

* This English manuscript is a translation of a paper originally published in the *Psychiatria et Neurologia Japonica*, Vol.125, No.5 p. 406-414 which was translated by the Japanese Society of Psychiatry and Neurology and published with the author's confirmation and permission. If you wish to cite this paper, please use the original paper as the reference.

Special Feature Article

Issues in Cooperation related to Administrative Involuntary Hospitalizations by a Prefectural Governor from the viewpoint of a Psychiatric Emergency Core Hospital

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Psychiatria et Neurologia Japonica 125: 406-414, 2023

Abstract

Kyoto Prefectural Rakunan Hospital is a psychiatric emergency medical core hospital in the southern part of Kyoto Prefecture. It receives about 70% of the patients referred from the psychiatric emergency information center, and because it is a public hospital, also receives most of the emergency enforced medical examinations on nights and holidays. At such times, it may be difficult to conduct a preliminary survey; thus, a medical examination conducted with insufficient information gathering. For this reason, there are cases in which there is a possibility that medical examination may not be necessary due to liaison and coordination with judicial organizations such as when there was a serious harmful activity or when there are no psychotic symptoms. As a result, it may be difficult to respond at the time of medical examination or after hospitalization. In addition, in post-discharge support after hospitalization, there are cases where discharge support does not proceed because the support of the local government cannot be received such as when the patient has little connection with the community due to the history of imprisonment. Regarding such cases, it is necessary to cooperate and divide roles between community mental health and welfare-related organizations and judicial-related organizations, however, the points of contact are limited and cooperation is difficult. So, I think that creating a mechanism and rules for cooperation is an issue. Recently, support

for the establishment of community life by judicial organizations is being implemented; however, their ultimate purpose is to prevent recidivism, which is different from the purpose of community mental health and welfare. Therefore, in order to enable cooperation and division of roles, it is important to give due consideration to the protection of rights, such as the will of the individual, and the protection of personal information.

Keywords: psychiatric emergency, involuntary hospitalizations, judicial agencies, cooperation, advocacy

Introduction

Kyoto Prefectural Rakunan Hospital (hereinafter referred to as “our hospital”) is a municipally operated, single-specialty psychiatric hospital located in Uji City, Kyoto Prefecture, and it has served as the core hospital in the psychiatric emergency system of southern Kyoto Prefecture since 2002. At our hospital, we consider it the responsibility of a public hospital to handle enforced medical examinations during nights and holidays, and we respond to nearly all such cases. During night-time and holiday examinations, we receive requests for cases that would not immediately lead to enforced medical examinations if they occurred on a weekday during the daytime, such as cases involving serious harmful behavior, those without evident psychotic symptoms where judicial agencies require careful evaluation of criminal responsibility, or cases where,

during the preliminary investigation, arrangements with the family have been made and it has been determined that the family is capable of managing the situation. This leads to questions about whether alternative approaches might be possible (entry issue). In addition, although we also provide post-discharge support for individuals who have been involuntarily hospitalized, there are cases in which coordination with related agencies does not proceed smoothly, resulting in insufficient support, thereby making post-discharge support particularly challenging (exit issue). In this paper, we discuss issues related to cooperation with related agencies, particularly administrative and judicial agencies, at the time of involuntary hospitalization by a prefectural governor and discharge, from the perspective of a core hospital involved in psychiatric emergency care. While writing this manuscript, ethical

considerations were taken into account, and care was taken to ensure that individuals described in case examples could not be identified and that there was no personally identifiable information.

I. Overview of the Hospital

Our hospital, the only prefectural hospital in Kyoto Prefecture, was established in June 1945. In recent years, we have been actively engaged in psychiatric emergency care, dementia care, and treatment for substance use disorders. The hospital has a total of 256 beds, including two wards with 36 beds each designated for emergency psychiatric admissions, a 34-bed acute care ward specializing in dementia, and three general psychiatric wards with 51, 50, and 49 beds respectively.

Trends in the number of new admissions are shown in Figure 1. In fiscal year 2019, there were 814 new admissions. Of these, there were: 58 involuntary hospitalizations by a prefectural governor, 39 emergency hospitalization, 510 involuntary hospitalizations for medical care and protection, and 206 voluntary hospitalizations. Among the new admissions, 311 patients (38.2%) were admitted outside of regular hours, such as during nights and holidays, of which 71 were emergency involuntary

hospitalizations by a prefectural governor.

The average length of stay was 71.2 days, and the average number of outpatients per day was 167. The status of inpatients at the end of the fiscal year is shown in Figures 2 and 3.

