PSYCHIATRIA ET NEUROLOGIA JAPONICA

Statistical Compilation

The Reality of Involuntary Treatment in Yamanashi Prefectural Kita Hospital

Fuminari MISAWA, Yasuo FUJII, Ryouji MIYATA
Yamanashi Prefectural Kita Hospital
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Abstract

In psychiatric practice, involuntary treatment may be recommended when patients refuse treatment due to a lack of insight. However, there is a growing demand for transparency regarding the use of involuntary treatment and the processes involved. In 2012, Yamanashi Prefectural Kita Hospital introduced a review system for involuntary treatment exclusively in the psychiatric emergency ward. In 2016, this initiative was expanded to encompass all psychiatric wards following a successful trial. The review system involves the participation of the director, chief nurse from each psychiatric ward, and a psychologist. It assesses the patient's competency and best interests, and subsequently determines the appropriateness of involuntary treatment for patients whose psychiatrists in charge deem such treatment necessary, 72 hours or more after hospitalization.

Between December 2016 and March 2023, a total of 169 reviews (an average of 2.2 per month) were conducted. The median time from hospitalization to review was 21 days, and the median time from the application for involuntary treatment to review was 1 day. Over 70% of the reviews were conducted in psychiatric emergency wards, and 115 cases (68.0%) were related to modified electroconvulsive therapy. Among all reviews, nine (5.3%) were not approved, of which four were not approved because the patients had complete competency. Finally, 50 cases (29.6%) underwent involuntary treatment under manual restraint.

The introduction of this review system has provided us with a deeper insight into involuntary treatment within our hospital. The review offers several advantages, such as preventing inappropriate involuntary treatment, facilitating the implementation of necessary involuntary treatment, and enabling transitions to less invasive treatments with greater confidence. However, the system has problems such as the absence of involvement of an independent third party.

To improve trust in psychiatric practice in Japan, it is essential to illuminate the process of involuntary treatment, which has been underrepresented in deliberations, and to explore the appropriate review process.

Keywords: involuntary treatment, competency

Introduction

In psychiatric practice, involuntary treatment (treatment administered without the patient's consent) may be performed in cases where the patient lacks insight into their condition and refuses treatment despite receiving a thorough explanation, particularly when they are experiencing active hallucinations, delusions, severe agitation, or resistance, or there is an imminent risk of self-harm or harm to others. The legal basis for psychiatrists to administer involuntary treatment is Principle 11[9] of the "Principles for the Protection of Persons with Mental Disorders and Improvement of Mental Health Care (UN Principles)," adopted by the United Nations in 1991, which permits treatment without the patient's consent when it is deemed to be in the patient's best interests in light of their health needs, for patients who are involuntarily hospitalized and lack competency.

However, due to a series of recent media reports regarding patient abuse in psychiatric hospitals, public scrutiny of involuntary hospitalization and involuntary treatment in psychiatric practice has become marked. The unique situation in which treatment is administered to patients who, due to their symptoms, find it difficult to express their will, often in a closed environment and, in some cases, without the patient's consent, may raise suspicions among the public. Furthermore, if involuntary treatment is carried out without adequate oversight mechanisms, inappropriate treatment may be administered without consent, and there is a risk that this could foster an adverse mindset among

healthcare professionals who fail to recognize the issues involved. We believe that ensuring transparency in involuntary treatment and standardizing its procedures are the first steps required to provide care in accordance with UN Principle 11.

At Yamanashi Prefectural Kita Hospital (hereinafter referred to as "this hospital"), with the aim of implementing appropriate procedures regarding involuntary treatment to the greatest extent feasible at this time, we have established a "Compulsory Treatment Review System" (in this paper, treatment not based on patient consent is referred to as "involuntary treatment"; however, regarding this hospital's review system, we use the terms "Compulsory Treatment Review," "Compulsory Treatment Review System," and "Compulsory Treatment Application Form" as they are specific to our institution) and have compiled the review status into a database. Therefore, we conducted this study with the aim of clarifying what types of involuntary treatment are being performed in psychiatric hospitals and how they are carried out, by presenting an overview of our hospital's "Compulsory Treatment Review System" and the status of involuntary treatment that has been performed.

I. The "Compulsory Treatment Review System" at Our Hospital

1. The origins of the "Compulsory Treatment Review System"

Our hospital is a core psychiatric hospital in Yamanashi Prefecture with 188 beds, consisting of four wards. There are two psychiatric emergency service wards (hereinafter referred to as "psychiatric emergency wards"), which account for a total of 100 beds (53.2%); one of these includes a 5-bed ward designated under the Medical Treatment and Supervision Act. The remaining two are general psychiatric wards; one houses a polyphagia unit, and the other houses a unit for children, adolescents, and those with alcohol dependence.

In the past, there was a period at this hospital when involuntary treatment was performed based solely on the judgment of the psychiatrist in charge, without conducting a rigorous competency assessment. However, as doubts arose regarding the necessity of involuntary treatment and concerns grew about deterioration of the patient-practitioner relationship, which sometimes led to prolonged hospitalization or isolation without necessary treatment being administered, discussions began regarding the appropriate procedures for involuntary treatment. In 2011, designated inpatient beds for the Medical Treatment and Supervision Act

were established within the psychiatric emergency ward, and the "Guidelines for Inpatient Treatment" under the Medical Treatment and Supervision Act stipulated that cases where treatment is initiated without the patient's consent must be reviewed by an ethics committee that includes external members.[6] Drawing on this practice, we explored methods applicable to general psychiatric care, developed a "Compulsory Treatment Review System," and began a pilot program in 2012 on the psychiatric emergency ward with co-located Medical Treatment and Supervision Act beds. The system was launched on another psychiatric emergency ward in 2013, and by 2016, it had been performed on all four wards.

