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Special Feature Article

A Study on the Establishment of the Standard and an Educational Method About Medical Examination for Administrative Involuntary Hospitalization

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Abstract

In response to the massacre at the Sagamihara Facility against Persons with Disabilities, we have been analyzing the current status of the Administrative Involuntary Hospitalization scheme in Japan. Thereafter, based on the new series of guidelines we proposed, the Ministry of Health, Labor and Welfare (MHLW) issued "Guidelines for the Operation of Administrative Involuntary Hospitalization" and "Guidelines for Post-Discharge Support of Persons with Mental Disorders by Prefectural Governments" to optimize the scheme's operation under the current Mental Health and Welfare Act.

According to the results of our survey among prefectural governments, designated physicians, and police officers, the establishment of the guidelines contributed to the enhancement of mutual collaboration among relevant facilities, but there were many concerns about conflict among the facilities. In particular, the criteria to determine administrative involuntary hospitalization has been fluctuating. There are no structural educational methods for the determination of whether a person should be admitted for administrative involuntary hospitalization. To optimize the operation of this scheme, there is a need to provide clarification on the necessary knowledge and technique for medical examination and the methodology for learning them.

We conducted a questionnaire survey among designated physicians regarding their experiences and the optimal way to educate about administrative involuntary hospitalization. In addition, based on the best available evidence, we held a pilot training session for young, designated physicians about this issue.

The interim analysis of the questionnaire results revealed that the mainstream of education was the teaching of supervisors and seniors and the treatment of patients who had been involuntarily hospitalized. Several methods, such as participation in training sessions and attendance at consultations with other designated physicians, were supported, but concerns about the neutrality of the decision-making were also raised.

We also conducted a training session for 17 young, designated physicians and 16 other medical practitioners. The results of a self-administered questionnaire confirmed that the participants gained confidence in the implementation of the medical examination after the training.

Based on the findings, it is urgent to establish an educational method on standardized medical examination techniques for administrative involuntary hospitalization. It may be possible to create opportunities for young, designated physicians who are not involved in the decision-making process to observe skilled designated physicians examining patients. Randomized controlled trials are necessary to verify the results of educational methods.

Keywords: Mental Health and Welfare Act, administrative involuntary hospitalization, designated physician, forensic mental health, medical education

Introduction

The administrative involuntary hospitalization scheme has played an important role in Japan's mental healthcare and welfare for more than half a century. Although its operation has evolved in response to changes in the times and regional characteristics, the national system itself has remained largely unchanged up to the present. As a result, there are significant regional

disparities in the operation of the administrative involuntary hospitalization scheme, and there is marked divergence in understanding of the system among stakeholders. This paper introduces recent developments in the reform of the administrative involuntary hospitalization scheme and raises issues concerning the "criteria for determination of the necessity of administrative involuntary

hospitalization," which is currently the most significant challenge. Furthermore, based on the need to standardize and improve the quality of education for designated physicians, this paper discusses research efforts to promote the appropriate future operation of administrative involuntary hospitalization.

I. Background

1. Sagamihara Facility Incident and Reform of Administrative Involuntary Hospitalization Scheme

On July 26, 2016, a former employee unlawfully entered a facility for persons with disabilities in Sagamihara City and stabbed residents with a knife, resulting in 19 deaths and 27 injuries.

It was revealed that the perpetrator had been under administrative involuntary hospitalization based on the Mental Health and Welfare Act due to having sent letters detailing the crime beforehand. It was also later revealed that the perpetrator had used cannabis before the incident. Furthermore, he was believed to have been motivated by deeply discriminatory views toward persons with disabilities rooted in so-called eugenics ideology. This incident triggered extensive debate on the future direction of mental healthcare and welfare policies in Japan.

The Ministry of Health, Labour and Welfare formed a team to investigate the incident and consider measures to prevent any future recurrence, releasing an interim summary on September 14, 2016, and a final report on December 8, 2016.⁴⁾ The report included recommendations to promote understanding of the current situation and examine possible improvements related to the administrative involuntary hospitalization scheme, emphasizing the necessity of establishing a post-discharge support system for patients subjected to administrative involuntary hospitalization.