II. Psychiatric Emergency Care in Kyoto Prefecture

Since 2002, the psychiatric emergency system in southern Kyoto Prefecture, which serves a population of approximately 2 million, has been in operation, and our hospital is the sole core hospital. Excluding a few rotating hospitals, our hospital accepts about 70% of emergency admissions during nights and holidays. All consultation calls from residents of the prefecture are received by the psychiatric emergency information center, which is attached to public facilities within the prefecture. After triage, patients are referred to our hospital, the core facility in the system (Figure 4). On certain days of the week, some of these duties are handled by rotating hospitals.

In cases of night-time or holiday reports from the police under Article 23 of the Act on Mental Health and Welfare for the Mentally Disabled (hereinafter, “the act”), the psychiatric emergency information center first receives the report and then contacts the relevant departments of Kyoto Prefecture or City.

If it is determined that an enforced medical examination is necessary, a request is made to our hospital, and one may be carried out if deemed appropriate.

III. Flow of Enforced Medical Examinations in Kyoto Prefecture and City

When considering cooperation with related agencies in involuntary hospitalizations by a prefectural governor, the role of preliminary investigations conducted by administrative agencies is considered particularly important. However, during nights and holidays, it is difficult to conduct thorough preliminary investigations compared with weekday daytime hours. As shown in Figure 5, during weekday daytime hours in Kyoto Prefecture and City, face-to-face preliminary investigations are conducted, and based on the results, a decision is made on whether an examination is necessary.

In contrast, during nights and holidays, except for daytime hours on holidays in Kyoto City, preliminary investigations are often limited to telephone communication, and the involvement of professionals is insufficient, making it difficult to conclude that adequate preliminary investigations are being conducted. As a result, in cases reported by police

officers under Article 23 of the act during nights and holidays, it is rare for a case to be deemed not to require examination, and nearly all such cases require enforced emergency medical examinations. The difficulty in collecting information through preliminary investigations has an impact on the enforced examinations themselves.

IV. Issues in Cooperation during (Emergency) Involuntary Hospitalization by a Prefectural Governor: Entry Phase

1. Preliminary Investigations by Administrative Agencies

According to Article 23 of the act, “When a police officer, in the course of duty, discovers a person who, based on abnormal behavior or other surrounding circumstances, is deemed likely, due to a mental disorder, to harm themselves or others, the officer must immediately report the case to the prefectural governor via the head of the nearest public health center.”⁶⁾ However, police officers are not in a position to determine whether the person has a mental disorder; therefore, some of the individuals reported may exhibit psychotic symptoms due to a mental disorder, while others may not. The Guidelines on the Operation of Involuntary Hospitalization³⁾ by a prefectural governor (hereinafter, the

guidelines) state the following: “When a prefectural governor, etc., receives a report from a police officer, they must, in principle, promptly dispatch staff to the subject’s residence or current location, conduct an interview with them, and perform a preliminary investigation before deciding whether an enforced medical examination is necessary.” “It is desirable that the preliminary investigation be conducted by multiple staff members whenever possible, and that the staff members be professionals such as ‘Mental Health and Welfare Officers’ as defined in Article 48, Paragraph 1 of the Act. Furthermore, the decision on whether an enforced medical examination is necessary should not be made solely by the attending staff members but should be discussed and decided upon in an organized manner within the prefectural government or other relevant body.” The guidelines further state: “To ensure such responses, prefectural governors, etc., must establish a system for the operation of involuntary hospitalizations by a prefectural governor, particularly one that allows for prompt responses during nights and holidays.”

During weekday daytime hours, public health centers and other relevant agencies usually conduct preliminary investigations in accordance with the guidelines, and examinations are

generally limited to individuals found to exhibit certain psychotic symptoms. Although the guidelines call for establishing systems for night-time and holiday coverage as well, in some prefectures or municipalities, such systems remain insufficient, and enforced medical examinations may be conducted without adequate preliminary investigation. Tsukamoto et al.⁷⁾ conducted a survey of local governments in the Kanto region, and found that only 5 of 12 municipalities conducted face-to-face preliminary investigations at night, highlighting system development as an ongoing issue. Due to this background, difficulties in coordination with related agencies and insufficient information can complicate processes of making hospitalization decisions and providing care after admission. In this section, we examine issues regarding cooperation at the time of emergency involuntary hospitalization by a prefectural governor.

2. Cases Where Cooperation with Judicial Agencies Is Desirable

Reports under Article 23 of the act concern individuals deemed at risk of self-harm or harm to others. Particularly in cases involving harm to others, which may constitute criminal acts, when such harmful behavior is not due to a mental disorder, responses by

judicial agencies are generally required. However, as mentioned earlier, during enforced emergency medical examinations conducted at night or on holidays, it is often difficult to gather sufficient information or coordinate with related agencies, and such cases may still become the subject of enforced examinations. In some instances, even cases involving “serious harmful behavior” that would normally fall under the Medical Treatment and Supervision Act are still processed as enforced medical examinations.