Following the system's rollout across all wards, the "Compulsory Treatment Review System Committee" was established in 2016 to review the system's operational methods and verify that reviews were being conducted appropriately; the committee has met monthly ever since. The committee consists of one physician, one nurse from each ward, and one psychologist, who review the details of all reviews conducted that month and confirm that no involuntary treatment has been administered without a review.

Additionally, regarding the competency assessment as part of the review process, the MacArthur Competence Assessment Tool for Treatment (MacCAT-T)[2] was initially used; however, starting in 2016, the revised Structured Interview for Competency and Incompetency Assessment Testing and Ranking Inventory (SICIATRI-R)[4] has been used for reasons of convenience. SICIATRI-R is a semi-structured interview lasting approximately 20 minutes, consisting of 13 questions, and classifies competency comprehensively into five levels, ranging from Level 0 (completely incompetent) to Level 4 (fully competent).

Furthermore, starting in 2022, as part of efforts to prevent the traumatization associated with involuntary treatment and avoid repeat involuntary treatment should symptoms worsen again, we have systematized debriefings for patients who received involuntary treatment prior to discharge. The debriefing involves the patient, psychiatrist in charge, chief nurse, assigned nurse, and a psychologist. They review the involuntary treatment that was administered and, in advance, discuss and decide between the patient and medical staff on the treatment to be performed and the designated proxy should a similar situation arise again. The decisions made during this advance consultation are reflected in a crisis

plan, which is handed to the patient upon discharge.

2. Process of the "Compulsory Treatment Review"

The review applies to patients who have refused treatment 72 hours or more after admission and for whom the psychiatrist in charge has determined that involuntary treatment (medication administration or modified electroconvulsive therapy [mECT]) is necessary. This review applies to psychiatric treatment and does not cover physical treatments, such as fluid replacement or tube feeding. Furthermore, rapid sedation administered in response to imminent risks of self-harm or harm to others is not subject to this review; instead, the "Compulsory Treatment Review System Committee" conducts a post-hoc evaluation.

The review process is shown in Figure 1. First, the psychiatrist in charge submits an application for involuntary treatment using the "Compulsory Treatment Application Form" (Figure 2). The application must include details of the involuntary treatment, the target symptoms, reasons for treatment refusal, the patient's physical condition (presence or absence of physical complications, ability to eat and drink), availability and acceptance of alternative treatments, impact on the quality of life (QOL), status of treatment explanation (staff who provided the explanation, number and duration of sessions, content of the explanation, and patient's reaction to the explanation), status of surrogate consent (name of surrogate, method of obtaining consent, and reaction during the explanation), and whether an expedited review is necessary.

Subsequently, the nurse in charge of the patient under review requests a competency assessment from a psychologist and coordinates the schedule for formal review.

The psychologist evaluates the patient's competency using SICIATRI-R and records the results on the "Compulsory Treatment Application Form." Then, three individuals, the director (or hospital director or deputy director if the director is the patient's psychiatrist in charge), chief nurse, and psychologist, review the "Compulsory Treatment Application Form," medical records, and patient interview to assess the appropriateness of the requested involuntary treatment.

If the application is approved as a result of the review, the review officer uses a notification form to inform and explain to the patient that the involuntary treatment requested by the psychiatrist in charge has been approved, the specific methods of that treatment, and that the treatment will

be performed regardless of the patient's consent. If the application is not approved, the reasons are communicated to the psychiatrist in charge, and discussions and advice are provided regarding future treatment plans.

Furthermore, the approval is valid for two weeks following the review (four weeks for mECT). If involuntary treatment continues to be necessary after that period, the psychiatrist in charge must submit a new application, and the review process will be repeated.

II. Research Methods

1. Subjects

The study included all 117 patients (169 cases) who underwent review for involuntary treatment for which surrogate consent was obtained between December 2016, when SICIATRI-R was adopted for assessing competency in our hospital's "Compulsory Treatment Review," and March 2023. However, reviews regarding applications for continuation of the same treatment were excluded (27 cases).

2. Methods

We extracted the following data from the subjects' medical records and "Compulsory Treatment Review System" database: age (at time of initial review), sex, primary psychiatric diagnosis (ICD-10), admission date, date of application for and review of involuntary treatment, SICIATRI-R results, details of the application for involuntary treatment, review results, and status of involuntary treatment implementation.

Review results were classified as: "Approved," "Partially Approved," "Not Approved," and "Consent Obtained." "Partially Approved" refers to cases where only a portion of the requested involuntary treatment was approved [e.g., applications for involuntary treatment involving short-acting injectable antipsychotics (SAI) and long-acting injectable antipsychotics (LAI) were applied for, but only the short-acting treatment was approved], while "Consent Obtained" refers to cases where consent was obtained from the patient between submission of the application for involuntary treatment and actual treatment administration.

Regarding the status of involuntary treatment implementation, for cases judged as approved or partially approved during review, we classified them as "Performed Under Restraint," "Performed Without Restraint," and "Not Performed." "Performed under restraint" refers to cases where treatment was administered after manual restraint or sedation (excluding anesthesia associated with mECT); "Performed Without Restraint" refers to

cases where treatment was administered with only verbal intervention; and "Not Performed" refers to cases where the requested involuntary treatment was not carried out.

Regarding methods of administering medication without consent, cases were classified as follows: "under sedation with intravenous benzodiazepines (oral medication administered once drowsiness set in following intravenous benzodiazepine administration)"; "under sedation for mECT (oral medication administered before awakening from anesthesia associated with mECT administration)"; "administration via nasogastric tube"; "administration without disclosure"; and "manual oral administration (manually opening the patient's mouth to administer oral medication)."

3. Ethical considerations

This study was approved by our hospital's Institutional Review Board (Approval No.: 2023-2).

