

## Forensic Psychiatric Patients: A Comparison between Hawaii and Japan

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This descriptive study investigated the characteristics of forensic patients hospitalized more than one year in a mental hospital in Tokyo and Hawaii. There were 64 Hawaiian and 30 Japanese subjects. Using a survey instrument the medical records were assessed for such factors as crime committed, nursing diagnoses, and reasons why the patients remain hospitalized. The study revealed Japan has more forensic patients who committed murder and their conditions are more unstable than the Hawaii patients. In Hawaii the patients tend to remain hospitalized because of a not guilty because of an insanity plea and in Japan because the patients are clinically unstable. An additional factor contributing to longer hospitalization in Japan is societal prejudice against the mentally ill. As in the US, Japanese physicians are also very cautious about evaluating patients' medical conditions since violent behavior is difficult to predict. In both countries there is a need for mental health programs capable of successfully managing patients who are clinically stable in community settings.

**Key Words :** Forensic psychiatric patients, Nursing care, Nursing diagnosis, Comparison between Hawaii and Japan

The land of the rising "sun" is in the mist of a community mental health movement seen in the United States nearly 30 years ago. As mandated by the Mental Health Law enacted in 1989, mental health treatment in Japan is beginning slowly to change from hospital-oriented care to community-based treatment. Despite the passage of this law the integration of psychiatric patients into the community has met with limited success.

While the number of inpatient beds has decreased in the past 20 years, the overall number of patients hospitalized has remained stable. Despite this downsizing Japan still has 1,673 psychiatric hospitals and 362,962 beds. In contrast, in the United States (US) with a population of approximately 220 million in 1995 there were 69,000 patients in public psychiatric beds (Butterfield, F., 1998). The average length of a stay in Japan for psychiatric patients exceeds 400 days. Attending physicians frequently do not obtain informed consent to treatments, medications, and other medical procedures (Ito, Iwasaki, Komine, 1997). They seldom prescribe the new atypical antipsychotic drugs. The Japan government has not approved the use of Clozapine in Japan and only in early 1997 did the Ministry of Health grant permission to prescribe Risperidone (Anders, et.al., 1997).

Quality control activities commonly found in the US are

mostly absent in Japanese psychiatric hospitals. This is ironic given the fact most of the quality management techniques employed in US institutions are derived from total quality management ideas well established in other industries in Japan. Only recently with support from the Japanese government, the Japan Medical Association, the Japan Hospital Association, and the Japanese Association of Psychiatric Hospitals was The Japan Council for Quality Health Care established (Ito, Iwasaki, Komine, 1997).

Primarily from a change in 1995 concerning Article 32 of the Mental Health Welfare Law the number of individuals receiving public assistance for mental illness has markedly increased. The 1995 revision encourages the development of community-based services such as dormitories, group homes, and sheltered workshops. The revision also provides for more community support activities for discharged patients and encourages families to assume responsibility for their care. It appears however, that this newly developed treatment option (which is quite limited) is benefiting primarily newly diagnosed patients with fewer severe psychiatric symptoms. It seems that few long-term hospitalized patients with severe and persistent mental illness can take advantage of these community-based services (Kokusho, H., Kawano, M., Mori, C., Anders, R. 1998).

Patients who have committed a crime while insane appear to have an even lower priority for the services under the 1995 Act. Forensic patients in Japan are rarely considered candidates for community placement. In part because of societal concerns about violence and the stigma of mental

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illness many of these patients spend years of their lives in locked psychiatric units (Fujii, Fukushima, & Yamamoto, 1993; Kawano, 1997; Ito, Iwasaki, & Komine, 1997).

In the United States attempts to integrate psychiatric patients into the community have been the accepted practice for a number of years. However, the integration of psychiatric patients who have committed a crime into the community has met with less success (Anders, R., 1995). The primary purpose of this study is to compare the characteristics of forensic psychiatric patients in Japan with those in Hawaii and to discuss the resulting policy implications.

### Japanese Literature

The Japanese literature concerning the management of hospitalized psychiatric patients who commit a crime while insane is limited. In Japan, the term Mentally Disordered Offenders (MDO) is applied to individuals who have committed a crime while mentally ill. The term applies to individuals charged with a crime (Xie and Yamagami, 1996).