Miyake et al.⁵⁾ from our hospital stated: “In the field of psychiatric emergency care, we often encounter cases in which psychiatric treatment is initiated, but as more details become clear, it seems that a judicial response might be more appropriate, leading to difficulties in treatment and disposition”; “We also encounter cases where hospitalization is requested by the police or family, even though the need for involuntary treatment appears limited.” Based on their experience, Miyake et al. identified three types of cases where cooperation with judicial agencies may be necessary: (1) serious harmful behavior with psychotic symptoms, (2) serious harmful behavior without psychotic symptoms, and (3) other deviant behaviors without psychotic symptoms.

Based on this report, it can be considered appropriate for cases involving serious harmful behavior with psychotic symptoms to be referred to the Public Prosecutors Office, with the possibility of a petition under the Medical Treatment and Supervision Act being considered. However, in practice, such considerations are often not made, and the case proceeds to an enforced medical examination, resulting in either involuntary hospitalization by a prefectural governor or involuntary hospitalization for medical care and protection, with treatment being provided within the framework of the Act on Mental Health and Welfare for the Mentally Disabled. As a result, even in cases involving non-negligible harm to others, such as “bodily injury,” petitions under the Medical Treatment and Supervision Act are often not submitted.

Conversely, in cases involving “serious harmful behavior without psychotic symptoms,” careful consideration should, in principle, be given to the presence or absence of criminal responsibility. However, in reality, enforced medical examinations may proceed without such deliberation. Harmful acts in these cases include arson and forcible indecency, and the diagnoses may include mild intellectual disability or pervasive developmental disorder. Some of these cases result in

involuntary hospitalizations by a prefectural governor or for a medical care and protection. In certain instances, individuals are arrested afterward, but not all cases lead to judicial responses.

Cases involving “other deviant behaviors without psychotic symptoms” are the most frequent. While careful consideration of criminal responsibility should ideally be undertaken, enforced medical examinations may still be conducted without such review. Approximately 70% of these cases are judged not to warrant involuntary hospitalization by a prefectural governor and do not result in admission. Most of these involve acts of harm stemming from family or relationship conflicts, and by the time examination occurs, the individual is often already calm, leading to the judgment that hospitalization is unnecessary. Even when admission does occur, the patient’s condition usually stabilizes quickly, and discharge follows after a short stay.

Even in such cases, making judgments about non-applicability for involuntary hospitalization by a prefectural governor or non-admission during night-time or holiday hours, when information is limited, can be difficult, and designated physicians responsible for emergency care often struggle with these decisions. Regarding the diagnosis, in addition to

intellectual disability and pervasive developmental disorder, there are also cases of acute stress reaction, alcohol abuse, and personality disorders, including cases of emotional instability that do not clearly meet diagnostic criteria.

During weekday daytime hours, such cases are often coordinated in advance between the police, individual, and family before reaching the stage of enforced medical examination, and such an enforced examination is not always conducted. Thus, it is essential for administrative agencies to collect information through preliminary investigations and coordinate with relevant parties, and it is necessary to improve and strengthen systems for receiving and processing emergency reports during nights and holidays.

3. Cases Where Physical Medical Care Should Be Prioritized

The guidelines state that “in cases where physical symptoms or injuries are severe enough to require emergency medical care in a general (non-psychiatric) medical department, physical treatment necessary for life-saving or other essential care should be prioritized over determining the necessity of a forced psychiatric examination, and prefectural governments, etc., should provide support necessary to improve the

reported individual's survival and physical outcome." In situations such as nights or holidays, where interviews with the reported individual through preliminary investigation have not been conducted or it is difficult to collect information, enforced medical examinations may proceed without recognizing the possibility of physical illness, only for such conditions to be discovered during the examination itself. Therefore, the decision must be temporarily suspended, the individual must first receive emergency care in a general medical department, and then the enforced medical examination must be conducted again afterward. This places a significant burden on the individual, family, administrative staff, and police officers.

Whenever possible, information should be collected in advance through face-to-face preliminary investigations, and it is preferable to have the individual receive emergency care in a general medical department before conducting the enforced examination.

There are also cases where, after receiving emergency care and undergoing enforced medical examination, the individual is admitted to a psychiatric ward; however, because the examination at the emergency medical institution was insufficient, the individual experiences a decline in consciousness a few hours later, and

they are transferred to a general medical department. In such situations, in addition to strengthening preliminary investigations by administrative agencies, smooth cooperation with general medical institutions also becomes an important issue.

4. Future Challenges

During nights and holidays, preliminary investigations are more difficult to conduct than during regular weekday hours, resulting in insufficient information-gathering. As a result, even cases that would not ordinarily require immediate enforced medical examination may actually be subject to examination. As stated in the guidelines, it is hoped that systems will be developed to enable face-to-face preliminary investigations by professionals.