III. Results

1. Characteristics of the study population

The demographic and psychiatric diagnoses of the study population are shown in Table 1. The mean age was 54.2 years; the 50s age group was the largest, at 33.3%, while those under 20 years old accounted for 1.7% and those 75 years or older accounted for 9.4%; 45.3% were male. Regarding diagnoses, cases in the schizophrenia category (ICD-10 F2; the same applies hereafter) accounted for nearly 80%, followed by the mood disorder category (F3: 14.5%), and then organic mental disorder category (F0: 3.4%).

2. Review status (Table 2)

During the 76-month study period, 169 patients (monthly average: 2.2) were treated. There were 26 patients (22.2%) who underwent multiple reviews during the study period, and 14 patients (12.0%) received multiple reviews during the same hospitalization; of these, one patient underwent a total of 8 reviews: 3 during one hospitalization and 5 during another.

The median time from admission to the review was 21 days. Of all reviews, 120 (71.0%) were conducted on the psychiatric emergency ward, indicating that reviews for involuntary treatment were frequently performed in the context of acute care. Furthermore, the median time from the application for involuntary treatment to review was one day, demonstrating that reviews were generally conducted promptly.

In the competency assessment using SICIATRI-R administered by psychologists, there were 39 (23.1%)

where the patient refused the assessment interview, while in 4 cases (2.4%), the patient consented to treatment during the interview. Furthermore, 4 cases (2.4%), involving 4 patients, were rated at Level 4, indicating full competency, on SICIATRI-R. These four patients involved three cases of schizophrenia and one of autism spectrum disorder; the requested treatments were mECT in two patients, LAI in one, and manual oral medication in one.

Of the total of 169 cases, 9 (5.3%) were denied approval; three of these involved a single patient who had previously undergone 8 reviews. The reasons for denial were as follows: 4 cases where the patient was deemed to have full competency; 2 cases where improvement of the patient's physical condition should take priority; 2 cases where improvement was possible with an alternative treatment for which consent had already been obtained; and 1 case where the requested treatment was contraindicated (administration of LAI to a patient currently taking clozapine).

3. Status of involuntary treatment implementation

The relationship between the SICIATRI-R results and status of involuntary treatment implementation is shown in Table 3. Of the 151 cases judged as "Approved" or "Partially Approved" following review, "Performed Under Restraint" accounted for 50 cases (33.1%), representing 29.6% of the 169 cases submitted. Among cases of involuntary treatment "Performed Under Restraint," those who refused the SICIATRI-R interview accounted for the largest proportion, at 47.2%, followed by those rated as unmeasurable or competency Level 2, both at 33.3%.

The details of applications, review results, and implementation status for each type of requested involuntary treatment are shown in Table 4.

1) Modified electroconvulsive therapy (mECT)

The most common type of involuntary treatment for which reviews were requested was mECT-related, with 115 cases (68.0%) conducted. Of these, 101 were "Approved," 7 were "Not Approved," and consent was obtained prior to treatment administration in 7 cases ("Consent Obtained"). Of the 101 approved cases, 30 were "Performed Under Restraint."

2) Oral psychotropic medication (per os: PO)

There were 25 cases related to PO administration. The methods of administration were as follows: under sedation with intravenous benzodiazepines in 11 cases, under sedation for mECT in 7 cases, administration via nasogastric tube in 3

cases, administration without disclosure in 2 cases, and manual oral administration in 2 cases. The one approved case of administration without disclosure involved a patient with dementia in their 70s, in whom antipsychotic medication was mixed into food and administered.

3) Short-acting injectable antipsychotics (SAI)

There were 33 cases related to SAI, involving 15 administered as involuntary treatment. Of the 20 cases involving SAI alone, all were approved; however, 12 were not administered because the patient was able to take oral medication.

4) Long-acting injectable antipsychotics (LAI)

There were 23 cases related to LAI, of which 16 were approved. Of these, 2 were not administered because the patient agreed to take oral medication following the review.

IV. Discussion

The above was presented at our hospital's "Compulsory Treatment Review System" along with the results of a survey on the status of reviews and implementation of involuntary treatment from December 2016 to March 2023. To the best of the authors' knowledge, this report is the first to clarify the details of involuntary treatment in psychiatric hospitals in Japan since our initial report[10] on the introduction of this review system across all wards of our hospital. Summarizing the survey results, the total number of involuntary treatment cases was 169, with an average of 2.2 per month. Of these, 71.0% were submitted from the psychiatric emergency ward, and cases related to mECT accounted for the largest proportion, at 68.0%. Of the 169 cases, 9 (5.3%) were denied approval; among these, 4 (2.4%) were denied on the grounds that the patient possessed full competency.

1. Procedures for treatment without consent

WHO Resource Book on Mental Health, Human Rights and Legislation[1] identifies two approaches to procedures for treatment without consent: the "combined approach," in which the review for treatment without consent is conducted simultaneously with involuntary admission, and the "separate approach," in which the review for treatment without consent is conducted as a separate procedure from admission. In both cases, the book requires an independent body to verify that the patient's competency is impaired, and that the treatment is in the patient's best interests.

According to the WHO Resource Book, the primary purpose of involuntary

hospitalization is to treat and alleviate worsened psychiatric symptoms; hospitalization without treatment is meaningless. Therefore, the "combined approach" is valid in that involuntary treatment is permissible provided the necessity of involuntary hospitalization has been appropriately reviewed. Furthermore, the "separate approach" has been criticized as the time required for the two separate procedures may cause significant delays in treatment, and it imposes a burden in terms of both human resources and financial costs. However, there is also criticism of the combined approach based on the position that consent or lack of consent to hospitalization and consent or lack of consent to treatment are separate issues, and that competency, in particular, should be assessed individually.