In response to this incident, as part of the 2016 fiscal year Ministry of Health, Labour and Welfare administrative promotion research subsidy [Comprehensive Research Project on Disability Policy (Mental Disorders Field)] "Policy to Promote Community Living Support for Persons with Mental Disorders (Principal Investigator: Chiyo Fujii)," a sub-research project entitled: "Study on the Community-Based Comprehensive Support for Post-Discharge Patients Subjected to Administrative Involuntary Hospitalization (Co-Investigator: Akihiro Shiina)" was granted on December 21, 2016.

The nature of the administrative involuntary hospitalization scheme

under the Mental Health and Welfare Act has undergone discussion. Various issues regarding this system have been identified, and needs for system reform and optimization of its operation have been repeatedly pointed out. For example, as of 2010, a significant increase in police officer reports and trend toward shortening the duration of administrative involuntary hospitalization have been noted, suggesting that the nature of the scheme has been changing alongside enforcement of the Medical Treatment and Supervision Act. Additionally, cases were reported in which medical examinations could not be conducted because the protection of the individual by police officers was discontinued before the administrative involuntary hospitalization examination.⁶⁾ Furthermore, many persons subjected to administrative involuntary hospitalization had not responded to past psychiatric treatment, highlighting the need to promote general psychiatric care.¹¹⁾ It was also pointed out that the burden of administrative involuntary hospitalization examinations was loaded on a limited number of physicians, emphasizing the necessity of increasing the number of skilled examining physicians.⁷⁾ Moreover, calls for follow-up systems after hospital transfer or cancellation of administrative involuntary

hospitalization had already been frequently expressed at that time.⁷⁾¹¹⁾

Therefore, we organized these previous studies and collected new data to nurture understanding of the actual operation of the current system. Subsequently, as discussions on legal amendments became more concrete within the Ministry of Health, Labour and Welfare, the drafting of guidelines based on the amended law also became necessary.

The Ministry of Health, Labour and Welfare released the report of the Study Meeting on How the Future of Mental Healthcare and Welfare should be on February 17, 2017.²⁾ Based on the recommendations of this report and other considerations, the government submitted a bill to amend the Mental Health and Welfare Act to the 193rd ordinary session of the Diet. This bill was first deliberated in the House of Councilors and passed with supplementary resolutions; however, since the session ended, the bill was carried over to the next session. Subsequently, due to dissolution of the House of Representatives during the 194th extraordinary session of the Diet, the bill was scrapped.

Although the legislative process thus stalled, the many challenges facing Japan's mental healthcare and welfare, including the administrative involuntary hospitalization scheme,

remained unresolved. The Ministry of Health, Labour and Welfare therefore first aimed to improve the operation of the system under the current Mental Health and Welfare Act. Accordingly, we reviewed the contents of the draft guidelines, planned to extract parts that could be applied under the existing system, and thereby contribute to the improvement of mental healthcare and welfare.

We held repeated discussions with the Ministry of Health, Labour and Welfare, Prefectural governments, the National Police Agency, and other stakeholders, and organized issues surrounding the operation of the administrative involuntary hospitalization scheme. In addition, we repeatedly discussed how local governments should provide community living support for patients discharged from psychiatric hospitals, not limited to those hospitalized under administrative involuntary hospitalization. As the results of our research, we published the Guidelines for the Operation of Administrative Involuntary Hospitalization and Guidelines for Post-discharge Support of Persons with Mental Disorders by Prefectural Governments.⁸⁾

Based on these research findings, on March 27, 2018, the Ministry of Health, Labour and Welfare issued the following notifications from the Director of the Department of Health and Welfare for

Persons with Disabilities, Social Welfare and War Victims' Relief Bureau, Ministry of Health, Labour and Welfare: "Guidelines for the Operation of Administrative Involuntary Hospitalization" (MHLW Notification No. 15 of March 27, 2018), and "Guidelines for Post-discharge Support of Persons with Mental Disorders by Prefectural Governments" (MHLW Notification No. 16 of March 27, 2018). It should be noted that, due to the nature of these being official government documents, the wording of the guidelines in these notifications differs in part from the research group's draft guidelines.

