defines at what stage cooperation with the judiciary should occur and through what procedures the appropriateness of the situation should be determined.

II. Cooperation in Practice Through Physical Evaluation

1. Physical Evaluation in Medical Examination for Involuntary Hospitalization

1) Necessity of Physical Evaluation in Medical Examination for Involuntary Hospitalization

It is difficult to establish a definitive diagnosis of a mental disorder in a short period; however, medical examination for involuntary hospitalization requires diagnosis based on the immediate clinical presentation and information that can be collected. Furthermore, considering subsequent treatment, exclusion of physical illnesses is necessary, but the purpose of medical examination for involuntary hospitalization is primarily to "judge" the need for medical care and protection, and not to establish a definitive diagnosis. Therefore, the degree of emphasis placed on physical evaluation becomes a significant issue. In recent years, infection control measures in medical examination for involuntary hospitalization and the selection of medical institutions that conduct involuntary hospitalization have increasingly required responses mindful of COVID-19. During the COVID-19 pandemic, the necessity of physical evaluation increased, and the importance of cooperation with departments of physical medicine also grew. However, from another perspective, COVID-19 can be considered to have made more apparent the issue of physical comorbidities that had long been latent in medical examination for involuntary hospitalization.

2) Conditions Requiring Physical Evaluation

The "Guidelines for the Operation of Involuntary Hospitalization"[1] state that judgment of the necessity of medical examination for involuntary hospitalization may be postponed if:

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"there are physical symptoms or injuries requiring emergency medical care in a physical medicine department, necessary physical medical treatment such as life-saving measures should take precedence over the judgment of the necessity for the medical examination for involuntary hospitalization," which is naturally considered appropriate. The issue concerns mental symptoms caused by physical illnesses, including symptomatic and organic mental disorders. Table 2 shows a personal summary by the author of mental states in which physical evaluation is considered necessary during the medical examination for involuntary hospitalization.

3) Timing of Physical Evaluation

To illustrate, the author presents a case encountered while working at a psychiatric hospital. A person reported by the police was in an excited state at the time of the police report, but by the time of the secondary medical examination for involuntary hospitalization, the individual showed a tendency toward somnolence, raising suspicion of consciousness disorder. The author insisted to the accompanying prefectural staff that a physical evaluation at a medical facility specializing in physical (somatic) care was necessary. However, as there was no available institution able to provide such care, involuntary hospitalization was reluctantly implemented. Several hours later, the patient's respiratory condition deteriorated, the involuntary hospitalization was rescinded, and the patient was transferred to an emergency medical facility, where hepatic encephalopathy was diagnosed. Based on this experience, the author has come to consider that if there is even the slightest suspicion of physical illness influence, physical evaluation should be performed before the medical examination for involuntary hospitalization. However, in the current psychiatric department of a general hospital with inpatient beds where the author works, such cases are initially admitted to a psychiatric ward, and a detailed evaluation to identify the cause of the altered consciousness is considered after admission. This is because the hospital has an internal system to promptly coordinate with physical medicine departments after admission. However, as this is not a designated hospital, it is likely that such responses cannot always be implemented in practice.

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This case demonstrates that the timing of physical evaluation varies depending on the medical institution's clinical system planning for involuntary hospitalization and status of cooperation with physical medicine institutions. Furthermore, the timing of physical evaluation is influenced by differences among facilities in their capacity to respond to issues such as COVID-19.

4) Goals of Physical Evaluation Before Medical Examination for Involuntary Hospitalization

An internist in charge of a fever outpatient clinic stated: "Even if a patient has a fever, it is not sufficient to consider only COVID-19, and it takes time from differential diagnosis to definitive diagnosis." When performing physical evaluation prior to the medical examination for involuntary hospitalization, due to time constraints, it is necessary to narrow the purpose of the physical evaluation. Additionally, a plan must be considered for handling cases in which physical abnormalities unrelated to psychiatric symptoms are incidentally discovered. Thus, when requesting physical evaluation, it is important to dispel any concerns of the requested medical institution. If the purpose and content are vague, it becomes difficult to identify a medical institution willing to perform the evaluation.

As a side note, physical evaluation incurs costs, and under the current involuntary hospitalization system, the reported individual is responsible for these costs. It should also be noted that, if the subject has financial difficulties or if family members or others are absent and consent for testing cannot be obtained, the physical evaluation may not be adequately performed.