Xie and Yamagami (1996) examined the records of all MDO in Japan who were acquitted, not prosecuted, or whose sentences were commuted by reasons of insanity during 1994. Of the 1,131 cases 159 had attempted to commit a homicide or had killed someone. Of this number 101 (63.5%) were men and 58 (36.5%) women. Twenty-nine or (18.5%) had received psychiatric treatment but had stopped treatment. Psychiatric outpatient care was being provided to 76 (48%) of the individuals when they committed their offense. Of the total 111 (70%) had no prior criminal record. Alarming however, was that in 1994, 13 individuals while in a psychiatric hospital committed a violent crime with 10 of them killing their fellow inpatients. Women primarily kill family members while men killed their parent ( $n=30$ ; 30.3%), an acquaintance ( $n=31$ ; 31.3%), or a stranger ( $n=15$ ; 13.1%). Most of the women ( $n=33$ ; 56.9%) killed their child.

Between 1980 and 1991 inquest (1996) followed all Japanese MDO patients. During this eleven-year period he reports that 21.8% ( $n=206$ ) of the 946 subjects were re-arrested one or more times. He found those individuals who received psychiatric treatment were less likely to commit another crime. However, for those individuals with a substance abuse diagnosis treatment there was no reduction in the number of crimes they committed. Inquest concludes by recommending that a comprehensive treatment program consisting of mandatory outpatient care, and support with activities of daily living be available. He also suggests long-term supervision protocols be developed to manage MDO patients.

In a 1993 study, Yamagami reported that 20% of all homicide convictions in Japan were MDO. His study covered MDO convictions between 1987 and 1991. In Yamagami's study 60% of the MDO were diagnosed as schizophrenics.

### United States Literature

In the US, the plight of the mentally ill who have committed a crime is similar to that found in Japan. Out of approximately the 200,000 individuals in US prisons, 1 out of 10 suffer from a serious mental illness. The rate is four times greater than in the general population. According to Laurie Flynn, executive director of the National Alliance for the Mentally Ill, Part of mental illness in America now is that you are going to get arrested. (Butterfield, F., 1998)

The US trend in the late 1960's to move patients from state hospitals to the community has resulted in many of the mentally patients being jailed for minor offenses. In most US states admission criteria for the existing long-term public hospital beds is so restrictive that most patients end up in jail. Judges are hesitant to grant bail to these individuals because of their need for special treatment. For example, mentally ill prisoners in New York City's jail stay incarcerated an average of 215 days while other prisoners are released within 42 days. The Los Angeles County jail houses between 1,500 to 1,700 mentally ill patients each day. Most of the prisoners have only committed minor offenses (Butterfield, F., 1998).

Some advocates for the mentally ill suggest the US is moving back to the trends in the early part of the 19<sup>th</sup> century when the mentally ill were kept in jails or locked up in asylums. Dorothea Dix, the mental health reformer, would undoubtedly be distressed to see how once again the US is placing the mentally ill in jails. Dr. E. Fuller Torrey, a noted expert on schizophrenia, states that: Criminalization has been both a personal disaster for the mentally ill, and an institutional disaster for the criminal justice system (Butterfield, F., 1998).

### Comparison between Japan and Hawaii

Previous published reports have shared the characteristics of Japanese subjects with a similar population in Hawaii (Anders, et al., 1997; Anders, et al., 1998). However, these studies did not report on the forensic characteristics of the Hawaii sample as compared with the Japanese patients. This report compares the characteristics of Japan and Hawaii forensic patients, focusing primarily on the implications of these findings for the management of patients in Japan. Because of space limitations the US forensic literature relevant to this comparison is not addressed. The reader is referred to previous publications which have addressed this issue (Anders, 1995; Anders, et.al, 1998). This current research provides a cross-cultural basis for exploring the crucial and often conflicting issues of least restrictive placement of long-term forensic psychiatric patients, the need to provide high quality nursing care for such patients, and the limited resources available for mental health care.