As a result of these developments, the issuance of the two guidelines marked meaningful progress in the reform of the administrative involuntary hospitalization scheme.

2. Opinions of Prefectural Governments on Administrative Involuntary Hospitalization Scheme

In 2019, we conducted a questionnaire survey targeting prefectural governments across Japan to examine the extent to which the contents of the guidelines had spread among them, approximately one year after the issuance of the guidelines. A total of 43 prefectures and 19 government-designated cities, accounting for more than 80% of Japan,

agreed to provide information based on the questionnaire results. Many respondents stated that establishment of the guidelines had contributed to nurturing collaboration among relevant facilities; however, it was also revealed that in some prefectural governments, previous methods no longer applied, creating new difficulties. Although many prefectural governments had established forums for discussion and meetings among stakeholders, the actual situation regarding these initiatives remained unclear.

There were also many opinions that providing uniform support to all persons subjected to administrative involuntary hospitalization would be inefficient and unrealistic, and that discussion was needed regarding the scope of those to be supported. In addition, some pointed out difficulties in providing care for patients and families not wishing to receive support, for patients with poor insight into their illness, and for those discharged after a short hospitalization period. Furthermore, many comments highlighted discrepancies in understanding between hospitals and local governments or communities, such as delays in notification despite the need for post-discharge care.⁹⁾

3. Opinions of Designated Physicians on the Administrative Involuntary Hospitalization Scheme

We also conducted a nationwide survey targeting designated physicians responsible for administrative involuntary hospitalization examinations. In 2018, we sent designated physicians across Japan a document that included a portion of the "Gray Zone Model Case Collection in Psychiatric Clinical Practice," which we had prepared the previous fiscal year, and collected their professional opinions on individual cases. The details of this survey are described elsewhere, but many designated physicians expressed concern about the situation in which mental healthcare alone was expected to be sufficient to handle individuals who present social problems. In addition, many opinions were put forward regarding inquiries from judicial authorities and police about investigative information, as well as dissatisfaction with the way information is provided by police and correctional facilities. Furthermore, many designated physicians requested quicker responses from administrative agencies and pointed out a lack of collaboration among such agencies.⁹⁾

4. Opinions of Police Officers on Administrative Involuntary Hospitalization Scheme

We also investigated how police officers, who play a central role in the actual operation of the administrative

involuntary hospitalization scheme, understand the definition of persons with mental disorders and handling of administrative involuntary hospitalization under the Mental Health and Welfare Act. In 2020, we mailed questionnaires to the Tokyo Metropolitan Police Department and prefectural police departments nationwide, obtaining a total of 241 responses. The results showed that, while many police officers frequently encountered situations in which they had to be aware of the Mental Health and Welfare Act in their duties, they had relatively few opportunities to consider the Medical Treatment and Supervision Act. The survey also revealed marked dissatisfaction with the facts that public health centers do not respond during night-time or holidays and that the response process takes a long time. In addition, it became clear that many police officers felt dissatisfied with judgments deeming a person not in need of a medical examination or administrative involuntary hospitalization simply because they appeared calm at the time of the interview. They also regarded it as a problem that, even when administrative involuntary hospitalization was deemed unnecessary, public health centers did not take any actions despite the need to refer the person to medical care.

Furthermore, the survey indicated that police officers had limited opportunities for education and training in mental healthcare and welfare, and that many officers regarded intellectual disabilities, personality disorders, and developmental disorders as outside the scope of administrative involuntary hospitalization.¹⁰⁾

5. Variations in Criteria for Determining Necessity for Administrative Involuntary Hospitalization

As described above, there are marked discrepancies in opinions among stakeholders concerning the administrative involuntary hospitalization scheme. These discrepancies are illustrated in Figure 1. Many of them may be resolved to some extent by deepening collaboration among relevant facilities and fostering mutual understanding of the differences in their respective professional roles.

