—Review—

Current Situation and Future Tasks for Psychiatric Services in Japanese Prisons

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Abstract

I outline the current situation and future tasks for psychiatric services in Japanese prisons. I describe the provision of facilities specializing in psychiatric services, preparation of legal aspects related to involuntary treatment, provision of therapeutic educational programs regarding addictive crimes, and the measures required for continuation of treatment after release from prison. I also discuss how, in the current system, under the "Act on Mental Care and Treatment for Persons who have Caused Serious Cases under the Condition of Insanity," unfairness arises in the treatment of mentally disordered offenders, requiring a division between medical care and justice (correctional institutions).

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Key words: mentally disordered offender, psychiatric services in prisons, forensic psychiatry, medical prison, Mental Treatment and Supervision Act

Introduction

In Japan, as well as in Western countries, in cases evaluated lacking criminal responsibility is found to be absent, the person in question will not be prosecuted, will not be found guilty in court, and will not be sent to prison (Article 39 of the Criminal Law). However, a considerable number of patients with schizophrenia, bipolar disorders, of other forms of mental disorders are now imprisoned. According to the white paper on crime for 2006, 2,151 (6.6%) of the 32,789 newly imprisoned persons in that year were considered to have mental disorders[1].

According to the white paper on crime for 2008, the number of inmates nationwide in Japan was approximately 80,000[2]. If 6.6% of these people have mental disorders, more than 5,000 mentally disordered persons would be imprisoned. This figure significantly exceeds the number of people treated according to the Act on Mental Care and Treatment for Persons who have Caused Serious Cases under the Condition of Insanity (hereafter, "the Mental Treatment and Supervision Act") and, thus, clearly indicates that the consideration of treatment of mentally disordered offenders in correctional institutions, especially in prisons, cannot be overlooked. Nevertheless, although the poor psychiatric services provided in prisons has been the subject of critical discussions[3–7], the situation is rarely presented in a proper manner[8–18].

After the Mental Treatment and Supervision Act was enacted in 2005, discussions of forensic psychiatry tended to concentrate on this law. However, because the Mental Treatment and Supervision Act represents just one part of the treatment of mentally disordered offenders, the tendency to limit the discussion of forensic

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psychiatry to this law is inappropriate. Representative European and American textbooks of psychiatry and texts on forensic psychiatry have described psychiatric treatment in correctional institutions[19–26], and monographs for the personnel employed in correctional institutions have been published[27]. However, in Japan, psychiatric treatment in correctional institutions is poorly covered by textbooks of psychiatry and even by references of forensic psychiatry. Thus, in the present paper I summarize the various problems related to psychiatric treatment in correctional institutions, in particular, psychiatric services in prisons, and give an outlook for the future.

Psychiatric Services in Prisons

Correctional institutions for adults are divided into detention houses (jails) for people with pending sentences or confirmed capital sentences on one hand and prisons for people who have been sentenced to penal servitude. Throughout the country there are 7 detention houses, 107 branch detention houses, 59 prisons, and 8 juvenile prisons. The various institutions each have infirmaries (departments), where physicians and co-medical staff members are employed. Moreover, in recent years Private Finance Initiative prisons run jointly by the state and the private sector have been established. These institutions commission medical services from the private sector.

A large number of prisoners wish to receive psychiatric care, but providing them with comprehensive medical care is difficult. A prison is an institution that has the purpose of carrying out sentences, and as long as the inmates adapt sufficiently to life in prison for the term of their sentence, medical care will not be performed unless there is an explicit request from the inmate. For this reason, for example, the negative symptoms of inmates with schizophrenia are often overlooked.

Although it is necessary to educate the prison officers to understand mental disorders, it is more important to improve the comprehensiveness of the psychiatric services. Increasing the quota of prison officers and medical staff is necessary to avoid overlooking the need for psychiatric services. While commissioning the tasks to the private sector could possibly improve the situation, there is also a possibility of the situation worsening[28,29].

Problems Related to Medical Prisons

Inmates of general prisons who are observed to have obvious psychiatric problems are transferred to medical prisons. In Japan there are 4 medical prisons, 2 of which are institutions specializing in psychiatry. If the treatment of inmates proves to be difficult in general prisons, they are transferred to these medical prisons for treatment.

