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## **Special Feature Article**

### **Cooperation with the Police in the Administrative Involuntary Hospitalization System**

Chiyo FUJII

Department of Community Mental Health and Law, National Institute of Mental Health,  
National Center of Neurology and Psychiatry

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#### **Abstract**

The Specialist Committee on the Future of Mental Health and Medical Welfare that was established by the Ministry of Health, Labour and Welfare from 2016 to 2017 pointed out significant regional differences in the number of police officer reports per 100,000 population and the percentage of reports that led to a medical examination and those that led to hospitalization. Therefore, our research team proposed a draft guideline on the administrative hospitalization operation based on a survey of the police reports and discussions with mental health professionals, local government officials, and police officials. On March 27, 2018, the Ministry of Health, Labour and Welfare issued the Guidelines for the Operation of Administrative Hospitalization based on this draft. The guideline, mainly for local government officials and police officers, presented the concept and operation of accepting police reports, the process from the preliminary investigation after accepting the report for medical examination, and the setting of a place for consultation meetings by relevant community parties. After the guidelines were issued, the regional differences in police reports were modestly corrected, and consultation meetings by local stakeholders were established. The effectiveness of the guidelines needs to be continuously verified. Police officers' reports play an important role in connecting people with mental disorders who need urgent medical care and thus

cooperation between the police, local governments, and psychiatric hospitals is important to prevent involuntary hospitalization. While promoting the guidelines through continuous training and other means and considering revisions as necessary, the establishment of appropriate cooperation with the police through the use of consultation meetings among relevant parties in the community can improve the quality of community mental health care.

**Keywords:** administrative involuntary hospitalization, Mental Health and Welfare Act, police report, community mental health

### Introduction

The system of administrative involuntary hospitalization was established by the Mental Health and Welfare Act enacted in 1950. Since then, several revisions have been made, including introduction of the emergency administrative involuntary hospitalization system, provisions for discharge from hospital, and confidentiality obligations in the 1965 amendment, as well as the establishment of emergency hospitalization and other related system changes. However, the fundamental framework of the administrative involuntary hospitalization system itself has not undergone major changes. In 2001, following a random mass stabbing incident at Ikeda Elementary School affiliated with Osaka Kyoiku University, where the perpetrator had a history of administrative involuntary

hospitalization, discussions were held regarding the system's future. However, in 2003, the Medical Treatment and Supervision Act, which governs the medical treatment and observation of persons who committed serious, harmful acts in a state of insanity, was enacted, and no revisions were made to the administrative involuntary hospitalization system itself. Since then, the need for system revisions and operational improvements has continued to be pointed out, particularly issues surrounding police reports, which account for the majority of administrative involuntary hospitalization cases.<sup>7)</sup> Among these issues, the way police, local governments, and medical institutions cooperate regarding administrative involuntary hospitalization is one of the most critical.

## I. Regional Differences in Operation of Administrative Involuntary Hospitalization System

Operation of the administrative involuntary hospitalization system is based on the article-by-article commentary of the Act on Mental Health and Welfare for the Mentally Disabled (hereinafter referred to as the “Mental Health and Welfare Act”) and related notifications. However, because the national government had not provided clear guidelines on the handling of tasks such as the acceptance of reports and determination of whether a medical examination for administrative hospitalization was necessary, each local government developed its own operational manuals for administrative involuntary hospitalization according to the region-specific circumstances. Although regional differences in the number of police reports and percentage of cases that proceed to a medical examination for administrative hospitalization have been repeatedly pointed out, efforts to correct these disparities have been insufficient. Under these circumstances, a mass stabbing incident, one of the most severe in the postwar period, occurred at a facility for persons with disabilities in Sagamihara City on July 26, 2016, perpetrated by a former administrative involuntary hospitalization patient. This incident

drew significant attention to issues concerning the initial stages of administrative involuntary hospitalization. It became clear once again that there were marked regional differences in: the number of police reports per 100,000 population, percentage of reports leading to a medical examination for administrative hospitalization, and percentage of cases progressing from a police report to administrative involuntary hospitalization by prefecture (Figure 1).

As above-mentioned, in the absence of clear national guidelines, each local government has made independent efforts to develop systems for operation of the administrative involuntary hospitalization system, and to some extent, regional differences were unavoidable. However, considering that administrative involuntary hospitalization is an administrative process carried out under the same law, it is not acceptable to leave such significant regional disparities unresolved. Therefore, it was considered necessary to examine background factors that caused these regional differences and, based on this, clarify issues that need to be addressed and implement appropriate measures.