In cases involving serious harmful behavior, rather than immediately proceeding with an enforced emergency medical examination, it is preferable to first conduct a face-to-face preliminary investigation and, where possible, carry out the enforced medical examination during weekday daytime hours. A flexible response tailored to the circumstances of each case is desirable. However, if examinations are conducted at night or on holidays for those that would not require examination during

weekday daytime hours, such examinations may be deemed unnecessary. These examinations should be avoided whenever possible, not only to uphold the rights of the reported individual, but also to prevent undue burden placed on designated emergency physicians.

Currently, in Kyoto Prefecture, an annual psychiatric emergency care liaison and coordination meeting is held, but it primarily consists of status reporting. Such opportunities should be utilized to deepen shared understanding among administrative agencies, police, and hospitals, clarify each party's role, and promote discussions to ensure more appropriate operation of the involuntary hospitalization by a prefectural governor system. In addition, to achieve smooth cooperation, it is essential to establish clearly grounded mechanisms and rules that respect patient consent and the protection of personal information.

V. Issues in Cooperation at the Time of Discharge from Involuntary Hospitalization by a Prefectural Governor: Exit Phase

1. Post-discharge Support Program for Individuals hospitalized involuntarily

In March 2018, the Ministry of Health, Labour and Welfare issued the Guidelines on Post-discharge Support

for Persons with Mental Disorders by Prefectural Governments,⁴⁾ and in October of the same year, Kyoto Prefecture and City launched the post-discharge support program for individuals hospitalized involuntarily. This program aims to enhance post-discharge support for individuals who have undergone involuntary hospitalization by a prefectural governor.

However, at our hospital, the number of cases supported under the program has remained quite low: three cases in FY2018, two in FY2019, two in FY2020, and zero cases as of the end of August FY2021, despite our hospital admitting approximately 50 to 60 individuals per year under involuntary hospitalization by a prefectural governor. Several factors are considered to underlie this low implementation rate: “difficulty in obtaining the patient’s consent,” “unclear effectiveness of the program (it may appear similar to conventional support practices),” “increased administrative burden,” “difference in views between administrative agencies and hospitals (the types of cases envisioned by administrative agencies do not always align with those considered by hospitals),” “out-of-pocket costs for support plan preparation in cases where the patient is discharged following a transfer from involuntary hospitalization by a prefectural

governor to involuntary hospitalization for medical care and protection ,” and “difficulty in coordinating discharge to another prefecture.”

2. Issues in Cooperation with Judicial Agencies

In many cases where the post-discharge support program for individuals hospitalized involuntarily has been utilized, community reintegration is achieved. However, there are also cases in which support must be discontinued due to poor coordination with judicial agencies. For example, there are cases in which, although the individual had begun to receive support through a post-discharge support program and the assistance was starting to have an effect, judicial action became necessary due to past criminal behavior. As a result, all support that had been gaining traction had to be terminated, all welfare services including housing were suspended, and the support system that had been built up over time was ultimately lost. Such responses from judicial agencies are entirely unforeseeable from the perspective of medical institutions. While prior information-sharing may be difficult, it is desirable to consider more appropriate methods of coordination, such as taking the timing of interventions into account. After release,

it remains an open question whether probation offices or regional support centers for community reintegration will take the lead in providing support, or whether regional mental health and welfare services will once again assume responsibility. Coordination frameworks and role allocation are ongoing issues.

3. Issues affecting Cooperation with the Community

Among psychiatric emergency cases and reports under Article 26 of the act, there are instances where the individual has little to no community ties at the time of discharge planning. Due to the lack of connection between the individual and community, difficulties may arise in community cooperation following discharge from involuntary hospitalization by a prefectural governor. Common characteristics of such cases include a diagnosis of schizophrenia combined with intellectual disability or personality disorder, multiple past incarcerations, lack of a fixed residence, and difficulty obtaining family cooperation. Coordination by public health centers for discharge arrangements may also be challenging, with discussions regarding public assistance in the municipality where the individual is expected to reside sometimes not progressing at all during

hospitalization. Consequently, there are cases in which the individual must visit the municipal office after discharge to apply for public assistance and determine their place of residence, making a somewhat unsatisfactory impression.

Conversely, support for community living after incarceration is provided by probation offices and regional support centers for community reintegration; however, in many cases, support is not received during incarceration, and the reality is that support is also lacking after release. In such cases, cooperation between regional mental health and welfare services and regional support centers for community reintegration is necessary, but at present, almost no coordination takes place. Therefore, establishing a system that enables cooperation and role-sharing is required.