In Japan, because there are no clear legal provisions justifying involuntary treatment, the combined approach is effectively the norm in practice.[8] The Mental Health and Welfare Act requires designated mental health physicians to assess the necessity of involuntary hospitalization during examinations for measures such as compulsory hospitalization or medical protection hospitalization; however, it contains no provisions regarding the assessment of a patient's competency after admission, or whether the implementation of treatment without consent is in the patient's best interests. Consequently, once involuntary hospitalization is decided and subsequent treatment is left to the individual judgment of the psychiatrist in charge, involuntary treatment may be administered without providing sufficient explanation to patients who refuse treatment. Furthermore, even if the treatment is inappropriate, there is no mechanism for evaluation, so it may be carried out without obtaining consent. Although the Mental Health and Welfare Act stipulates procedures for requesting discharge or improvements in treatment conditions, reviews rarely delve into the specifics of individual treatments administered during hospitalization. However, based on the principles of non-discrimination and equality required by the Convention on the Rights of Persons with Disabilities, which Japan has ratified, there is a growing need to more rigorously assess the severity of the illness and patient's competency as fundamental requirements for involuntary treatment.[3]

Furthermore, the lack of established procedures for involuntary treatment creates difficulties in data collection. Since legal provisions exist for behavioral restrictions such as isolation and physical restraint, and data can be compiled accordingly, surveys on the

actual duration of isolation and restraint on acute care wards[7] and the 630 Survey[5] have been published, covering the situation at individual medical institutions and nationwide, thereby ensuring a certain degree of transparency. However, because it is difficult to compile such data regarding involuntary treatment, to the best of the author's knowledge, no studies have been conducted to date on the implementation status of involuntary treatment in Japan, and so the actual situation remains unclear.

2. Advantages of the "Compulsory Treatment Review System"

This review system takes the form of a "separate approach," conducting reviews of involuntary treatment independently from reviews of involuntary hospitalization. One of its major advantages is that it can prevent the implementation of inappropriate involuntary treatment. First, the mere existence of the review process heightens the psychiatrist in charge's awareness regarding the appropriateness of involuntary treatment, including the treatment content, patient's competency, and method of explanation, and serves as a motivator for selecting more appropriate treatment options. Nevertheless, nine cases were "Not Approved" during the review process, of which four were due to the patient having full competency, and one was due to the treatment being contraindicated. Since these cases might have been overlooked and the involuntary treatment carried out without the review, this demonstrates the importance of conducting prior checks on treatment capacity and treatment content through this review system.

A second benefit is the ability to promptly administer necessary involuntary treatments. Failure to provide appropriate treatment can delay improvement or recovery, potentially causing significant harm, such as self-harm or harm to others, prolonged hospitalization, or extended periods of behavioral restrictions. However, even if the treatment is appropriate, the psychiatrist in charge may hesitate to administer it out of concern that doing so could damage the therapeutic relationship, such as in cases of strong patient resistance. In such situations, having obtained approval through the review process makes it easier for the psychiatrist in charge to administer necessary involuntary treatment at the most appropriate time. Furthermore, while applications from the psychiatrist in charge typically initiate the review process, a multidisciplinary team may

also urge the psychiatrist in charge to apply for involuntary treatment.

It is worth noting that in more than half of the cases approved for non-consensual administration of SAI, it was not administered because the patient took oral medication; overall, approximately one-third of the approved involuntary treatments were performed under restraint. While these cases do not suggest that the patient voluntarily accepted treatment, and the situation remains one involving coercion, the review process demonstrates the potential to transition to less invasive treatments, which is another benefit of conducting such reviews.

3. Challenges of the "Compulsory Treatment Review System"

Since this review system is performed within the scope currently feasible at our hospital, it naturally has various shortcomings. The greatest drawback is that no independent third-party organization is involved in the review. UN Principle 11 stipulates that when involuntary treatment is administered, an independent third-party organization should assess the patient's competency and whether the treatment is in his/her best interests. In our review, the process is conducted by three professions: physicians, nurses, and psychologists, who are not directly involved in the treatment; however, since all are employees of our hospital, their independence is not guaranteed. We are currently considering establishing a system to set up an independent external committee to conduct post-review evaluations. However, building a system where a third-party body reviews cases prior to treatment is difficult for a single medical institution to achieve on its own, as it requires not only addressing personnel and budgetary issues but also establishing an organization with no vested interest in our hospital.

Furthermore, under the current review system, the median time from the application for involuntary treatment to completion of the review is one day; therefore, the review process rarely causes significant delays in treatment. However, if third-party bodies established by administrative or judicial authorities were to assume this role, conducting reviews swiftly and providing treatment without delay could become more difficult than it is now.

Thus, given the difficult dilemma between independence and speed in the review process, a nationwide discussion is needed on how to establish an effective system that ensures transparency in involuntary treatment.

Another major shortcoming is the lack of uniform review criteria. While

this is partly related to the relatively large number of staff involved in the review process, as shown in Table 4, treatments such as LAI administration and non-disclosed administration, which are generally considered treatments that should not be performed in situations where consent has not been obtained, were approved [16 out of 23 cases (69.6%) for LAI, and 1 out of 2 cases (50.0%) for non-disclosed administration]. In response to these findings, starting in fiscal year 2022, LAI administration and non-disclosed administration without consent were prohibited in principle; however, if such treatments are deemed necessary, it was decided that for LAI administration, a decision should be made at a department meeting attended by all physicians, and for non-disclosed administration, a special meeting including at least one external expert would be convened to determine approval. If variations in judgment criteria can be corrected by repeatedly verifying and improving the review system in this manner, it is believed that the implementation of involuntary treatments resulting from inappropriate review outcomes can be eliminated; however, it will be necessary to standardize the review criteria in the future, for example, by creating a manual.

4. Limitations of this study

The first limitation of this study was that it solely involved a single institution. In this survey, the most common type of involuntary treatment applied for was related to mECT. The reason for this was that our hospital has long practiced treatment with minimal use of physical restraints (even now, there are only about two or three cases per year of physical restraint using bed restraints); therefore, initiation of mECT is considered relatively early in cases where there is an imminent risk of self-harm or harm to others, or when a patient is unable to eat or drink for an extended period.