The authors examined the operational status of accepting police reports in 45 prefectures and 18 ordinance-designated cities that

consented to the research use of data from a questionnaire survey on operation of the administrative involuntary hospitalization system, conducted by the Ministry of Health, Labour and Welfare targeting all 47 prefectures and 20 ordinance-designated cities. In addition, they conducted interviews with local governments and police departments regarding operation of the administrative involuntary hospitalization system. Based on the results, they examined factors contributing to regional differences in system operation.<sup>8)</sup> The questionnaire covered the processes from accepting police reports at public health centers and other institutions to the medical examination for administrative hospitalization, including procedures for accepting police reports, the circumstances at the time of acceptance, specific procedures for determining whether a medical examination was necessary, the existence of operational manuals for administrative involuntary hospitalization, the involvement of mental health professionals involved in processing reports, systems for night-time and holiday responses, and the securing of designated mental health physicians. Diagnostic categories of the people reported were not surveyed. As a result, it became clear that there were issues with the accuracy of data from

the Health Administration Report, which had been used as the statistical basis for demonstrating regional differences.<sup>8)</sup> Specifically, in some prefectures, the number of police reports recorded in the Health Administration Report included cases where the police contacted the prefectures and other authorities for “consultation,” which did not meet the reporting requirements of Article 23 of the Act on Mental Health and Welfare for the Mentally Disabled.

A major concern pointed out by local government officials was the regional disparity in “police reports made when the person being reported was not in custody.” According to the municipal survey, in about half of the prefectures and ordinance-designated cities, police reports were made when the person being reported was not in custody (Figure 2).<sup>8)</sup> If, at the time of the preliminary investigation, the person being reported is not in custody, it becomes difficult or even impossible for the local government to conduct the investigation itself. Therefore, when the police have not taken the person into protective custody or arrested them, it is likely that the case will be considered not to pose a risk of self-harm or harm to others, and that a medical examination for administrative hospitalization will be deemed unnecessary. Previous studies also

pointed out that when the police continue to protect the person being reported, there is a higher likelihood that he/she is considered to pose a risk of self-harm or harm to others, and that a medical examination for administrative hospitalization will be judged as necessary.<sup>10)11)</sup> Situations in which a medical examination for administrative hospitalization is judged unnecessary include cases where a report is submitted after the person being reported has already been hospitalized under a form of hospitalization other than administrative involuntary hospitalization, cases where a report is made without the person being in police custody, cases where a significant period of time, ranging from several days to years, has elapsed since the incident necessitating police involvement, and cases where the report is based on information from a third party that police officers have not directly confirmed.<sup>10)11)</sup>

Interviews with police and local government officials suggested that the consultative support system in local governments, accessibility of mental health care, and coordination system between local governments and the police may be related to regional differences in police reports. In addition, it was also suggested that there may be regional differences in the factors that

local government officials prioritize when determining the necessity of a medical examination for administrative hospitalization.<sup>8)</sup> Specifically, some local governments prioritize prompt access to medical care and conduct preliminary investigations on the premise that a medical examination will, in principle, be conducted. In contrast, other local governments, considering that a medical examination for administrative hospitalization itself involves some degree of coercion for the person being reported, manage the system in a more restrained manner and seek to minimize the use of medical examinations for administrative hospitalization.

## **II. Guidelines for Operation of Administrative Involuntary Hospitalization**

Considering the above circumstances, the authors conducted multiple discussions with the Ministry of Health, Labour and Welfare, local governments, mental health professionals, the National Police Agency, and frontline police officers to organize the key issues and corresponding measures related to the operation of administrative involuntary hospitalization. Based on the research team's conclusion, the "Guidelines for the Operation of Administrative Involuntary Hospitalization"<sup>8)</sup> compiled by the

authors, the Ministry of Health, Labour and Welfare issued the official notification from the Director-General of the Department of Health and Welfare for Persons with Disabilities, Social Welfare and War Victims' Relief Bureau, entitled: "Guidelines for the Operation of Administrative Involuntary Hospitalization" (Notification No. Shōhatsu 0327 No. 15)<sup>4)</sup> (hereinafter referred to as "the guidelines") in March 2018 (Table). The following describes the content of the guidelines related to cooperation with the police in the administrative involuntary hospitalization process.