2. Impact of COVID-19

1) Diagnosis of COVID-19

COVID-19 resembles influenza and the common cold, but a distinguishing feature is the high frequency of olfactory and gustatory dysfunction. The presence of influenza-like symptoms together with olfactory and gustatory dysfunction is considered highly indicative of COVID-19. However, it is difficult to identify COVID-19 based on interview and clinical findings alone. Although criteria for suspected cases have been established, there are no specific signs unique to the disease. Furthermore, due to the influence of psychiatric symptoms, the subject of the report may be unable to

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accurately communicate physical symptoms. Therefore, detection of SARS-CoV-2 by PCR or antigen testing serves as the diagnostic basis. At present, PCR testing is the most reliable method, but because some techniques require several hours to yield results, it is difficult to use as a test before the medical examination for involuntary hospitalization. Conversely, antigen tests can be performed rapidly but have a higher risk of false-negatives compared with PCR tests, raising concerns about their reliability. Moreover, in subjects with prior COVID-19 infection, a positive PCR result may not always indicate infectivity, making interpretation of test results increasingly complex.

2) Response to COVID-19

In Saitama Prefecture, where the author works, during the peak of the pandemic, a system was established to screen for COVID-19 based on physical symptoms during the preliminary investigation before the medical examination for involuntary hospitalization. If infection was suspected, the severity and risk of worsening were assessed, and appropriate medical institutions responded accordingly (Figure 2). When the screening results led to judging of the symptoms to be mild, or when mild symptoms such as low-grade fever appeared after screening, imaging examinations and other evaluations were conducted at medical institutions, which were located on a case-by-case basis.

Thus, the COVID-19 pandemic increased the procedures required before the medical examination for involuntary hospitalization, such as screening and coordination of medical institutions conducting involuntary hospitalizations, which in turn affected operation of the involuntary hospitalization system. The author also heard that longer response times increased the burden on the reported individuals, local government staff, and police officers who had to wait, as well as increased expenses for transport vehicles. However, it has been reported that psychiatric institutions have improved their COVID-19 testing capabilities, and it is hoped that the current situation will improve with widespread COVID-19 vaccination, as well as developments in testing technology and treatment methods.

3. How Cooperation Should Be

1) Current Status of Cooperation Through Physical Evaluation

The “Guidelines on the Operation of Involuntary Hospitalization” 1) state that: “a physical condition requiring medical treatment is a

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reason to delay the medical examination for involuntary hospitalization but is not a reason to deny the necessity of such an examination." The author has the impression that psychiatric medical institutions have become more sensitive to physical symptoms due to the influence of COVID-19. However, there are reports that even when physical symptoms are recognized, it is difficult to identify a medical institution to perform the required physical evaluation, or that after the evaluation, it is difficult to find a psychiatric medical institution to take charge of the medical examination for involuntary hospitalization, thus complicating the coordination until the examination takes place. Although not a designated hospital, the author's institution has occasionally admitted patients when coordination for the medical examination could not be arranged due to physical symptoms, despite having accepted the report. These may be treated as cases where the medical examination for involuntary hospitalization is unnecessary because priority is given to treatment of the physical illness; however, in practice, it is likely that such cases will be categorized as: "impossible to perform" the examination. There may be regional differences, but the current situation may be that securing medical care for physical illness itself is difficult.

2) Limitations of Conventional Cooperation Models

Conventional cooperation models between physical medicine and psychiatry include the serial and parallel models. The former is a model whereby either psychiatry or physical medicine provides initial treatment based on priority, and the other department provides subsequent support. The latter model involves simultaneous treatment of mental and physical disorders.

Before the COVID-19 pandemic, these models were used depending on regional circumstances; however, the impact of COVID-19 has increased the need for physical evaluation within the involuntary hospitalization system. Ideally, if physical symptoms are suspected before the medical examination for involuntary hospitalization, it should be actively managed by psychiatry departments in general hospitals with inpatient beds, but the number of such hospitals remains insufficient. Furthermore, facilities differ in their response capacities depending on the scale of

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psychiatric beds, number of psychiatrists, after-hours care systems, whether they are designated hospitals, and their COVID-19 response status on psychiatric wards. Therefore, it is necessary for physical and psychiatric medical institutions in the region to explore cooperation modeled after physical comorbidity care systems. In the future, it may be worth considering a system where designated hospitals capable of managing physical conditions first accept involuntary hospitalizations, and when physical management is no longer needed, patients are transferred to psychiatric medical institutions. To realize this, in addition to increasing the number of psychiatry departments in general hospitals with beds, strengthening the capacity of psychiatric medical institutions to manage physical symptoms will be necessary. Moreover, for infectious diseases requiring special responses such as COVID-19, cooperation models differing from the conventional physical comorbidity cooperation model should be considered, as hospital care systems and ward structures affect such responses.