I was affiliated with the Hachioji Medical Prison, which is the most important medical correctional institution in Japan. It was specifically designed for this purpose by the Ministry of Health, Labor and Welfare, and inmates requiring specialized general or psychiatric services are transferred here from all over the country. The number of psychiatric patients is usually about 70, and the institution accepts patients with schizophrenia, mood disorders, drug-induced mental disorders, prison reaction, refractory epilepsy, or organic mental disorders, including dementia, eating disorders, various psychogenic disorders, and developmental disorders. Many of these patients have extremely severe symptoms or complications (comorbidity) with personality disorders or both.

The treatment of acute psychiatric disorders in these medical prisons is not very different from that in general psychiatric hospitals. The psychiatric services in medical prisons are constantly improved on the basis of considerations of standards of general medical care. For example, in the Hachioji Medical Prison multiple selective serotonin reuptake inhibitors and serotonin-dopamine antagonists are used, and modified electroconvulsive therapy is performed with pulse generators (thymatron).

Various problems in the medical care environment of medical prisons arise once the acute phase has passed. In cases of acute confusion following prison reactions or as sequelae of psychostimulant abuse, work within the institution becomes possible when the symptoms decrease, which also makes it possible to return the inmates to general prisons. However, for the required psychiatric rehabilitation following a suitable break in the treatment of the acute phase, there are limits to the medical prison, which is still a

prison and lacks sufficient functionality. In medical prisons in Japan rehabilitation programs are implemented during the chronic phase for patients with schizophrenia, dementia, or mental retardation. In this program 5 to 8 persons who cannot participate in plant work are gathered and perform light work or engage in games under the supervision of nurses and prison officers are instructed by an occupational therapist. Each of these activities has a certain effect, but improvements in quality and quantity are still needed. For this purpose it is essential to increase the number of personnel[14].

One significant problem in relation to the psychiatric services in prisons is the insufficient number of beds in medical prisons. In many cases inmates are waiting for transfer to a medical prison, which often requires a considerable amount of time. For this reason, during emergencies it is necessary to admit patients to hospitals near the prison. If patients serving their sentences are hospitalized, legal procedures for transferring them outside the prison are required, and several prison officers must accompany them as guards. In addition, because the treatment lies outside the services covered by health insurances, the large associated expenses may be a barrier to treatment. For these reasons therapeutic interventions are frequently postponed. It would be preferable for medical prisons to always maintain a certain number of free beds, but the current situation does not allow this type of surplus[7,14,15].

Involuntary Treatment

Prison officers or medical staff recommend examinations for inmates continuing to refuse food for several days or displaying obviously eccentric behavior. Sometimes the inmates follow these recommendations but do not always do so, If they refuse examination, the patients must be kept under observation, but if marked loss of body weight, self-mutilation, disruptive behavior, such as shouting and damaging property, continue, the situation cannot be left unaddressed. In cases of schizophrenia, bipolar disorders, substance abuse disorders, anorexia nervosa, or prison reaction, mental symptoms mentioned above can develop, and then, involuntary treatment must be performed[14,15].

Such treatments are implemented under the stipulations of the Mental Health and Welfare Law, but in correctional institutions where the Mental Health and Welfare Law does not apply, the legal basis for the implementation of psychiatric treatment is very important to address both inappropriate and insufficient treatment. In the current situation, psychiatrists working at correctional institutions hesitate to intervene and, thus, tend to administer treatment only halfheartedly. The revision of the law in 2006 clearly states that forced intervention is possible if there are threats to life, but regarding intervention in cases of mental symptoms, the relevant legal improvements are still lacking. With reference to the standards of the United Nations or the task force of the American Psychiatric Association, the preparation of guidelines pertaining to involuntary treatment in correctional institutions in Japan is also desirable. This is an urgent task[30–35].

Therapeutic Education Regarding Addictive Crimes

Drug abuse, sexual crimes, arson, and some cases of habitual theft (kleptomania) have strong addictive characteristics. In a narrow sense, these are not psychiatric disorders, and pharmacologic therapy cannot be expected to be effective, but both addiction and dependence could, in a broad sense, be considered to be the subject of psychiatric treatment.