#### 1. Confirmation of Whether Contact Constitutes a Police Report

In this regard, when the police contact a local government office, such as a public health center, it is necessary to confirm whether this contact constitutes a police report. While this may seem self-evident, in practice, situations arise in which police reports and consultations are confused. This confusion is partly due to the fact that a police report is not a formalized legal procedure; it is not an act that must comply with specific legal formalities, such as the submission of a written document or an official notification, for its validity. Therefore, depending on local government practices, various

means of communication, such as written documents, oral communication, and telephone calls, may be used for reporting. In addition, when the police contact a local government concerning people with mental disorders, such contact may constitute not only a police report but also a consultation under Article 47, Paragraph 1 of the Act on Mental Health and Welfare for the Mentally Disabled. For this reason, particularly in cases of oral or telephone contact, it is easy for the two to be confused. Normally, in such cases, cooperation between the police and local government begins with the former contacting the latter. Therefore, depending on local government practices, various means of communication, such as written documents, oral communication, and telephone calls, may be used for reporting.

#### 2. Reporting When a Person Has Not Been Detained or Taken into Custody

When drafting the guidelines, one particularly problematic issue was how to handle cases of reports made when the individual had not been detained or taken into custody, identified as one of the factors contributing to regional differences in the operation of administrative involuntary hospitalization. According to Article 23 (Police Report) of the Act on Mental

Health and Welfare for the Mentally Disabled, a police officer who identifies a person deemed to pose a risk of self-harm or harm to others due to a mental disorder must immediately report the situation. The question here is what constitutes “discovering” such a person. Prior to the 1965 amendment of the Act, Article 23 required police officers to report only in cases where the person had been taken into protective custody under Article 3 of the Police Duties Execution Act (hereinafter referred to as the “Police Duties Execution Act”). However, in practice, there were many cases in which a report was also made after the arrest of a criminal suspect who was subsequently recognized as having a risk of self-harm or harming others due to a mental disorder. Therefore, the 1965 amendment revised the provision to reflect this reality, replacing “when detained or arrested” with “when discovered.”

Considering the legislative history, the typical subject of police reports refers to cases where the police have conducted protection or arrest. The “protection of mentally disturbed persons” carried out by police officers is based on Article 3, Paragraph 1 of the Police Duties Execution Act. This provision requires police officers to protect “a person who, due to mental disturbance, is considered likely to cause harm to the life, body, or property

of themselves or others and is deemed to require emergency aid.” Thus, even if a police officer recognizes a person as having a risk of self-harm or harm to others due to mental disturbance, the officer may, in accordance with the law, decide not to take that person into protective custody immediately if the situation (such as the person’s location or possibility of supervision without taking custody) does not warrant urgent aid. For example, if the subject of the report is residing in a facility such as a child consultation center, the facility staff notify the police, and the staff are judged as capable of supervising the person within the facility, this may constitute a police report in a situation where the person is not in police custody. Also, even after a police report following protection, this protection may have to be lifted depending on the circumstances. However, in such cases, since the police have “discovered a person who, due to mental disturbance, is likely to cause self-harm or harm to others,” the police stated that a report “in situations where the person is not protected or arrested” can occur. Conversely, local governments receiving police reports expressed the view that “reports in situations where the person is not protected or arrested” are difficult to accept, as the preliminary investigations conducted after receiving such reports can become difficult or

impossible. Ultimately, given the discrepancy between the Act on Mental Health and Welfare for the Mentally Disabled and the Police Duties Execution Act, it was concluded that protection or arrest cannot be set as mandatory conditions for reports in the guidelines. Therefore, the concept of reports made without the person being in custody was included in the guidelines as an exception.

The guidelines describe exceptional situations in which reports may occur without the person being in custody, and the aim was to minimize such reports. However, when reports are actually made in situations where protection or arrest has not been carried out, difficulties in conducting the preliminary investigation are unavoidable. Therefore, in such cases, the guidelines also mention the necessity of coordinating, at the reporting stage, with the police and family of the reported person on how the preliminary investigation should be conducted.