Thus, since the nature of involuntary treatments administered is likely to vary depending on the treatment culture of each medical institution, it is not possible to infer the nationwide status of involuntary treatments based on these results. Moving forward, to ensure transparency regarding involuntary treatments and psychiatric care as a whole, it will be necessary to develop review systems to ensure the appropriate implementation of involuntary treatments at each medical institution, and compile this information into a database for public disclosure.

Second, this survey did not evaluate the efficacy, appropriateness, or patient perception of the involuntary

treatments administered. To enable such evaluations, we began conducting post-treatment debriefings in 2022, and we plan to compile and analyze the results of these debriefings in the future.

Conclusion

Although our hospital's "Compulsory Treatment Review System" has significant shortcomings, such as not being conducted by an independent third-party organization, we believe it offers marked benefits in terms of enabling us to grasp and report on the actual state of involuntary treatment performed at our facility. However, the fact remains that the full scope of involuntary treatment in Japan remains unclear; therefore, for psychiatric care in Japan to become more trusted by the public in the future, it will be crucial for every professional involved in such care to reflect on the introduction and structure of review systems for involuntary treatment and engage in nationwide discussion. We strongly hope that this paper will contribute to this effort.

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

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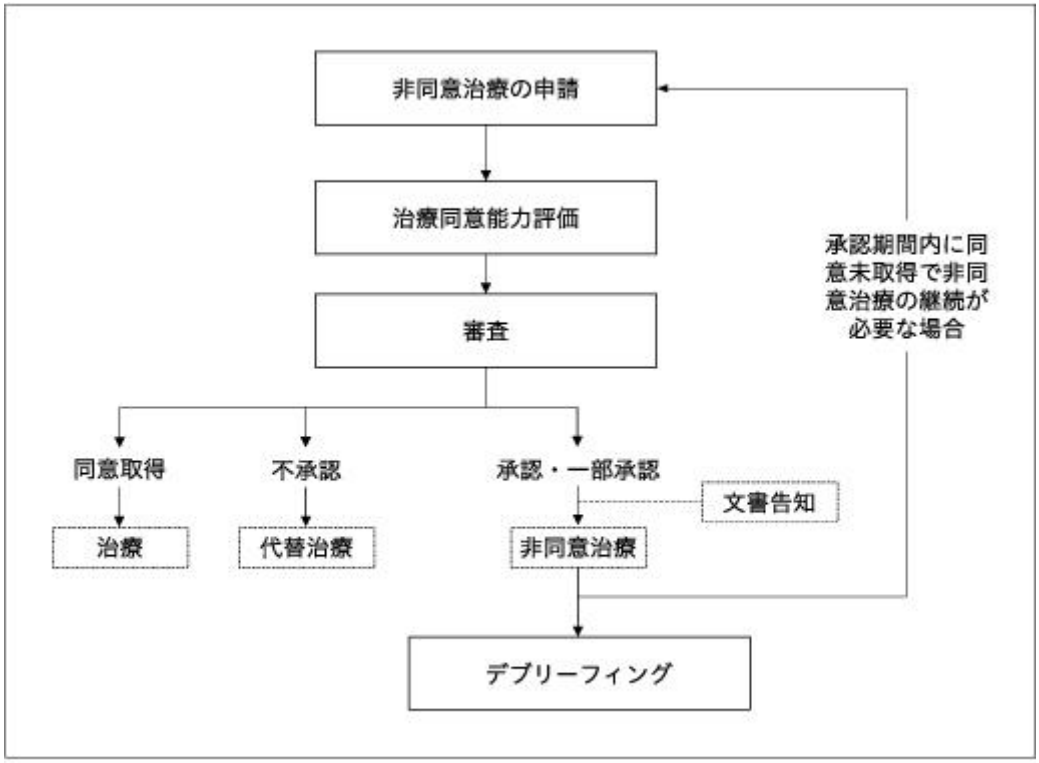
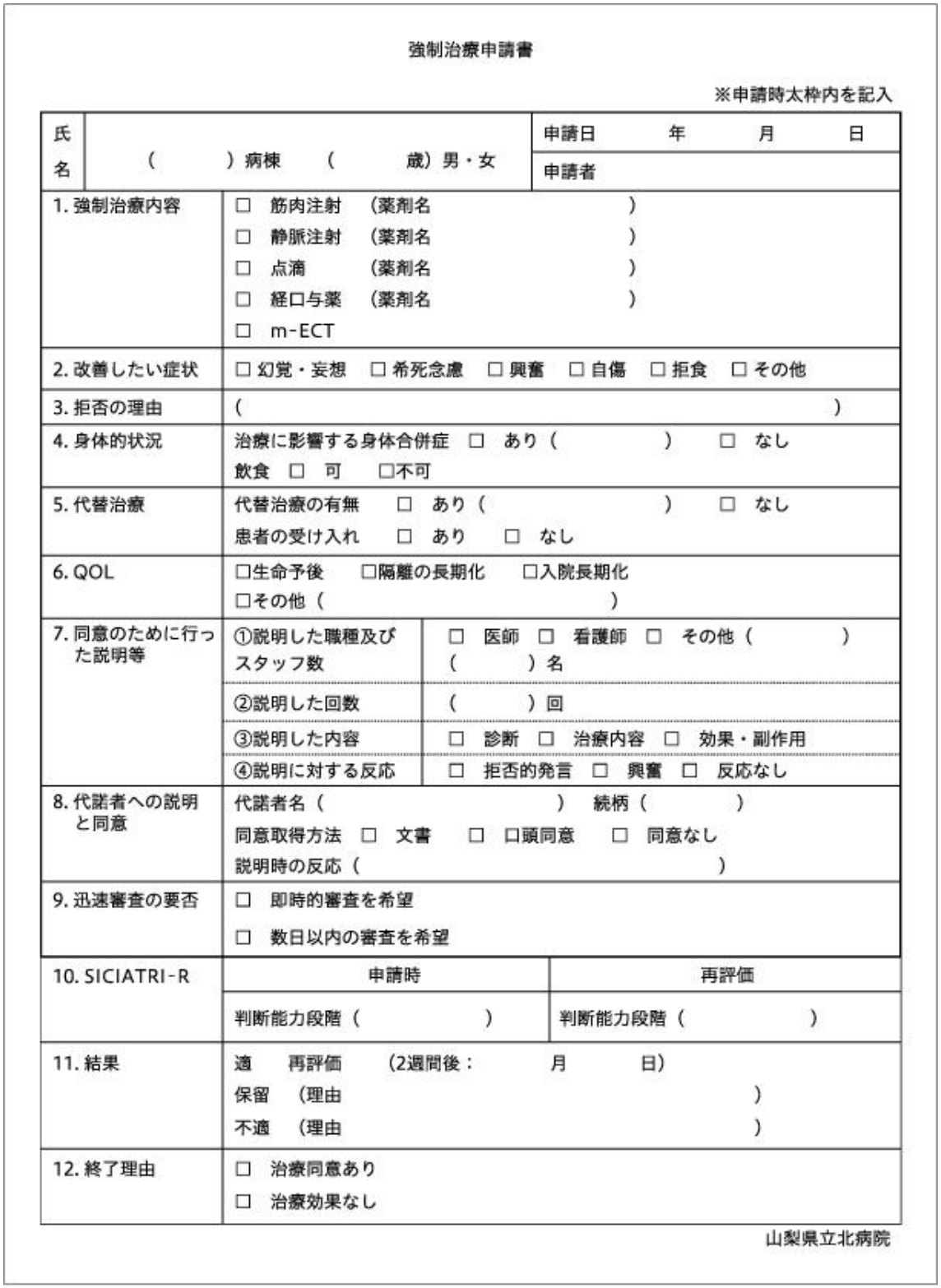