4. Future Challenges

The post-discharge support program for individuals hospitalized involuntarily is significant in that it outlines specific procedures for community mental health and welfare activities, and aims to promote the construction of a comprehensive support system for community living. At present, it is difficult to say that the program has brought about a marked change compared with conventional community mental health and welfare

activities; however, since it is implemented primarily by local governments as part of consultation support services under Article 47 of the current law, certain limitations are unavoidable.

As mentioned earlier, there remain cases in which post-discharge support for individuals hospitalized involuntarily is difficult. This is particularly strongly felt in cases involving a history of incarceration, where responses from both community mental health and welfare services and judicial agencies are required. To the author's knowledge, cooperation with probation offices and regional support centers for community reintegration is currently limited in post-discharge support. Therefore, it is necessary for judicial agencies and community mental health and welfare services to share awareness of these challenges and discuss cooperation and role-sharing. To facilitate these, the establishment of legal frameworks and rules that consider the individual's wishes and protection of personal information is required.

VI. Efforts by Judicial Agencies and Issues in Cooperation

1. Efforts under the Act for the Prevention of Recidivism

This section introduces efforts on the judicial side and examines challenges in

future cooperation. In December 2016, the Act for the Prevention of Recidivism was promulgated and enforced. In response, the government formulated the “Recidivism Prevention Promotion Plan” in 2017. Among the seven priority issues in this plan, the second is “Promotion of Use of Health, Medical, and Welfare Services,” and one of its main measures is “Strengthening Cooperation between Criminal Justice Agencies and Health, Medical, and Welfare Agencies.”¹⁾

Specifically, as part of building support systems from the investigation and trial stages, efforts are defined to provide bridge support to welfare services upon release for suspects and defendants who require welfare support. This is implemented at the Prosecutor’s Office, where welfare professionals are assigned, in cooperation with related organizations and groups such as lawyers, welfare professionals, and probation offices (entry support). Additionally, as part of support for released inmates and others (exit support), efforts are underway to ensure that elderly or disabled individuals among inmates who do not have an appropriate post-release residence can smoothly access welfare services, such as admission to social welfare facilities after release. This includes establishing regional support centers for community reintegration and assigning social

workers to correctional and rehabilitation facilities. Furthermore, collaboration among correctional facilities, probation offices, rehabilitation facilities, regional support centers for community reintegration, and other welfare-related agencies is conducted to carry out necessary coordination (special coordination).

Among the activities performed by probation offices as part of entry support, examples such as “coordination of welfare services” and “provision of lodging at rehabilitation facilities” after release due to suspended prosecution, etc., are illustrated in Figure 6.²⁾ Although several initiatives by judicial agencies are introduced in this way, in reality, these efforts rarely intersect with community mental health and welfare activities.

2. Future Challenges

These measures aim to facilitate community reintegration by having judicial agencies serve as a bridge to health, medical, and welfare services for individuals requiring welfare support. There is some overlap with community mental health and welfare activities, and going forward, cooperation and role-sharing will be necessary. Coordination between health, medical, and welfare agencies and judicial agencies is expected to promote support for stable

community living. However, even support provided by judicial agencies must not be imposed against the user's will, and careful consideration must be given to advocate the individual's rights.

However, considering that the purpose of judicial measures is the prevention of recidivism, it does not always align perfectly with the goals of community mental health and welfare activities. Therefore, cooperation and role-sharing require careful examination. This point reiterates that the Medical Treatment and Supervision Act aims at preventing recurrence of harmful behavior and promoting social reintegration, a point that drew criticism during its enactment. Since psychiatric medical care and community mental health and welfare activities aim to promote social participation, it is necessary that system design and rule-making for cooperation and role-sharing with judicial agencies take this into full account.

Conclusion

From the standpoint of a core psychiatric emergency hospital, this paper has discussed issues related to cooperation at the time of admission and discharge in involuntary hospitalizations by a prefectural governor. Regarding admission, the necessity of establishing a system for

prior investigation and the importance of a shared understanding of the roles of administration, police, and hospitals were pointed out. Regarding discharge, it was noted that post-discharge support can be challenging and that cooperation and role-sharing with judicial agencies are required.

In cooperation between community mental health and welfare agencies and judicial agencies, since their objectives do not always align, it is necessary to give full consideration to the individual's will and advocacy for their rights in the creation of frameworks and rules regarding cooperation and role-sharing.

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.

Acknowledgments

I would like to take this opportunity to express my sincere gratitude to Dr. Takayasu Asami of the Gunma University General Health Support Center, who served as the coordinator of

this symposium, for his invaluable guidance during the preparation of this paper.