Regarding these crimes, prisons have implemented therapeutic educational programs in their educational sections. In recent years, the therapy and education of habitual sexual offenders in correctional institutions has attracted much social attention, so that the relevant therapeutic educational programs for sexual crimes are being expanded. These efforts have just begun, but, with the accumulation of further experience, improvements in the effects of this therapeutic education can be expected in the future[36–38].

It should be noted that the latest revision of the law makes it compulsory for sexual offenders to undergo therapeutic education. Psychiatric treatment can now be considered to be integrated

into the conventional punishment that used to consist only of penal servitude and imprisonment. However, for the treatment of addiction or dependence the therapeutic motivation of the person concerned is very important, so that passive participation in the therapeutic educational program as a part of the sentence is unlikely to have a significant effect. Regarding the question of how to increase the therapeutic motivation, systems, such as drug courts, should be referred to, and further improvements are still needed[14,16].

Ensure the Continuity of Treatment

When the inmates have completed their sentence, they are released from prison regardless of their condition. In general, inmates who have undergone psychiatric treatment cannot effectively serve their sentence, so they cannot be released on parole and are released only after serving their sentence without probation. Unfortunately, only a minority of inmates are met on their day of release by family members or friends, and many of these patients return to society on their own. For example, although many psychiatric patients released from the Hachioji Medical Prison need continuous treatment, there is a very high risk of cessation of treatment because of the problems of therapeutic motivation and medical expenses. Inmates sentenced for violent crimes are included in those for whom cessation of treatment is associated with a high risk of recidivism[39].

Article 26 of the Mental Health and Welfare Law requires that the institution director report when persons with mental disorders are released. At the Hachioji Medical Prison we comply with this law and inform the various self-governing bodies when persons with mental disorders are released. When the self-governing bodies receive these notifications, psychiatric evidence is requested for involuntary hospitalization ordered by prefectural governors when necessary. But the officers of some self-governing bodies seldom carry out the psychiatric evidence for inquiring the necessity of involuntary hospitalization by legal control. Almost all of psychiatrists working at correctional institutions can not understand the reason why their notifications are ignored.

According to an investigation of inmates released from the psychiatric department at the Hachioji Medical Prison after completing their sentences, about 40% of inmates were strongly recommended to undergo examination by the physician in charge to determine the appropriateness for an admission by legal control, but examinations were actually performed in only about 20% of the cases. The reason for this difference can be attributed to the discrepancy in evaluation between the high possibility of discontinuing treatment after release from prison and the high risk in the near future of committing a crime[39]. According to the Mental Health and Welfare Law the involuntary hospitalization ordered by a prefectural governor is based on an evaluation of the risk of self-harm or violence at the time of the examination, so that the risk for the near future is not the subject of this evaluation. Therefore, current implementation may not propose any legal problem. However, in light of the extremely high risk of subsequent offenses because of treatment interruption and because Article 26 of the Mental Health and Welfare Law is the only legal regulation that guarantees continued treatment of inmates, the present situation cannot be considered satisfactory.

However, from the point of view of the inmates, continued admission by legal control following their release after completion of their sentences can only be considered double punishment. The implementation of this law therefore needs further deliberation[39–42].

Mental Treatment and Supervision Act and Diversion System

Regarding the effect the enactment of the Mental Treatment and Supervision Act has had on psychiatric services in correctional institutions, definite statements are currently not possible. In the future, based on the assumption that the application of the Mental Treatment and Supervision Act will lead to more cases of nonprosecution, its enactment could possibly result in a decrease in the number of people with mental disorders detained in correctional institutions. On the other hand, the general consensus is that “offenders should take responsibility for the results of their actions

regardless of the degree of their mental disorder." Moreover, with the introduction of the citizen judge system, it remains to be seen how the results of psychiatric evidence will be evaluated. It is difficult to accurately predict whether the range of application of irresponsibility will, in the future, be either expanded or narrowed.