However, an issue that has not yet been sufficiently discussed by our research group is the problem regarding the criteria for determining the necessity of administrative involuntary hospitalization. Since the Sagami-hara Facility Incident, there has been increasing interest in so-called "gray zone cases," regarding which patients should be subject to administrative involuntary hospitalization. However,

judging from the regional disparities in rates of administrative involuntary hospitalization examinations and hospitalizations, there may be significant fluctuations not only in the handling of gray zone cases but also in the fundamental concept of where to position the boundary between requiring/not requiring administrative involuntary hospitalization.

Below are several examples that have been discussed to date, presented with some modifications or simplifications:

- The patient is unable to protect themselves, thus requiring administrative involuntary hospitalization.
- The patient has no place to return to, thus requiring administrative involuntary hospitalization.
- The patient is a foreign national and cannot use health insurance, thus requiring administrative involuntary hospitalization.
- The patient exhibited no problematic behavior during incarceration, so a medical examination is unnecessary.
- The patient has family members, so a medical examination is unnecessary.
- The patient's psychiatric diagnosis is intellectual disability, so a medical examination is unnecessary.
- The patient remained calm at the time of examination, so

administrative involuntary hospitalization is unnecessary.

- The patient is deemed suitable for admission to a juvenile medical reformatory, so administrative involuntary hospitalization is unnecessary.
- The patient is deemed suitable for criminal prosecution, so administrative involuntary hospitalization is unnecessary.

As the author, I find all of these judgments questionable; however, since individual cases must be considered from various perspectives, the judgments above may be appropriate in some instances.

From the outset, the requirements for administrative involuntary hospitalization have been ambiguous, and remained unchanged for many years. The "Standards Established by the Minister of Health, Labour and Welfare Based on Article 28-2 of the Act on Mental Health and Welfare for the Mentally Disabled (Ministry of Health and Welfare Notification No. 125, April 8, 1988)" envisioned that "psychopathy" also necessitated administrative involuntary hospitalization. However, as shown in our recent survey, few designated physicians or police officers support that interpretation at present.¹⁰⁾ Moreover, there are almost no systematic educational programs or textbooks explaining how to conduct

administrative involuntary hospitalization examinations, what to pay attention to during such examinations, or how to write the "Medical Certificate for Administrative Involuntary Hospitalization."³⁾ As a result, teachings have been passed down orally, and this may have led to the current regional disparities.

In light of this, in order to further optimize the administrative involuntary hospitalization scheme, it is necessary to reorganize criteria for determining the necessity of administrative involuntary hospitalization. Based on those criteria, it is also essential to clarify necessary knowledge and techniques for accurately conducting administrative involuntary hospitalization examinations, and establish a methodology for passing on these skills to young designated physicians.

II. Objective

Based on the above-described background, the objective of this study was to clarify the knowledge and techniques required to determine the necessity of administrative involuntary hospitalization, and establish a methodology for acquiring the techniques of administrative involuntary hospitalization examinations.

III. Methods

1. Identifying Educational Needs for Administrative Involuntary Hospitalization Examinations

In order to optimize administrative involuntary hospitalization examinations, it was first deemed necessary to clarify how the current knowledge and techniques related to these examinations were being taught and what challenges existed regarding this education. Therefore, we conducted a questionnaire survey targeting designated physicians currently actively engaged in administrative involuntary hospitalization examinations. The survey asked about their prior education and views on future educational needs.

The survey targeted designated physicians nationwide, regardless of age or sex, although the age was generally 30 years or older due to the qualification requirements for designated physicians. The questionnaires were mailed to psychiatric hospitals across Japan, and responses were requested. The survey items concerned experiences and needs regarding education and training for administrative involuntary hospitalization examinations.

The purpose of the study and other necessary information were described in the questionnaire, and returning a

completed questionnaire was considered as consent to participate.