図 1　強制治療審査システムの流れ

Figure 1: Flowchart of the compulsory treatment review system



強制治療申請書

※申請時太枠内を記入

氏名	（　　）病棟　（　　歳）男・女	申請日　年　月　日 申請者
1. 強制治療内容	☐ 筋肉注射　（薬剤名　　） ☐ 静脈注射　（薬剤名　　） ☐ 点滴　（薬剤名　　） ☐ 経口与薬　（薬剤名　　） ☐ m-ECT	
2. 改善したい症状	☐ 幻覚・妄想　☐ 希死念慮　☐ 興奮　☐ 自傷　☐ 拒食　☐ その他	
3. 拒否の理由	（　　）	
4. 身体的状況	治療に影響する身体合併症　☐ あり（　　）　☐ なし 飲食　☐ 可　☐不可	
5. 代替治療	代替治療の有無　☐ あり（　　）　☐ なし 患者の受け入れ　☐ あり　☐ なし	
6. QOL	☐生命予後　☐隔離の長期化　☐入院長期化 ☐その他（　　）	
7. 同意のために行った説明等	①説明した職種及びスタッフ数	☐ 医師　☐ 看護師　☐ その他（　　） （　　）名
	②説明した回数	（　　）回
	③説明した内容	☐ 診断　☐ 治療内容　☐ 効果・副作用
	④説明に対する反応	☐ 拒否的発言　☐ 興奮　☐ 反応なし
8. 代諾者への説明と同意	代諾者名（　　）　続柄（　　） 同意取得方法　☐ 文書　☐ ☐頭同意　☐ 同意なし 説明時の反応（　　）	
9. 迅速審査の要否	☐ 即時的審査を希望 ☐ 数日以内の審査を希望	
10. SICIATRI-R	申請時	再評価
	判断能力段階（　　）	判断能力段階（　　）
11. 結果	適　再評価　（2週間後：　月　日） 保留　（理由　　） 不適　（理由　　）	
12. 終了理由	☐ 治療同意あり ☐ 治療効果なし	

山梨県立北病院

図 2　強制治療申請書

Figure 2: Compulsory treatment application form

表 1　人口統計的特徴・精神科診断名（n＝117）

年齢，平均（範囲）	54.2（17～90）歳
20 歳未満	2 例　（1.7%）
20 歳代	5 例　（4.3%）
30 歳代	15 例（12.8%）
40 歳代	18 例（15.4%）
50 歳代	39 例（33.3%）
60 歳代	18 例（15.4%）
70 歳代	14 例（12.0%）
80 歳以上	6 例　（5.1%）
男性	53 例（45.3%）
女性	64 例（54.7%）
診断名（ICD-10）	
F0	4 例　（3.4%）
F1	2 例　（1.7%）
F2	91 例（77.8%）
F3	17 例（14.5%）
F4	2 例　（1.7%）
F8	1 例　（0.9%）

Table 1: Demographic characteristics and psychiatric diagnoses (n = 117)

Age, mean (range)	54.2 (17–90) years
Under 20 years old	2 cases (1.7%)
20s	5 cases (4.3%)
30s	15 cases (12.8%)
40s	18 cases (15.4%)
50s	39 cases (33.3%)
60s	18 cases (15.4%)
70s	14 cases (12.0%)
80 years or older	6 cases (5.1%)
Male	53 cases (45.3%)
Female	64 cases (54.7%)
Diagnosis (ICD-10)	
F0	4 cases (3.4%)
F1	2 cases (1.7%)

F2	91 cases (77.8%)
F3	17 cases (14.5%)
F4	2 cases (1.7%)
F8	1 case (0.9%)