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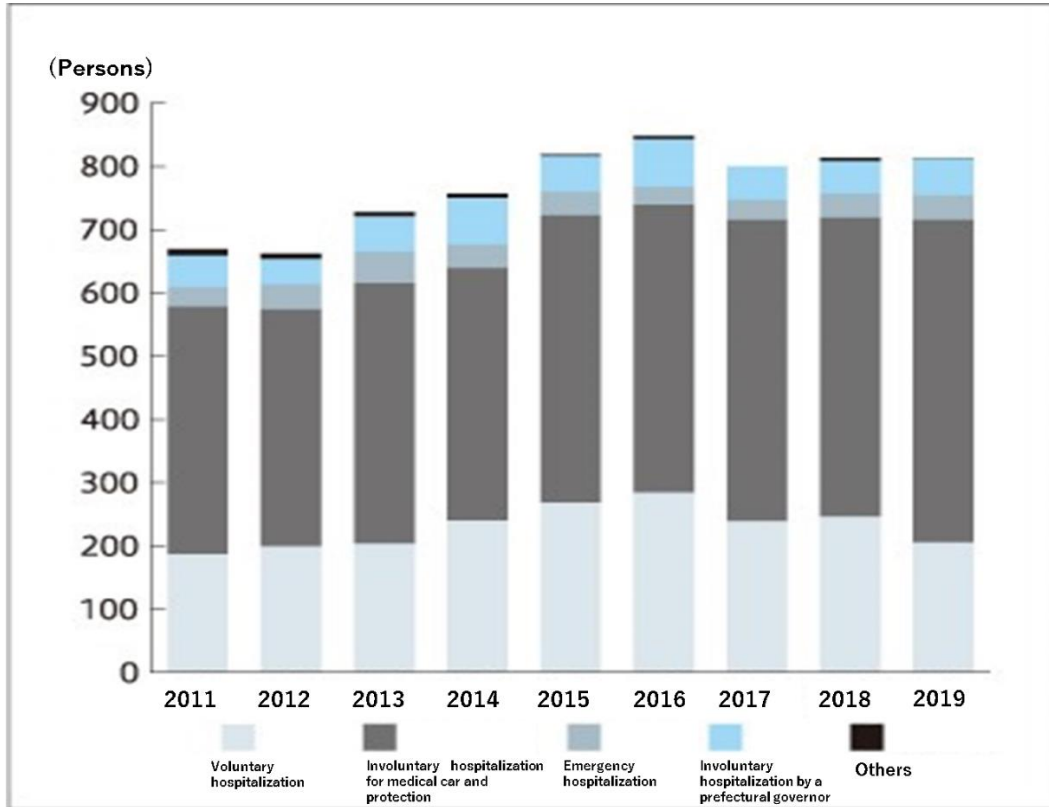


Figure 1: Number of New Admissions by Type at Our Hospital

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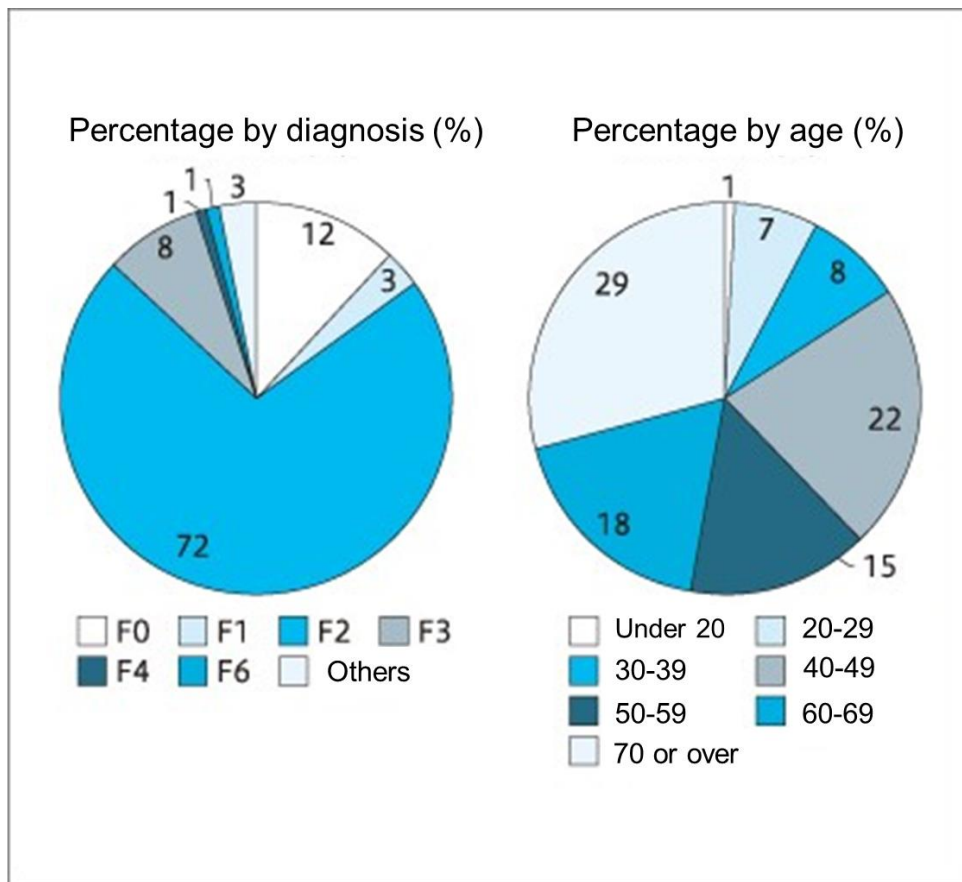