2. Implementation of Training Sessions on Administrative Involuntary Hospitalization Examinations

Next, based on the research group's guidelines,⁸⁾ we conducted a pilot training session for young designated physicians. In this training session, we first provided instruction summarizing key points for conducting administrative involuntary hospitalization examinations, using existing materials. Then, we presented these points to participants and conducted simulations of administrative involuntary hospitalization examinations using hypothetical cases.

Participants were primarily designated physicians who had obtained relevant qualifications within the past five years. However, since this was a trial, we also included observations by those who had been designated physicians for more than five years, physicians without a designated qualification, and non-physician co-medical staff. A signed, self-administered questionnaire survey was conducted before and after the training session.

3. Statistical Analysis

The data obtained in this study were statistically analyzed using IBM SPSS Statistics 24 and other tools. This study was positioned as exploratory, and analytical methods had not been finalized at the time of the survey.

4. Ethical Considerations

This study was conducted with funding from the Ministry of Health, Labor and Welfare's Comprehensive Research on Disability Policy Project: "Policy Research to Promote Strengthening of Community Mental Health and Welfare Systems."

We carefully reviewed the study content and confirmed that it was not subject to the Clinical Research Act or related laws and regulations. Simultaneously, we conducted each study in accordance with the Ethical Guidelines for Medical and Health Research Involving Human Subjects.

Regarding this study, the research plan was submitted to the Ethics Review Committee of the Graduate School of Medicine, Chiba University as: "Study on the Development of Educational Materials to Promote the Acquisition of Administrative Involuntary Hospitalization Examination Techniques: Phase 1" (Application No. 3992), and approved on December 14, 2020 (Approval No.: 1145, Graduate School of Medicine, Chiba University).

IV. Results

1. Prevalence and Validity of Various Educational Methods for Administrative Involuntary Hospitalization Examinations

The survey on educational needs for administrative involuntary hospitalization examinations was still ongoing at the time of writing. As an interim analysis, we present the results from 382 respondents, mainly designated physicians working in private hospitals.

The respondents' average age was 53 years, and their average psychiatric clinical experience was 24 years. In terms of specialty, 83% practiced general psychiatry and 9% psychiatric emergency care.

The most common methods for acquiring the techniques of administrative involuntary hospitalization examinations were learning from supervisors and senior colleagues, and through providing medical care of patients who had undergone administrative involuntary hospitalization. Excluding training required to obtain the designated physician qualification, few respondents voluntarily participated in training sessions organized by national or local governments, hospitals, or academic societies (Figure 2).

Regarding the validity of these learning methods, most were considered desirable. However, some respondents voiced critical opinions concerning activities such as observing the other designated physician's examination, seeking advice from supervisors based on preliminary investigation materials, and having supervisors review medical certificates for administrative involuntary hospitalization. These criticisms were based on concerns about preserving the neutrality of the necessity-determining process. Regarding training sessions, some respondents expressed concerns about the potential complication of their work (Figure 3).

2. Outcomes of Training Sessions on Administrative Involuntary Hospitalization Examinations

We conducted a training session on November 27, 2020, with 33 participants: 17 young designated physicians as trainees, and 16 others as auditors. We administered questionnaires to the trainees before and after the training and compared the results. Significant improvements were observed after the training in the following areas: confidence in conducting administrative involuntary hospitalization examinations (Wilcoxon signed-rank test, $P = 0.001$), understanding of the procedures

involved in conducting such examinations (same test, $P < 0.001$), and understanding of the criteria for distinguishing between requiring and not requiring administrative involuntary hospitalization (same test, $P < 0.001$).

Additionally, when asked to freely describe points that were insufficiently understood before the training, participants mentioned issues such as "the high threshold for emergency measures," "the inapplicability of the Medical Treatment and Supervision Act to juveniles," "the discrepancy between criminal responsibility for delusional disorder and the criteria for administrative involuntary hospitalization," "the importance of past judicial history inquiries," "deep consideration of the relationship between illness and self-harm or harm to others," and "conducting examinations while envisioning future treatment."