### 3. Support for Cases Not Resulting in Administrative Involuntary Hospitalization

Since the police operate closely within the community on a 24-hour basis, they frequently receive reports and consultations concerning self-harm or harm to others perpetrated by people

with mental disorders, regardless of it happening at night or on holidays. Therefore, for local governments to provide timely and appropriate consultative support to residents requiring psychiatric medical care, it is important to respond appropriately to consultations and information provided by the police. When the cooperation system between the police and local governments is well-established, consultative support by the local government based on Article 47 of the Act on Mental Health and Welfare for the Mentally Disabled is appropriately provided, and access to necessary psychiatric medical care is secured, consultative support can begin at the stage of police consultation or information provision, which may lead to implementing the necessary medical care without resulting in a police report. However, hearings with police officers revealed that sometimes, because “consultations” do not sufficiently lead to consultative support or referrals to medical institutions, they deliberately make a “police report.” Additionally, it was suggested that in some local governments, due to various factors such as difficulties in securing adequate human resources, support systems are not sufficiently established.

In the guidelines, even in cases where the medical examination for administrative involuntary

hospitalization is not conducted, or where it is determined that inpatient medical treatment is unnecessary as a result of the examination, if ongoing support for the case is deemed necessary, it is desirable for the local government to proactively provide consultation and guidance based on Article 47 of the Act on Mental Health and Welfare for the Mentally Disabled. Additionally, situations often arise in which ongoing support is necessary, but the local government responsible for the case's place of residence differs from the local government that made the decision regarding the necessity of administrative involuntary hospitalization. In such cases, it is desirable for the local government that made the decision regarding the necessity of hospitalization to contact the local government responsible for the case's residence and share information with them concerning the need for support. Regarding information-sharing, the consent of the individual involved is required in accordance with the Personal Information Protection Act; however, in practice, cases requiring a high level of cooperation tend to involve difficulty obtaining such consent. Since addressing this issue within the current laws is challenging, the guidelines are based on the premise of obtaining the individual's consent.

#### 4. Consultation Meetings Among Local Stakeholders

While formulation of the guidelines is expected to help standardize aspects of the administrative involuntary hospitalization system that had previously operated according to practices specific to each municipality, it is anticipated that many situations will remain where the guidelines cannot specify responses and cases must be considered on an individual basis. In such situations that require detailed and careful handling, it is important to deepen mutual understanding and align perspectives through opportunities for discussion among local stakeholders, including the police, regarding the operation of administrative involuntary hospitalization.

Therefore, the guidelines strongly recommend establishing consultation meetings within each community that include local stakeholders such as municipal officials, mental health professionals, welfare workers, disability organizations, family associations, police, and fire departments, to provide opportunities to discuss challenges related to the operation of administrative involuntary hospitalization. Topics for discussion may include: response policies from police reports to administrative hospitalization based on the guidelines, approaches to handling difficult cases,

and procedures for transport. Through collaboration among stakeholders in such consultation meetings, improvements are expected not only in the operation of administrative involuntary hospitalization, but also in the overall quality of support for people with mental disorders in the community. It should be noted that the consultation meetings described in the guidelines are intended for discussion on the appropriate operation of administrative involuntary hospitalization among local stakeholders, and do not involve the sharing of personal information.

### III. Effectiveness of Guidelines

Although the effectiveness of the guidelines has not yet been fully verified, there are some reference data regarding changes in police reports where the reported individual was not taken into custody. According to a nationwide survey conducted in fiscal year 2017 targeting prefectures and government, designated cities, 32 of the 63 responding municipalities (50.8%) had received police reports without the reported individual being taken into custody.<sup>8)</sup> In the same fiscal year, during a three-month period, there were 5,445 police reports, of which 1,128 reports (20.7%) involved no custody protection. However, a survey conducted in fiscal year 2019 targeting 374 public health centers nationwide found that among

the 176 centers that responded to questions regarding police reports without custody, 58 (33.0%) had received such reports.<sup>9)</sup> In that fiscal year, out of a total of 4,280 police reports, 243 (5.7%) involved situations where the reported individual was not in custody. Since the two surveys had different target populations, these figures should be regarded as reference values; however, there is a possibility that police reports without the individual being taken into custody have decreased since implementation of the guidelines.

Regarding the establishment of consultation meetings, it has been shown that more than half (51%) of public health centers and similar institutions had opportunities to hold consultation meetings with the police.<sup>9)</sup> The topics discussed at these meetings are diverse and include confirmation of the overall operation of the administrative involuntary hospitalization system, responses during reports under Article 23, criteria for reporting, matters related to the psychiatric emergency system, support for cases where hospitalization is deemed unnecessary, support for suicide attempters, and responses to intoxicated individuals. These consultation meetings may be utilized to nurture cooperation among local stakeholders.