As a person involved in correctional medicine, I feel there is inconsistency in the following situation. Patients who have committed the same crime and suffer from the same condition are judged, in some cases, as not guilty (because of lack of criminal responsibility) and are, therefore, treated in forensic psychiatric wards for which an enormous budget is given, whereas in other cases, these patients are found guilty and, thus, must serve a sentence. In the present system psychiatric evidence tends to be performed depending on the severity of the incident, its topicality, and the financial power of the perpetrator. The result is that patients with mild conditions who have committed serious crimes are treated in a medical setting, whereas patients with severe symptoms of schizophrenia who have committed less serious offenses must serve sentences, thus be treated in prisons. Moreover, in Japan the treatment of mentally disordered offenders is channeled at the start through filters into medical (hospital) or judicatory (correctional institutions), and once the site of the treatment has been decided, it will not be changed. This situation was not changed even after the implementation of the Mental Treatment and Supervision Act. If the mental condition of the patients worsens within the correctional institution, there is a possibility of suspension of the sentence, but the decision is left to the prosecutor, and cases in which the sentence were actually suspended are rare. Yet, with the advancing age of inmates, the degree of independence they have in their daily life decreases, and, not infrequently, inmates are cared for by the prison officers, even while serving their sentences[43–45]. The number of patients with dementia is also increasing. Carrying out the sentence is impossible for these patients, and, thus, the meaning of being sentenced decreases significantly. Thus, a system is required that allows suspension of the sentence and a connection to medical and welfare services.

In my opinion, resolution of this injustice and unfairness requires that the application range for irresponsibility is strictly observed[46], and the principle of treatment in judicial (correctional) institutions should also be observed, with a diversion system between medical and correctional institutions. For this purpose relevant legal improvements are required, and for the treatment of inmates with mental disorders some new medical facilities are also necessary. The British system and systems in other countries may serve as references[47,48]. The implementation of these measures requires a rather long-term outlook. In the meantime, improvement of medical prisons would be the realistic measure.

The resolution of the three tasks—"administering appropriate treatment for medical conditions", "assessing penalties for crimes", and "preventing repeat offences"—which tend to be contradictory, will require considerable further improvements of the system.

References

1. Research and Training Institute of the Ministry of Justice, ed: White paper on crime for 2006, 2006; Tokyo.
2. Research and Training Institute of the Ministry of Justice, ed: White paper on crime for 2008, 2008; Tokyo.
3. Ando K, Okada T: Treatment of mentally disordered offenders in the judicial system. In Forensic psychiatry, 5: 2006; pp 50–60, Nakayama Shoten, Tokyo.
4. Committee for psychiatric health of the Fukuoka prefecture Bar Association, ed: Treatment of mentally disordered offenders and improvements in psychiatric care, 2002; Akashi Shoten, Tokyo.
5. Hirata T, Nakajima S, Yoshioka R, et al.: Simple diagnosis and current state of psychiatric care in correctional institutions. Journal of the Japanese Society of Psychiatry and Neurology 2004; 106: 1539–1582.
6. Nakajima N: Psychiatric care in detention houses and general prisons. Psychiatry 2002; 4: 22–30.
7. Nakajima N: Crime and forensic psychiatry, 2008; Hihyousha, Tokyo.
8. Fukushima Y: Current situation and tasks of correctional medical care. The Japanese Journal of Correction 2007; 118: 24–33.
9. Hayashi K: Research into Forensic Psychiatry—psychiatric evidence and correctional medical care, 2001; Shinko Igaku Publications, Tokyo.
10. Itoi K: Correcational Medicine, 1992; Correctional Association, Tokyo.
11. Itoi K, Iwahori T: Mental health considerations in correctional institutions. In Psychiatry MOOK