表 2 「強制治療審査」の実施状況（n＝169）

審査件数	169 件
複数回審査を受けた症例	
2 件	14 例（12.0%）
3 件	5 例（4.3%）
4 件	3 例（2.6%）
5 件	3 例（2.6%）
8 件	1 例（0.9%）
同一入院中の一人あたりの審査件数*	
1 件	130 例
2 件	10 例
3 件	2 例
4 件	2 例
5 件	1 例
救急病棟での審査	120 件（71.0%）
入院から審査までの期間，中央値（範囲）	21（0～1,716）日
申請から審査までの期間，中央値（範囲）	1（0～40）日
治療同意能力評価	
Level 0	14 件（8.3%）
Level 1	58 件（34.3%）
Level 2	14 件（8.3%）
Level 3	3 件（1.8%）
Level 4	4 件（2.4%）
測定不能	33 件（19.5%）
拒否	39 件（23.1%）
同意取得**	4 件（2.4%）
審査結果	
承認	146 件（86.4%）
一部承認	5 件（3.0%）
同意取得	9 件（5.3%）
不承認	9 件（5.3%）
治療同意能力あり	4 件
身体状況の改善優先	2 件
代替治療で改善の可能性	2 件
申請された治療が禁忌	1 件

*1 例は 2 回の入院でそれぞれ 3 件と 5 件の審査を受けたため，両方の件数に計上されている．

**治療同意能力評価中に治療同意を表明されたため評価中止した例．

Table 2: Status of "compulsory treatment review" (n=169)

Number of reviews	169 cases
Cases undergoing multiple reviews	
2 cases	14 cases (12.0%)
3 cases	5 cases (4.3%)
4 cases	3 cases (2.6%)
5 cases	3 cases (2.6%)
8 cases	1 case (0.9%)
Number of reviews per person during the same hospitalization*	
1 case	130 cases
2 cases	10 cases
3 cases	2 cases
4 cases	2 cases
5 cases	1 case
Assessments on the psychiatric emergency ward	
	120 cases (71.0%)
Median (range) of time from admission to assessment	
	21 (0–1,716) days
Median (range) of time from application to assessment	
	1 (0–40) days
Competency assessment	
Level 0	14 cases (8.3%)
Level 1	58 cases (34.3%)
Level 2	14 cases (8.3%)
Level 3	3 cases (1.8%)
Level 4	4 cases (2.4%)
Unable to determine	33 cases (19.5%)
Refusal	39 cases (23.1%)
Consent obtained**	4 cases (2.4%)
Review results	
Approved	146 cases (86.4%)
Partially approved	5 cases (3.0%)
Consent obtained	9 cases (5.3%)
Not approved	9 cases (5.3%)
Competency confirmed	4 cases

Prioritizing improvement of physical condition	2 cases
Possibility of improvement with alternative treatment	2 cases
Contraindication for requested treatment	1 case

* One patient was hospitalized twice and underwent 3 and 5 reviews, respectively, so it is counted in both categories.
** Cases where the evaluation was discontinued because the patient gave consent during the competency assessment.

表３　SICIATRI-R 結果と非同意治療実施状況（n＝151）

	抑制下実施	非抑制下実施	未実施
Level 0（n＝14）	4（28.6%）	9（64.3%）	1（7.1%）
Level 1（n＝54）	14（25.9%）	29（53.7%）	11（20.4%）
Level 2（n＝12）	4（33.3%）	1（8.3%）	7（58.3%）
Level 3（n＝2）	0（0.0%）	2（100.0%）	0（0.0%）
測定不能（n＝33）	11（33.3%）	19（57.6%）	3（9.1%）
拒否（n＝36）	17（47.2%）	15（41.7%）	4（11.1%）
合計	50	75	26

Table 3: SICIATRI-R results and status of treatment without consent (n=151)

	Performed Under Restraint	Performed Without Restraint	Not Performed
Level 0 (n=14)	4 (28.6%)	9 (64.3%)	1 (7.1%)
Level 1 (n=54)	14 (25.9%)	29 (53.7%)	11 (20.4%)
Level 2 (n=12)	4 (33.3%)	1 (8.3%)	7 (58.3%)
Level 3 (n=2)	0 (0.0%)	2 (100.0%)	0 (0.0%)
Unable to measure (n=33)	11 (33.3%)	19 (57.6%)	3 (9.1%)
Refusal (n=36)	17 (47.2%)	15 (41.7%)	4 (11.1%)
Total	50	75	26

表 4　非同意治療の申請内容・審査結果・実施状況（n＝169）

	審査件数	審査結果				非同意治療実施状況		
		承認	一部承認	不承認	同意取得*	抑制下実施**	非抑制下実施	未実施
＜申請内容＞								
mECT	97	88	0	3	6	23	61	4
mECT＋PO	4	2	0	2	0	2	0	0
mECT＋SAI	5	4	0	0	1 SAI は未実施	1	1	2
mECT＋LAI	5	3	2 （mECT のみ承認 1， LAI のみ承認 1）	0	0	2	2	1
mECT＋貼付剤	1	1	0	0	0	1	0	0
mECT＋PO＋LAI	1	0	0	1	0	0	0	0
mECT＋PO＋SAI	2	2	0	0	0	1	1 PO 未実施	0
PO（徒手的）	1	0	0	1	0	0	0	0
PO（ベンゾジアゼピン鎮静下）	9	9	0	0	0	5	0	4
PO（胃管）	2	2	0	0	0	2	0	0
PO（非告知投薬）	1	1	0	0	0	0	1	0
SAI	20	20	0	0	0	6	2	12
LAI	14	10	0	2	2	5	4	1
PO（徒手的）＋SAI	1	1	0	0	0	1 PO 未実施	0	0
PO（胃管）＋SAI	1	1	0	0	0	0	0	1
PO（ベンゾジアゼピン鎮静）＋SAI	1	1	0	0	0	0	0	1
PO（ベンゾジアゼピン鎮静）＋LAI	1	1	0	0	0	0	1	0
SAI＋LAI	1	0	1 SAI のみ承認	0	0	1 SAI のみ施行	0	0
PO（非告知投薬）＋SAI＋貼付剤	1	0	1 貼付剤のみ承認	0	0	0	1	0
ベンゾジアゼピン鎮静＋SAI＋LAI	1	0	1 鎮静は不許可	0	0	0	1	0
合計	169	146	5	9	9	50	75	26
＜個別治療＞***								
mECT	115 (68.0%)	101 (87.8%)	—	7 (6.1%)	7 (6.1%)	30 (26.1%)	64 (55.7%)	7 (6.1%)
PO								
ベンゾジアゼピン鎮静下	11 (6.5%)	11 (100%)	—	0	0	1 (9.1%)	5 (45.5%)	5 (45.5%)
mECT 鎮静下	7 (4.1%)	4 (57.1%)	—	3 (42.9%)	0	1 (14.3%)	3 (42.9%)	0
胃管	3 (1.8%)	3 (100%)	—	0	0	2 (66.7%)	0	1 (33.3%)
非告知投与	2 (1.2%)	1 (50.0%)	—	1 (50.0%)	0	0	1 (50.0%)	0
徒手的	2 (1.2%)	1 (50.0%)	—	1 (50.0%)	0	1 (50.0%)	0	0
SAI	33 (19.5%)	31 (93.9%)	—	1 (3.0%)	1 (3.0%)	5 (15.2%)	10 (30.3%)	16 (48.5%)
LAI	23 (13.6%)	16 (69.6%)	—	5 (21.7%)	2 (8.7%)	8 (34.8%)	6 (26.1%)	2 (8.7%)
貼付剤	2 (1.2%)	2 (100%)	—	0	0	1 (50.0%)	1 (50.0%)	0