V. Discussion

In order to organize concepts regarding the criteria for determining the necessity of administrative involuntary hospitalization and establish educational methods, we initially gathered the experiences and needs of designated physicians currently engaged in administrative involuntary hospitalization

examinations. In parallel, we examined whether education using examination simulations could deepen the understanding and confidence of young designated physicians.

The survey results revealed that many designated physicians have not received systematic education on administrative involuntary hospitalization examinations. The findings suggested that oral instruction and supervision from workplace supervisors remain the mainstream educational methods. Considering that psychiatry is a developing discipline and that medical care requires both universality and individuality, this situation may not necessarily be problematic in itself. However, to optimize administrative involuntary hospitalization examinations, the establishment of standardized educational methods is an urgent issue.

Opinions of the designated physicians generally agreed on this point, calling for an increase in high-quality textbooks, guidelines, and training opportunities. However, some expressed doubts about the effectiveness of these measures and concerns regarding increased workload. If there is a large discrepancy with clinical practice, there is a risk that even excellent educational materials will not be utilized. Therefore, future education on administrative involuntary hospitalization

examinations should incorporate both theoretical and practical aspects.

Currently, in some regions, two designated physicians conduct examinations simultaneously. This approach provides valuable opportunities for less-experienced designated physicians to learn by closely observing the actual examinations conducted by skilled designated physicians. However, concerns have been raised that young designated physicians may hesitate to express their opinions freely, or that excessive consultation between designated physicians may compromise the neutrality and independence of the decision-making process regarding the necessity of administrative involuntary hospitalization. This issue has already been pointed out.⁵⁾

As a future educational method to be considered, it may be possible to create opportunities for young designated physicians, who are not involved in the judgment, to observe the examination scenes of skilled designated physicians. This is already practiced in some regions in the form of accompanying designated physicians during examinations. Although challenges remain regarding the protection of the examinee's privacy, this could provide a valuable opportunity for young designated physicians to learn examination techniques.

In this study, aiming to equip young designated physicians with practical skills applicable to future clinical practice, we held training sessions on administrative involuntary hospitalization examinations. The program included simulations and group discussions, designed so that participants could immediately practice the examinations while confirming key points learned in lectures. Results from self-administered questionnaires by participants confirmed that their understanding deepened and confidence in conducting administrative involuntary hospitalization examinations increased after attending the training.

Of course, to demonstrate that the training sessions actually improved examination skills, it is necessary to develop objective evaluation measures and conduct randomized controlled trials.

Conclusion

There are various other issues concerning the criteria for determining the necessity of administrative involuntary hospitalization beyond those discussed above. For example, whether all forms of deviant behavior, such as wandering on private property, destroying one's own belongings, making nuisance phone calls, or lying down on the street, should constitute

grounds for administrative involuntary hospitalization; whether administrative involuntary hospitalization should be applied in cases involving a combination of mental disorders and harmful acts, such as illegal drug use by drug dependents, transient excitement in persons with intellectual disabilities, or sexual offenses perpetrated by individuals with personality disorders; how much the treatability criterion should be considered in the judgment; and whether criminal responsibility assessments should be included in the determination of necessity; consensus on these matters has not yet been reached.

It is clear that the notion "punishment is warranted, so administrative involuntary hospitalization is unnecessary" is an unreasonable argument. However, once patients are subject to administrative involuntary hospitalization, their subsequent criminal proceedings often remain unclear, and their management becomes unsettled, highlighting the lack of structural reciprocity between judicial and medical systems.¹⁾ Greater collaboration among relevant facilities is required, which necessitates mutual understanding of differing perspectives and a deep consideration of the relationship between patients' pathology and harmful behaviors.

Furthermore, in light of these issues, it may be necessary to organize the conceptual framework regarding the determination of administrative involuntary hospitalization necessity and consider reviewing the criteria.

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.