Figure 2: Status of Inpatients at Our Hospital (1) (As of March 31, 2020)

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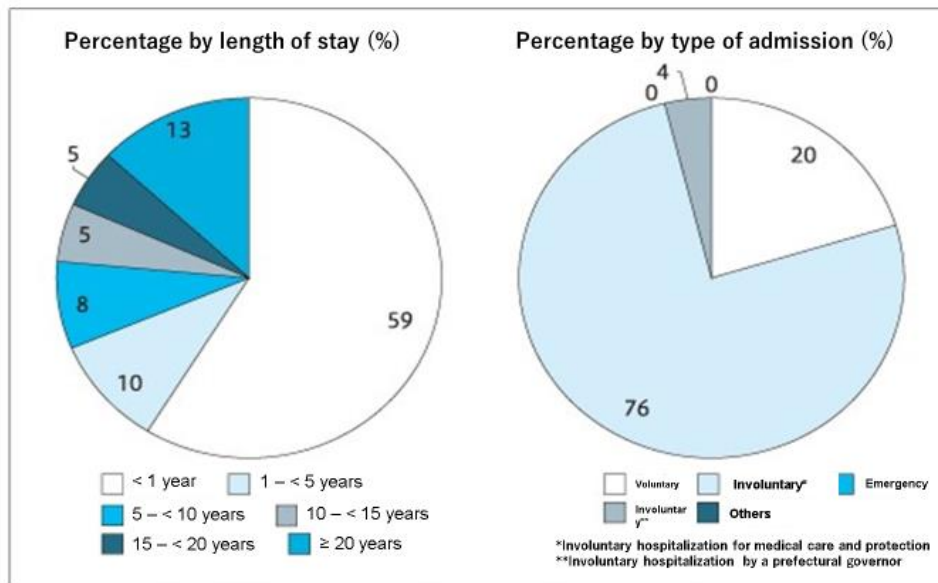


Figure 3. Status of Inpatients at Our Hospital (2) (As of March 31, 2020)

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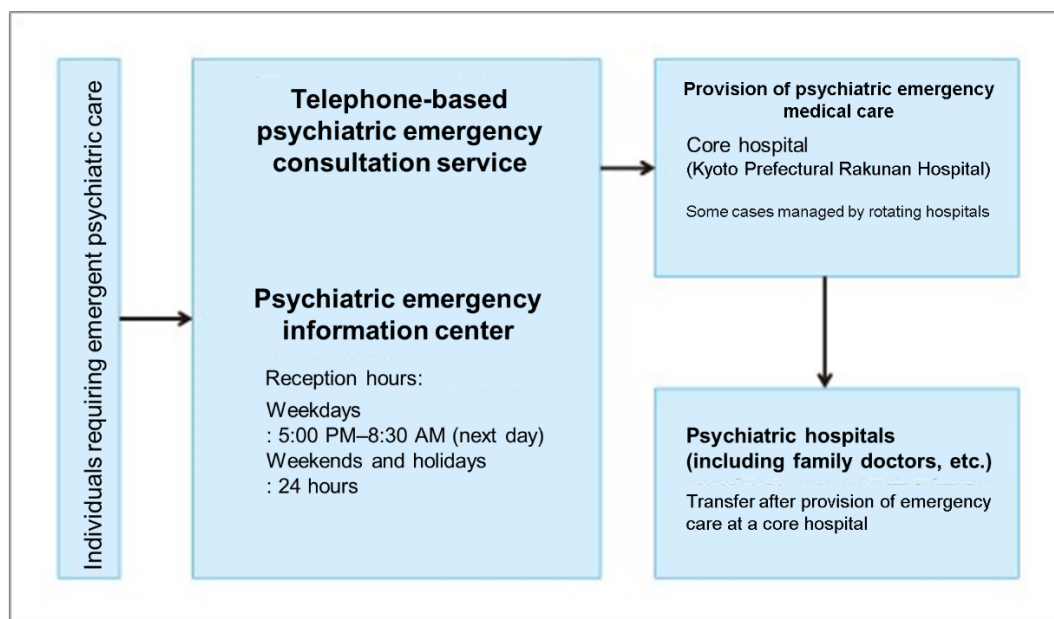