mECT：修正型電気けいれん療法，LAI：持効性抗精神病薬注射剤，PO：経口向精神薬，SAI：速効性抗精神病薬注射剤
*強制治療申請から治療実施までの間に同意を取得．
**徒手的に抑制もしくは薬物による鎮静を行ったうえで非同意治療実施．
***審査件数のパーセンテージは全審査件数（169 件）に対する割合，審査結果および非同意治療実施状況のパーセンテージは各個別治療の審査件数に対する割合．

Table 4: Application details, review results, and status of implementing involuntary treatment (n=169)

Number of reviews
Review results
 Approved
 Partially Approved
 Not Approved
 Consent Obtained*
Status of involuntary treatment implementation
 Performed Under Restraint**
 Performed Without Restraint
 Not Performed

<Application Details>
mECT
 97 88 0 3 6 23 61 4
mECT + PO
 4 2 0 2 0 2 0 0
mECT + SAI
 5 4 0 0 1 SAI not performed 1 1 2
mECT + LAI
 5 3 2 (1 approved for mECT only, 1 approved for LAI only) 0
 0 2 2 1
mECT + transdermal patch
 1 1 0 0 0 1 0 0
mECT + PO + LAI
 1 0 0 1 0 0 0 0
mECT + PO + SAI
 2 2 0 0 0 1 1 PO not performed 0
PO (manual restraint)
 1 0 0 1 0 0 0 0
PO (under benzodiazepine sedation)
 9 9 0 0 0 5 0 4
PO (nasogastric tube)
 2 2 0 0 0 2 0 0
PO (unannounced medication)
 1 1 0 0 0 0 1 0
SAI

20	20	0	0	0	6	2	12			
LAI										
14	10	0	2	2	5	4	1			
PO (manual) + SAI										
1	1	0	0	0	1 PO not performed			0	0	
PO (nasogastric tube) + SAI										
1	1	0	0	0	0	0	1			
PO (benzodiazepine sedation) + SAI										
1	1	0	0	0	0	0	1			
PO (benzodiazepine sedation) + LAI										
1	1	0	0	0	0	1	0			
SAI + LAI										
1	0	1 SAI only approved			0	0	1	SAI	only	performed
	0	0								
PO (non-disclosed medication) + SAI + transdermal patch										
1	0	1 Transdermal patch only approved					0	0	0	
	1	0								
Benzodiazepine sedation + SAI + LAI										
1	0	1 Sedation not permitted				0	0	0	1	
	0									
Total	169	146	5	9	9	50	75	26		

<Individual treatments>***

mECT						
115 (68.0%)	101 (87.8%)	—	7 (6.1%)	7 (6.1%)	30 (26.1%)	64 (55.7%) 7 (6.1%)
PO						
Under benzodiazepine sedation						
11 (6.5%)	11 (100%)	—	0	0	1 (9.1%)	5 (45.5%) 5 (45.5%)
Under mECT sedation						
7 (4.1%)	4 (57.1%)	—	3 (42.9%)	0	1 (14.3%)	3 (42.9%) 0
Nasogastric tube						
3 (1.8%)	3 (100%)	—	0	0	2 (66.7%)	0 1 (33.3%)

Non-disclosed administration						
2 (1.2%)	1 (50.0%)	—	1 (50.0%)	0	0	1 (50.0%)
0						
Manual						
2 (1.2%)	1 (50.0%)	—	1 (50.0%)	0	1	(50.0%)
0	0					
SAI						
33 (19.5%)	31 (93.9%)	—	1 (3.0%)	1 (3.0%)	5 (15.2%)	10
(30.3%)	16 (48.5%)					
LAI						
23 (13.6%)	16 (69.6%)	—	5 (21.7%)	2 (8.7%)	8	(34.8%)
6 (26.1%)	2 (8.7%)					
Transdermal patch						
2 (1.2%)	2 (100%)	—	0	0	1 (50.0%)	1 (50.0%)
0						

mECT: Modified electroconvulsive therapy; LAI: Long-acting injectable antipsychotic; PO: Oral psychotropic medication; SAI: Short-acting injectable antipsychotic

* Consent was obtained between the application for compulsory treatment and implementation of treatment.
** Treatment was performed without consent after manual restraint or sedation with medication.
*** The percentage of cases reviewed is the ratio of the total number of cases reviewed (169); percentages of review results and involuntary treatment implementation are the ratios of the number of cases reviewed for each individual treatment.