While certain effects are suggested as described above, there is also concern that for municipalities which have adapted to the lack of clear national guidelines through the efforts of local stakeholders and flexible operation of the system prior to the issuance of the guidelines, adverse effects may arise from the presentation of a “standardized” operation in the guidelines. Because no standard operation of the administrative involuntary hospitalization system had been presented for several decades, each municipality was compelled to create local rules for system operation, making regional differences in system operation an almost inevitable consequence. Nevertheless, given that the administrative involuntary hospitalization system is based not on municipal ordinances but on the Act on Mental Health and Welfare for the Mentally Disabled, significant regional disparities should be resolved as much as possible. It is desirable, in consultation meetings, for local stakeholders including the police to hold repeated discussions based on the guidelines about the appropriate operation of the system, thereby promoting collaboration among involved parties.

#### **IV. Remaining Issues**

In the process of operating the administrative involuntary hospitalization system, there are cases where a person reported poses a risk of harming others or has caused harm, but it is difficult to determine whether the harmful behavior is due to a mental disorder. Such cases, referred to as “gray zone cases” in the report by the review and recurrence prevention team investigating the incident at a disability support facility in Sagamihara City, present particular challenges.<sup>5)</sup> The report warns that, for gray zone cases where support through medical or welfare services is difficult, taking harm-prevention measures must be approached with extreme caution from the perspective of human rights protection. It also raises the issue that relevant parties such as prefectural governors and police should share a common understanding that gray zone cases exist where it is difficult to determine at the time of emergency medical examination or medical examination for administrative hospitalization whether the risk of harm stems from a mental disorder. This position has been maintained by the Ministry of Health, Labour and Welfare’s “Council on the Future Direction of Mental Health and Medical Welfare,” and the council’s report includes similar content.<sup>3)</sup>

In the field of psychiatric medical care, recognition by the government that this issue, one that many mental health professionals have long struggled to address, is a matter requiring national consideration that holds marked importance. Until now, when persons considered to be in the gray zone were subjected to administrative involuntary hospitalization or similar psychiatric medical interventions, even if it later became clear that the harmful behavior was not due to psychopathology, it remained difficult to expect renewed judicial involvement. While it is self-evident that the purpose of psychiatric care is not crime-prevention, in actual clinical practice, there are cases that require both medical and judicial responses.

The guidelines do not explicitly address responses to gray zone cases, leaving this as an important issue to be examined in the future. To ensure appropriate responses while respecting an individual's human rights, discussions regarding the handling of gray zone cases are expected to progress among the police, prosecutors, mental health professionals, and local governments. However, since this is an extremely sensitive matter involving challenges related to the handling of personal information, it is necessary to proceed with careful and ongoing deliberations while also seeking input

from the individuals involved and legal experts.

### Conclusion

Mental health, medical, and welfare services have gradually shifted from an inpatient-centered model to one focused on supporting community-living through the efforts of various stakeholders. In supporting the lives of people with severe mental disorders in the community, it is essential that crisis intervention for sudden worsening of symptoms is conducted appropriately. The police, who operate on a 24-hour, 365-day basis within the community, are indispensable for protecting the safety of residents, including people with mental disorders. Cooperation is important not only during police reports but also in responding to consultations from the police regarding residents suspected of having mental disorders, which may contribute to a reduction in involuntary hospitalizations. In foreign countries where deinstitutionalization of psychiatric care has advanced and community mental health care systems are well-established, various innovations in collaboration between the police and mental health professionals have been implemented, with positive outcomes.<sup>1)6)</sup> Although some regions in Japan have made progress in such cooperation, it remains an ongoing challenge in many areas.

Taking the issuance of the guidelines as an opportunity, it is hoped that cooperation between the police and community mental health professionals will advance through establishing forums for discussion among regional stakeholders.

#### Editorial Note

This special feature article is based on the symposium held at the 117th Annual Meeting of the Japanese Society of Psychiatry and Neurology, with Takayasu Asami (Gunma Univ. General Health Support Center) as the representative.

There are no conflicts of interest to disclose in relation to this paper.