Figure 4. Overview of the Southern Kyoto Prefecture Psychiatric Emergency Medical System: Cooperative Project of Kyoto Prefecture and City (July 2002–Present)

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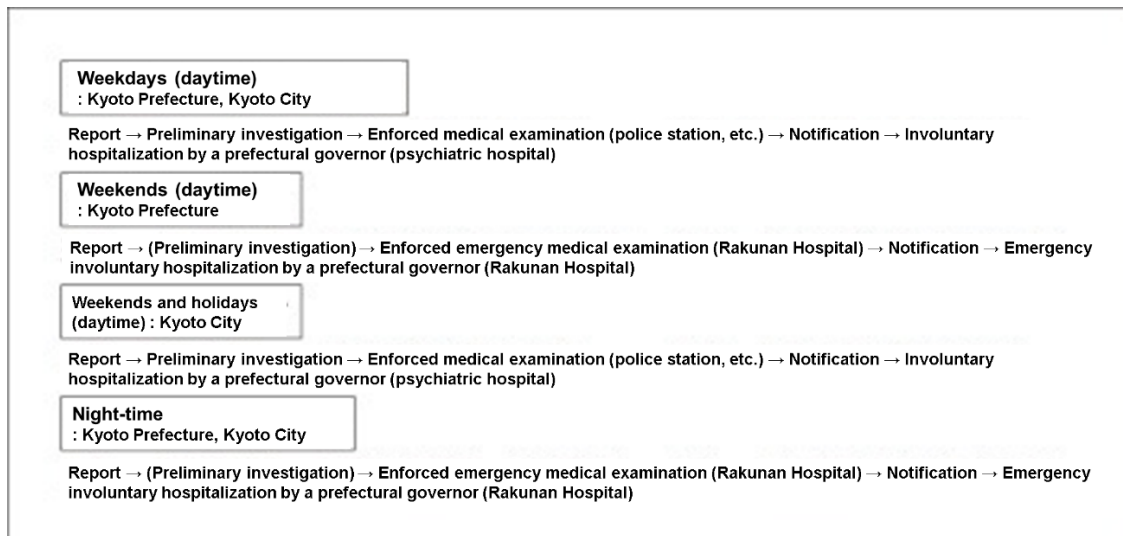


Figure 5. Process of Involuntary Hospitalization by a Prefectural Governor in Kyoto Prefecture and City

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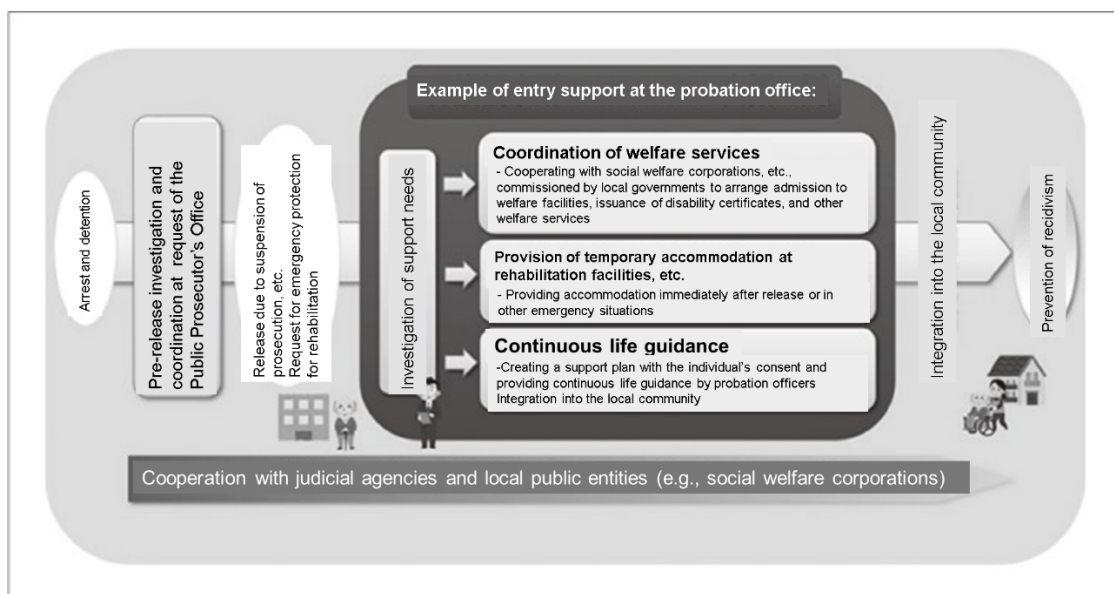


Figure 6. Overview of Entry Support by the Probation Office
(Source: Reference 2)

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