### Methods

This descriptive study surveyed forensically committed

patients who had been hospitalized more than one year in a 187 bed psychiatric hospital in Hawaii with those hospitalized in Japan in a 1,300 bed facility. The survey included 63 patients in Hawaii and 30 in Japan.

The survey assessed: nationality, gender, age, marital status, medical diagnosis, length of hospitalization, years of mental illness, treatment in the hospital, details of admission to the hospital, crimes committed, suicidal behavior, recent (within six months) violent behavior, and refusal to leave the hospital. The survey instrument was adapted from one developed by Barber and associates (1988). The Japanese version used a back translation technique and an expert panel review for content validity and reliability. Both locations conducted a pilot study with the instrument to insure the requested information could be obtained. Nurse researchers trained in the use of the instrument reviewed records of eligible patients at each respective study site. In Hawaii one researcher conducted the review while in Japan two individuals did the check. The Japanese researchers' inter-rater reliability was assessed in the beginning with a pilot sample and then throughout the data collection phase. The reliability coefficient averaged .096.

## Results

### Characteristics of Subjects

By ethnic origin, the surveyed samples in Japan were 96.7 % Japanese; in Hawaii 20.5% were Hawaiian, 19.3% Japanese, and 15.9% Caucasian. In Japan, 100% of the subjects were male, compared to 84.6% (n=53) in Hawaii. Japanese patients had a higher average age (47.5 years compared with 39.2 years in Hawaii  $p<0.001$ ). Ten percent (n=3) of the Japanese patients were married or had been married in the past, compared with 26% in Hawaii. (Table 1) Schizophrenia was the most common psychiatric diagnosis in both Japan and Hawaii. In Japan, however, the second most common medical diagnosis was chemical dependence, diagnosed in 40% (n=25) of the subjects. The second most common diagnosis among subjects in Hawaii was organic disorder. The period of illness averaged 17.2 years in Hawaii and 20.7 years in Japan. Length of hospitalization in Japan was longer, at 8.3 years, compared with 5.2 years in Hawaii ( $p<0.001$ ).

### Convictions

Murder was the most common crime by patients in both groups. However, 60% (n=18) of the patients in Japan committed murder, and 38.1% (n=24) of the subjects in Hawaii committed murder or attempted murder ( $p<0.01$ ). Patients whose crimes involved violence and force totaled 30% (n=9) in Japan; 25.4% (n=16) in Hawaii. In addition, 6.7% (n=2) of the patients in Japan had committed burglary, compared with 17.5% (n=11) in Hawaii. The Hawaiian subjects had also been involved in crimes such fraud,

kidnapping, drunken driving, and harassment (Table 2).

### Violent Behavior and Reasons for Continued Hospitalization

Past violent behavior was observed in 63.3% (n=19) of the subjects in Japan, compared with 17% of those in Hawaii. However, the figures are much closer for those who had committed violent acts within the past six months, 18.2% (n=5) in Japan and 13.6% (n=8) in Hawaii.

In Hawaii, 75.9% (n=48) of the patients stayed in the hospital because they had been found not guilty of crimes because of insanity. However, only 13.3% (n=4) of the patients in Japan cited this reason ( $p<0.001$ ). The main reason (76.6%;n=23) for subjects in Japan remaining in the hospital is the danger that they would injure themselves or someone else. This reason was cited by only 8.4% (n=5) of the time in Hawaii ( $p<0.001$ ). In addition, 66.7% (n=20) of patients in Japan could not live independently although their conditions had stabilized ( $p<0.001$ ). Sixty percent (n=18) ( $p<0.01$ ) had not shown enough improvement. These figures suggest that many patients in Japan did not improve during the hospitalization. Finally, 33.3% (n=10) of patients in Japan did not have a home where they could stay in their local community, compared with 14.5% (n=9) in Hawaii.

### Nursing Diagnosis

A comparison of the current condition of the legally committed patients according to the North American Nursing Diagnosis Association (NANDA) was done (Bowles, K. and Naylor, M. 1996). The review found the most common diagnosis to be abnormality in the thinking process (28.4%; n=18) in Hawaii, followed by the lack of individual coping skills (23.9%; n=15). In addition, 8% (n=5) of the patients had no nursing diagnosis.