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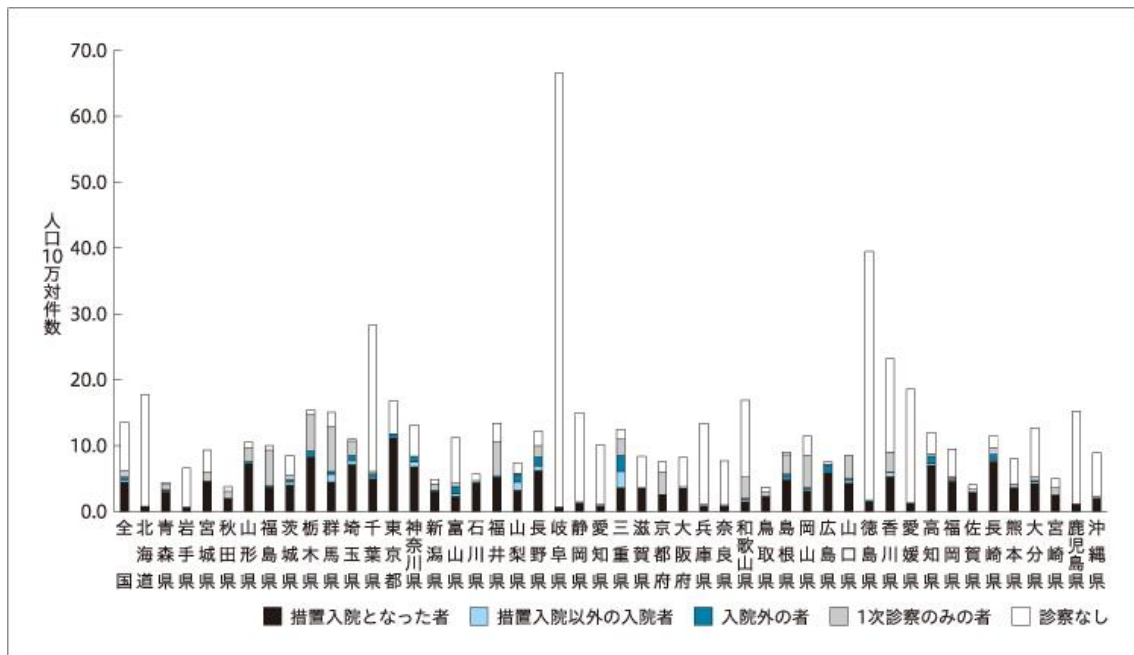


図1 2014年度 都道府県別警察官通報対応状況 (対人口10万人)  
(文献2より引用)

Figure 1. Status of Police Report Responses by Prefecture in Fiscal Year 2014 (per 100,000 Population)  
(Source: Reference 2)