References

- 1) 平田豊明: 精神科救急からみた司法精神医療体制の課題. 司法精神医学, 14 (1); 12-19, 2019
- 2) 厚生労働省: これからの精神保健医療福祉のあり方に関する検討会報告書. 2017 (<https://www.mhlw.go.jp/stf/shingi2/0000152029.html>) (参照 2023-03-13)
- 3) 西山 詮: 精神保健法の鑑定と審査—指定医のための理論と実際—, 改訂 2 版. 新興医学出版社, 東京, 1991

- 4) 相模原市の障害者支援施設における事件の検証及び再発防止策検討チーム: 相模原市の障害者支援施設における事件の検証及び再発防止策検討チーム報告書—再発防止策の提言—. 2016
(https://www.mhlw.go.jp/stf/shingi/other-syougai_373375.html) (参照 2023-03-13)
- 5) 佐伯千仞: 法律家から見た精神衛生法の諸問題. 精神経誌, 76 (12); 881-886, 1974
- 6) 瀬戸秀文, 吉住 昭: 医療観察法施行前後の措置入院の変化—特に警察官通報の現状ならびに指定医の判断傾向について—. 臨床精神医学, 43 (9); 1325-1334, 2014
- 7) Shiina, A., Iyo, M., Yoshizumi, A., et al.: Recognition of change in the reform of forensic mental health by clinical practitioners: a questionnaire survey in Japan. *Ann Gen Psychiatry*, 13 (1); 9, 2014
- 8) 椎名明大: 措置入院者の地域包括支援のあり方に関する研究. 厚生労働行政推進調査事業費補助金障害者対策相好研究事業[障害者制作相好研究事業(精神障害分野)]「精神障害者の地域生活支援を推進する政策研究」(研究代表者: 藤井千代) 平成 29 年度総括・分担研究報告書. p.27-196, 2018
- 9) 椎名明大: 措置入院者の地域包括支援のあり方に関する研究. 厚生労働行政推進調査事業費補助金障害者対策総合研究事業[障害者政策総合研究事業(精神障害分野)]「精神障害者の地域生活支援を推進する政策研究」(研究代表者: 藤井千代) 平成 30 年度総括・分担報告書. p.289-489, 2019
- 10) 椎名明大: 措置入院及び退院後支援のあり方に関する研究. 厚生労働行政推進調査事業費補助金(障害者政策総合研究事業)「地域精神保健医療福祉体制の機能強化を推進する政策研究」(研究代表者: 藤井千代) 令和 2 年度総括・分担研究報告書. p.103-175, 2021
- 11) 吉住 昭, 椎名明大, 伊豫雅臣: 医療観察法導入後における触法精神障害者への精神保健福祉法による対応に関する研究 その 1 千葉県における措置入院患者の予後調査. 厚生労働科学研究費補助金(障害者対策総合研究事業)「重大な他害行為をおこした精神障害者の適切な処遇及び社会復帰の推進に関する研究」(研究代表者: 平林直次) 平成 22 年度総括・分担研究報告書. p.41-53, 2011

Figure 1. Conflicts among relevant institutions concerning the Administrative Involuntary Hospitalization system

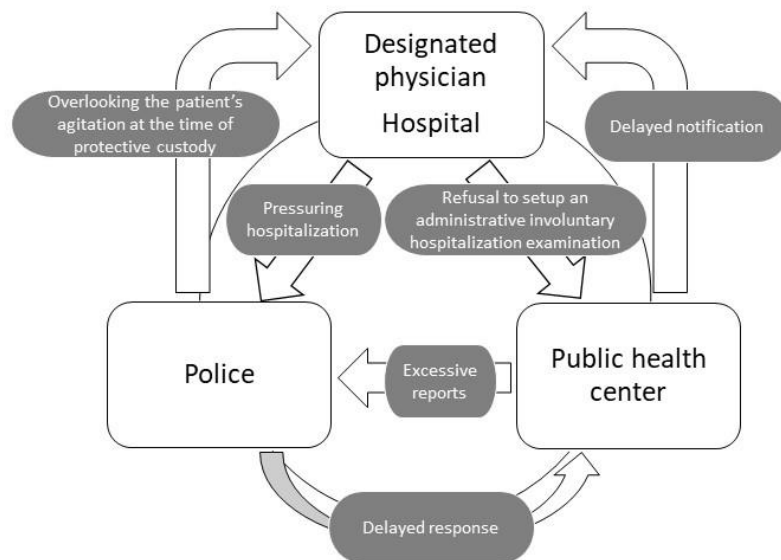


Figure 1. Conflicts among relevant institutions concerning the Administrative Involuntary Hospitalization system