In Japan, the most common diagnosis was the high risk of violent behavior (43.3%; n=13). Abnormality in the thinking process was present in 37% (n=11) of the patients while 3.3% (n=1) had no diagnosis. High risk for violent behavior in Hawaii was 9.1% (n=6), less than Japan. Subjects in both Hawaii and Japan had several different nursing diagnoses.

## Discussion

### Characteristics of Legally Committed Patients

No women were in the Japan sample. This is a surprising finding given that Xie and Yamagami (1996) found in their review of MDO records 58 women (more than 36% of the sample) had attempted or committed a murder. They suggest that while women had fewer arrests than men they committed violent crimes at a rate higher than men.

Unlike the Japan subjects ethnic origins of forensically committed patients in Hawaii varied. As reported earlier Hawaiians were over represented in the public psychiatric hospital while Caucasians on the other hand were under

**Table 1 Characteristics of Subjects**

	Japan (n=30)	State of Hawaii (n=64)	Significant Probability
Ethnicity	Japanese 96.7% Korean 3.3%	Hawaiian 20.5% Japanese 19.3% Caucasian 16.9% Filipino 13.3% Others 3.6%	
Gender			
Male	100%	84.6%	ns
Average Age	45.7 Years	39.2 Years	***
Length of Illness (Average)	20.7 Years	17.2 Years	**
Hospitalization	8.3 Years	5.2 Years	***
Education	10.5 Years	11.6 Years	ns
Marriage	10%	26.0%	ns

\*\*\* p<0.001    \*\*p<0.01

**Table 2 Crime Committed**

	Japan (n=30)	State of Hawaii (n=64)	Significant Probability
Murder	60.0%	38.1%	***
Violence or Force	63.3%	25.4%	***
Robbery	20.0%	11.1%	
Rape	0	2.4%	
Arson	0	6.7%	
Burglary	6.7%	11.1%	
Others	16.7%	21.7%	

\*\*\* p< 0.001

Note Total is not 100% since some subjects committed multiple crimes

represented (Anders, 1995; Olson and Anders, 1997). The Japanese patients were older than those in Hawaii and were hospitalized longer. They also were less likely to have been married.

### **Barriers to Discharge**

Most of the patients were diagnosed as schizophrenia. This finding is similar to those reported by Barber and associates (1988) who also found schizophrenic patients accounted for most of long-term hospitalized patients. Clearly patients in both settings who have committed crimes are subject to much greater length of hospitalization than patients as a whole. The average length of a stay in Hawaii for patients admitted to the hospital with schizophrenia in 1994 was 11 days while in Japan the stay was 120 days (Anders, et al, 1998). For patients in this study the length of a stay was much higher: 5.2 years for patients in Hawaii and 8.3 years in Japan. Forensic patients in both locations are faced with extended hospitalizations.

While the Japanese patients in this study may be clinically less stable than those in Hawaii (Anders, et al, 1998) it is uncertain if the availability of aftercare facilities would decrease the need for acute hospitalization. In both Japan and Hawaii there apparently continues to be the belief that mentally persons can be potentially dangerous violent criminals and society needs the protection that hospitalization affords (Anders, 1995; Xie and Yamagami, 1996; Inoue, 1996). This belief continues although in this study less than 2% (n=2) of the forensic patients were involved in any type of violent behavior after less than six months of hospitalization.

### **Nursing Implications**

If the forensic patients identified in this study are going to be able to rejoin society in a lesser restrictive environment they will need among other things psychosocial rehabilitation. In Japan the challenge of treating difficult patients was addressed in a report published in March of 1992 (Kokusho, H., Kawano, M., Mori, C., Anders, R. 1998). The Report on the Medical Treatment of Mentally Ill Persons recommends that experts in treating complex patients focus more services for these difficult patients. The report criticized psychiatric facilities for focusing primarily on treating short-term acute patients while not addressing the needs of the long-term patients who are often difficult to treat. A complicating factor for long-term forensic patients is that most psychiatric hospitals in Japan do not have specialized treatment programs for them.