Conclusion

The involuntary hospitalization system faces various challenges; this paper has discussed potential cooperation between the medical and judicial sectors regarding harmful behavior, as well as the possibilities for cooperation through physical evaluation during the medical examination for involuntary hospitalization. Since there are few empirical investigations on these topics, and this paper summarizes observations based on routine clinical practice, it may lack objectivity and contain content that does not apply in some regions. Nonetheless, it is hoped that this paper will raise interest in cooperation within the involuntary hospitalization system and stimulate active discussion.

Editorial Note

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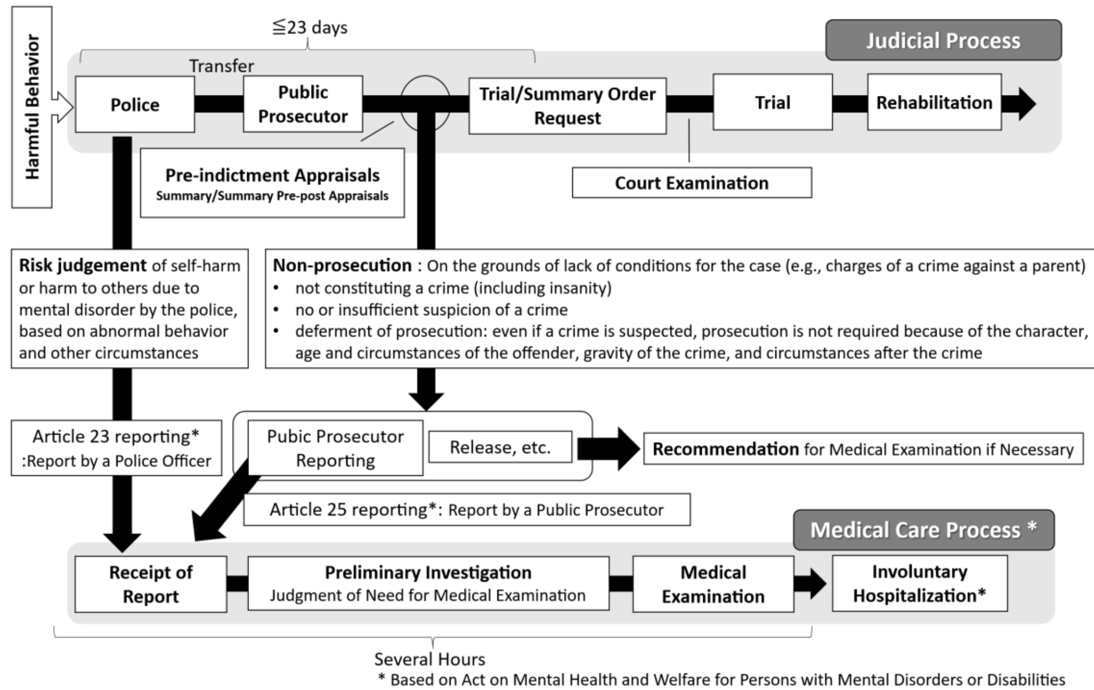

Figure 1: Flow of Judicial and Medical Processes Following Harmful Behavior

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	Medical Judgment in Medical Examination for Involuntary Hospitalization	Judicial Judgment
Purpose	- Determination of presence of mental disorder - Assessment of need for medical care and protection due to risk of self-harm or harm to others	- Proof of crime (elements of the offense, illegality, and responsibility) - Determination of necessity of prosecution
Timing of Judgment	- Shortly after the offense	- 2–23 days after the offense *If deemed necessary by the prosecutor, a psychiatric evaluation may be conducted during the detention period
Information Collection Period	Several hours	Up to 20 days
Amount of Information	Limited	Extensive
Cooperation	There is no cooperation with the judiciary.	For serious crimes, a petition may be filed under the Medical Treatment and Supervision Act. *If a psychiatric evaluation is conducted, opinions may be exchanged with the evaluator (typically a psychiatrist).