Figure 2. Methods of acquiring administrative involuntary hospitalization examination techniques (based on experience)

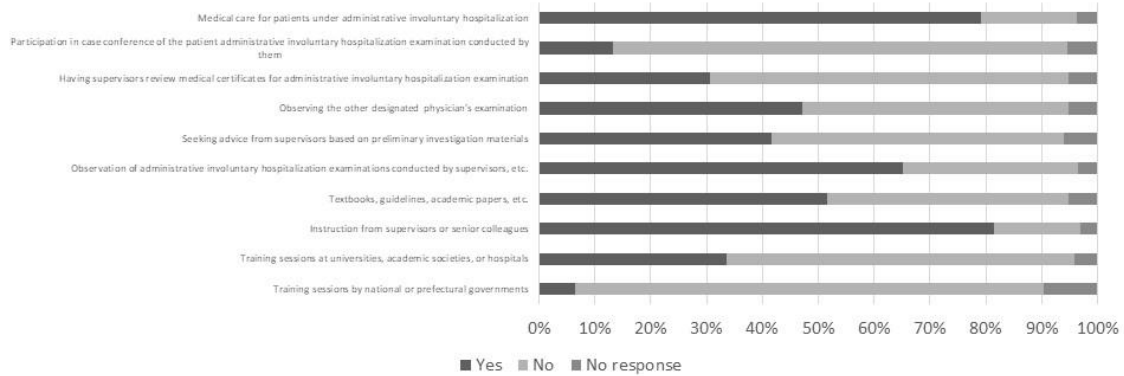


Figure 2. Methods of acquiring administrative involuntary hospitalization examination techniques (based on experience)

Figure 3. Methods of acquiring administrative involuntary hospitalization examination techniques (ideal approach)

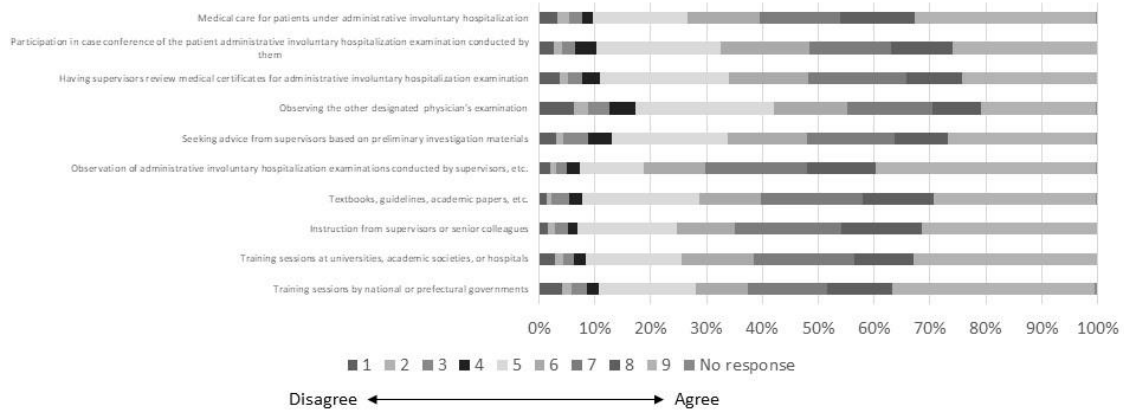


Figure 3. Methods of acquiring administrative involuntary hospitalization examination techniques (ideal approach)