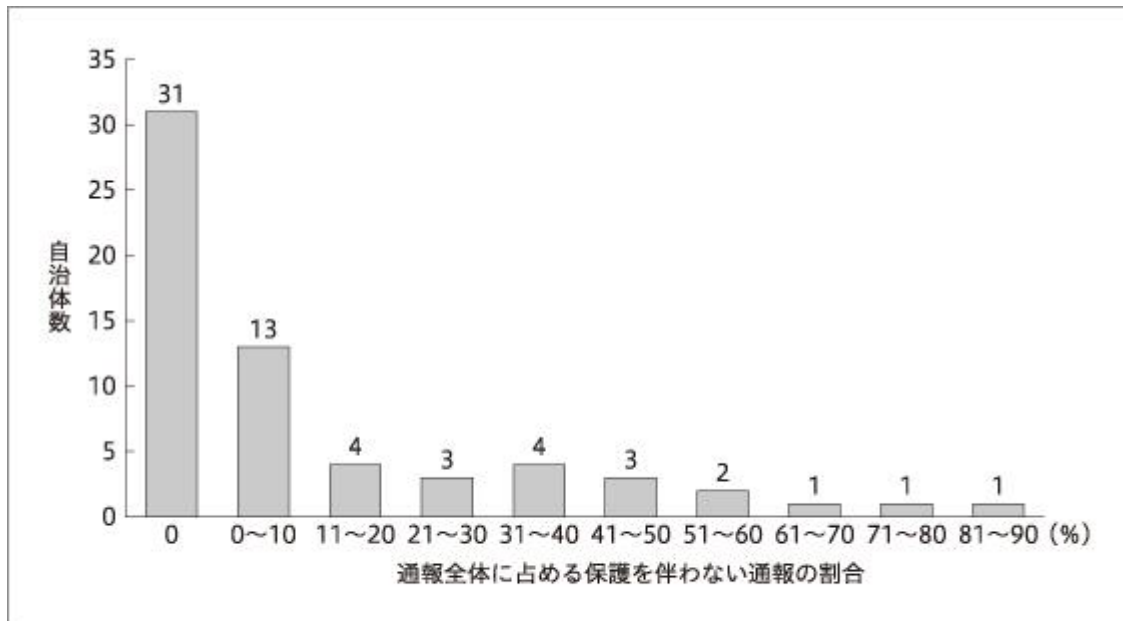


図2 被通報者の身柄の保護を伴わない通報の割合別自治体数  
(文献8より引用)

Figure 2. Number of Municipalities by Proportion of Police Reports Without Protection of the Subject

(Source: Reference 8)

表 「措置入院の運用に関するガイドライン」の概要

警察官通報の受理

- 都道府県等の職員は、警察から連絡があった際、「警察官通報であること」「警察官が対象者を発見した状況」等を確認。
- 被通報者が警察官に保護・逮捕等されていない状況での通報等への対応を明確化。

警察官通報の受理後、事前調査と措置診察まで

- 原則、職員を速やかに被通報者の現在場所に派遣し、面接を行わせ、事前調査の上で措置診察の要否を決定。
- 事前調査に際しては可能な限り複数名の職員で実施し、専門職による対応が望ましい。
- 措置診察の要否の判断は、都道府県等において、協議・検討の体制を確保し、組織的に判断することが適当。
- 措置入院の運用に係る体制（特に夜間・休日）の整備が必要。
- 被通報者に精神障害があると疑う根拠となる具体的言動がない場合等、「措置診察を行わない決定をすることが考えられる場合」を明確化。
- 措置診察に至らなかった場合や措置診察により入院不要とされた場合であっても、被通報者にその後の支援が必要と認められる場合には、自治体は精神保健福祉法第 47 条に基づく相談指導等を積極的に行うことが望ましい。

地域の関係者による協議の場

- 都道府県等は、自治体、精神科医療関係者、福祉関係者、障害者団体、家族会、警察、消防機関等の地域の関係者による「協議の場」を設け、以下の事項について年に 1～2 回程度協議することが望ましい（個人情報を取り扱わない）
  - ・ ガイドラインを踏まえた警察官通報等から措置入院までの対応方針
  - ・ 困難事例への対応のあり方など運用に関する課題
  - ・ 移送の運用方法 等

(文献 2 より引用)

Table: Overview of “Guidelines for the Operation of Administrative Involuntary Hospitalization”

Receiving of Police Reports

- When contacted by the police, prefectural staff or their equivalent confirm that it is a “police report” and verify the circumstances under which the police officer(s) discovered the individual.
- Clarify the response to reports made when the individual is not in police custody or under arrest.

### From Receiving Police Reports to Preliminary Investigation and Medical Examination

- In principle, staff should be promptly dispatched to the subject’s current location to conduct an interview, carry out a preliminary investigation, and decide whether a medical examination for administrative hospitalization is necessary.
- The preliminary investigation should ideally be conducted by multiple staff members, preferably including professionals.
- The decision regarding the necessity of a medical examination should be made systematically by prefectural or equivalent authorities through a process of consultation and review.
- It is necessary to establish a system for the operation of administrative involuntary hospitalization, especially for nights and holidays.
- Clarify situations in which “a decision not to conduct a medical examination may be considered,” such as when there are no specific words or actions indicating the presence of a mental disorder.
- Even if a medical examination is not conducted, or if hospitalization is deemed unnecessary, when it is considered that ongoing support is needed, local governments are encouraged to actively provide counseling and guidance based on Article 47 of the Act on Mental Health and Welfare for the Mentally Disabled.

### Consultation Meetings Among Local Stakeholders

- Prefectural or equivalent authorities should establish “consultation meetings” with local stakeholders including municipal staff, mental health professionals, welfare workers, disability organizations, family groups, police, and fire departments, and hold discussions approximately once or twice a year (without handling personal information) on the following topics:
  - Response policies from police reports to administrative involuntary hospitalization based on the guidelines
  - Operational challenges such as handling difficult cases
  - Methods for transporting individuals, etc.

(Source: Reference 2)