Table 1. Differences Between Medical and Judicial Judgments in Context of Medical Examination for Involuntary Hospitalization

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Symptom	Physical Illnesses to Consider	
Violence	Gastrointestinal	- Liver disease
	Neurological	- Epilepsy (during seizure or interictal period) - Central nervous system infections (syphilis, fungal infections, herpes encephalitis) - Normal pressure hydrocephalus - Traumatic brain injury - Alzheimer's disease - Huntington's disease - Parkinson's disease
	Renal	- Kidney disease
	Metabolic /Endocrine	- Wilson's disease - Cushing's disease - Hyperthyroidism - Hypothyroidism - Porphyria - Hypoglycemia
	Collagen Diseases	- Systemic lupus erythematosus
	Other	- Electrolyte imbalance - Systemic infections - Vitamin deficiencies
Irritability	Neurological	- Migraine
	Metabolic /Endocrine	- Hyperthyroidism - Syndrome of inappropriate antidiuretic hormone secretion (SIADH)
	Other	- Sleep apnea syndrome
Disinhibition (inappropriate jokes or clowning)	Neurological	- Frontal lobe brain tumor - Stroke - Huntington's disease
	Metabolic /Endocrine	- Wilson's disease
	Other	- Syphilis
Excessively Elevated Mood	Neurological	- Huntington's disease - Multiple sclerosis

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		- Stroke - Traumatic brain injury (e.g., contusion)
	Metabolic /Endocrine	- Hyperthyroidism
	Other	- Drug-induced psychiatric disorders
Hypersensitivity	Metabolic /Endocrine	- Wilson's disease - Adrenal insufficiency
	Other	- Pernicious anemia
Hallucinations	Neurological	- Stroke - Epilepsy - Huntington's disease - Metachromatic leukodystrophy - Encephalitis
	Renal	- Renal failure
	Metabolic /Endocrine	- Hyperparathyroidism - Hypoparathyroidism - Wilson's disease
	Other	- Alcohol withdrawal - Syphilis - Drug-induced psychiatric disorders - Systemic lupus erythematosus
Suicidal Behavior	Neurological	- Epilepsy - Huntington's disease
	Renal	- Renal failure
	Other	- Cancer
Unsteady Gait	Gastrointestinal	- Liver failure
	Neurological	- Normal pressure hydrocephalus - Central motor disorders - Prion diseases such as Creutzfeldt-Jakob disease - Progressive supranuclear palsy

(Adapted from Reference 3)

Table 2. Examples of Physical Illnesses That May Present with Symptoms Leading to Involuntary Hospitalization (Excluding Endogenous Psychoses)

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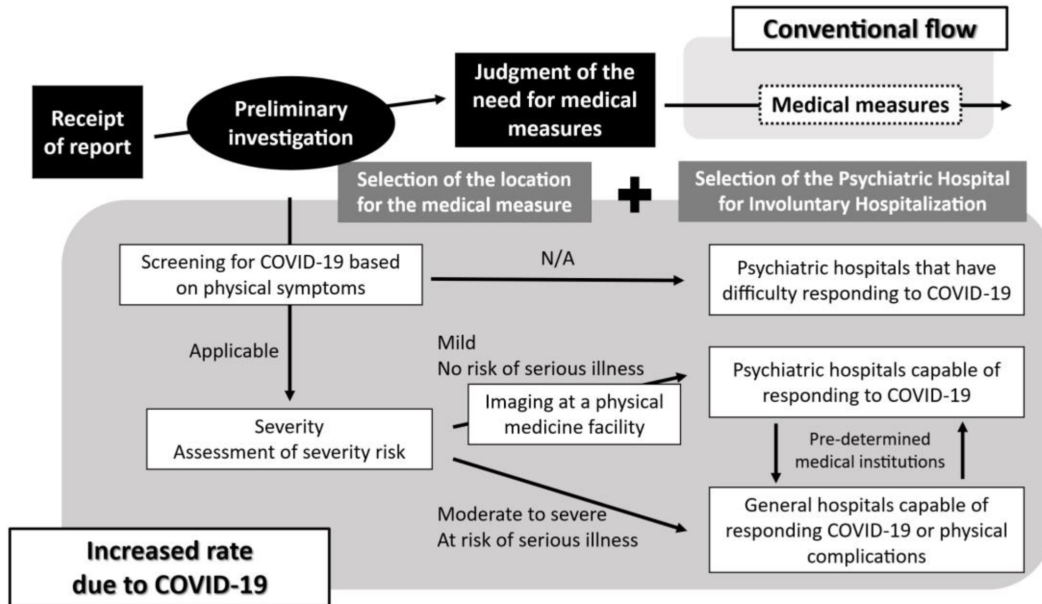

Figure 2: Process of Involuntary Hospitalization Affected by COVID-19

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