### **Social Support**

Given the societal pressures in Japan to keep psychiatric patients charged under the MDO statues in the hospital, few patients can move to a lesser restrictive environment. Two of

the long-term Japanese patients included in this study were discharged after the data collection phase of this study had been conducted. One patient who was clinically stable was discharged to live with relatives. The discharge was approved however, only after the detective in charge of the case testified in support of the release. One patient's wife agreed to have him return home with her. Without sponsorship neither of these patients would have returned to the community.

In Japan one primary criteria for release from the hospital is the availability of a stable home. Compared with Hawaii, Japan has many legally committed patients who cannot leave the hospital because of the lack of housing and community support services. If the patient does not have housing renting an apartment is challenging. At the time an individual signs a rental agreement he is required to pay the landlord a refundable deposit equivalent to another 2-3 months' rent. In addition, he will need to pay the real estate office a fee equivalent to one month's rent. Furthermore, Japanese houses and apartments normally come unfurnished. Thus without some type of housing support it is virtually impossible for most long-term patients to live independently.

As mentioned previously in Japan and somewhat in Hawaii there is a deep rooted societal pressure to keep psychiatric patients, in particular those who have committed a crime, hospitalized (Fujii, Fukushima & Yamamoto, 1993; Xie & Yamagami, 1996). The ethical question of treating patients in less restrictive environment is only now beginning to be addressed in Japan (Ito, Iwasaki & Komine, 1997). While it is not possible to predict with 100% accuracy a patient's potential for further violence or criminal behavior it is essential that guidelines that reduce the risk be developed.

As documented by Xie and Yamagami (1996) untreated psychiatric patients who have previously committed a crime are more likely again to become involved in the criminal justice system. Forensic patients who have housing, social supports, and court supervised outpatient treatment are less likely to commit another crime. In order to discharge these patients to less restrictive settings these supports need to be available.

In Japan steps are beginning to be made to include community-based services for the serious and persistently mentally ill. However, the funding for these activities remains limited. Hospitals are paid through a fee-for-service system. Thus, hospitals have no economic incentive to move long-term patients into a less acute setting. According to Dr. Eiki Makino (1997) of the Japan Hospital Association abuse of services is inherent in the fee-for-service system. The primary targets for misuse are drugs, laboratory tests, and the length of a hospital stay.

In Japan pharmaceutical pricing is fixed by a central pricing system. The charges for drugs are higher than the international standard and the availability of newer drugs, particularly the new atypical drugs for psychiatric patients are

very limited. There is some movement to abolish the central pricing system and move to a free market approach (Makino, 1997).

Given the medical care costs in Japan are continuing to rise 6% to 7% per year while real personal income is only rising 1% the government is seeking solutions to control health care costs. In May of 1997 the National Diet (Japanese congress) took the first step in addressing the problems by increasing patients' co-payment. In some government hospitals a pilot Diagnostic Related Grouping (DRG) payment system is being started (Makino, 1997). The impact of the co-payment and a DRG system for the serious and persistent mentally ill particular those who have committed a crime is unclear. Given that most of these patients once they are discharged from the hospital must rely upon government welfare payments for subsistence, the adding of a co-payment will probably have a significant impact on their ability to receive psychiatric treatment.

The challenges for managing the forensic psychiatric patient are many. The societal stigma against the mentally ill, the difficulty in treating mental illness, the inability to predict future criminal activity, the limited financial resources, and the lack of adequate support systems in the community all contribute to the challenge of moving these patients into community settings. As the storm clouds of change beginning to form in Japan perhaps there is hope that in the not-to-distance future the "sun" will again rise for these individuals.

In Hawaii the situation is somewhat similar. There are inadequate numbers of beds for long-term psychiatric patients. Many of the patients end up in the state prison system. A fortunate few are eventually sent to the state's only forensic hospital. However, that facility remains under US Federal Court supervision for abuses of patients' civil rights. The possibility of a better future for forensic patients in both Hawaii and Japan is cloudy. In both countries there is a need for mental health programs capable of successfully managing patients who are clinically stable in community settings. Changes in public policy concerning health care for the serious and persistently mentally ill are urgently needed. Without such changes and a significant commitment of resources these patients' care may continue to be compromised.

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