(Shimazono Y, ed), 17: 1987; pp 175–184.
12. Kurihara T: Psychiatric care in correctional institutions; of Modern Psychiatry, 24: 1976; pp 473–479, Nakayama Shoten, Tokyo.
13. The Japanese Association of Correctional Medicine, ed: text: Correctional Medicine, 52: 2003; Correctional Medicine.
14. Nomura T, Iwahori T: Task and future of treatment in correctional institutions. Science of the mind 2007; 132: 63–67.
15. Nomura T, Okumura Y: Clinical psychiatry of delinquency and crime, 2007; Seiwa Shoten, Tokyo.
16. Okumura Y, Nomura T, eds: Clinics of forensic psychiatry. In Clinics of the mind a la carte, 24: 2005; Seiwa Shoten.
17. Ohashi H: Recollections and prospects pertaining correctional medicine in general prisons. Correctional Medicine 1989; 37: 108–116.
18. Ohashi H: History and current situation of correctional medicine. In Forensic Psychiatry, 1: 2006; pp 167–184, Nakayama Shoten, Tokyo.
19. Kaplan BJ, Sadock VA: Kaplan & Sadock's Synopsis of Psychiatry, 9ed. 2003; Lippincott Williams & Wilkins, Philadelphia.
20. Halleck SL: The Mentally Disordered Offender, 1987; American Psychiatric Press, Washington.
21. Rosner R, ed: Principles of Practice of Forensic Psychiatry 2ed, 2003; Arnold, NY.
22. Simon RI, Gold LH: Textbook of Forensic Psychiatry, 2004; American Psychiatric Publishing, Washington, DC.
23. Wettstein RW, ed: Treatment of Offenders with Mental Disorders, 1998; The Guilford Press, NY.
24. Metzner JL: Guidelines for psychiatric services in prisons. Criminal Behavior and Mental Health 1993; 3: 252–267.
25. Steadman H, McCarty DW, Morrissey JP: The Mentally Ill in Jail, 1989; The Guilford Press, NY.
26. Gunn J: Future Directions for treatment in forensic psychiatry. British J of Psychiatry 2000; 176: 332–338.
27. Wool R, Pont J: Prison Health, A Guide for Health Care Practitioners Prison, 2001; Quay Books, London.
28. Dovis AY: Are Prisons obsolete? 2003; Seven Stories Press, NY.
29. Tsutumi M: The great nation of poverty America, 2008; Iwanami Shoten, Tokyo.
30. Kuroda O: Current situation and problems of psychiatric care in medical prisons. Psychiatry 2002; 4: 8–21.
31. Takiguchi N, Ishikawa Y: The right to refuse medical care of inmates with mental disorders and therapies reflection the intentions of the person in question. In Compulsory treatment of persons with mental disorders (Nishiyama S, ed), 1994; Kongo Shuppan, Tokyo.
32. American Psychiatric Association: Psychiatric Services in Jails and Prisons (2ed.), 2000; American Psychiatric Association, Washington, DC.
33. Nakayama K: On the "Various principles pertaining to the protection of persons with mental illnesses and reform of mental health services" (United Nations Commission on Human Rights, draft by the work group). Psychiatria et Neurologia Japonica 1991; 93: 266–283.
34. Nakayama K: "Various principles pertaining to the protection of persons with mental illnesses and reform of mental health services" (decision by the general assembly of the UN; 1991.12.17). Psychiatria et Neurologia Japonica 1992; 94: 386–387.
35. Saito M: Human rights of patients with mental illnesses as defined by the United Nations and the Japanese Mental Health and Welfare Law. In Lectures in clinical psychiatry, 19: 1997; pp 143–155, Nakayama Shoten, Tokyo.
36. Fujioka J: Group psychotherapy for drug abusers in juvenile prisons. In Clinical Practice of Juvenile delinquency (Ikushima H, Muramatsu H, eds), 1998; Kongo Shuppan, Tokyo.
37. Nomura T, Matsumoto S: Research into group psychotherapy for juvenile drug abusers; 2002, Collection of essays from the Yasuda Life Insurance Corporation 2003; 173–180.
38. Shudo J: Therapeutic education regarding sexual offenses. In Clinical psychiatry of delinquency and crime (Nomura T, Okumura Y, eds), 2007; pp 67–81, Seiwa Shoten, Tokyo.
39. Nomura T, Okumura Y, Matsumoto S, Harada K: Study pertaining to the appropriate implementation of the announcement of Article 26; Ancillary research by the Ministry of Health and Welfare; chief researcher Itaru Tominaga: Research into the cooperation between various institutions regarding the significance of reducing drugs; 2008.
40. Douglas KS, Webster CD, Hart SD: HCR-20, Violence Risk Management Companion Guide. In The Mental Health, Law, and Policy Institute, 2001; Simon Frazer University, London.
41. Webster CD, Douglas KS, Evans D, Hart SD: HCR-20, Assessing Risk for Violence; Version 2. In The Mental Health, Law, and Policy Institute, 1997; Siomon Frazer University, London.
42. Nakajima N: Problems of article 26 of the Mental Health and Welfare Law (report by directors of correctional institutions). Psychiatria et Neurologia Japonica 2001; 103: 1103–1104.
43. Yamamoto J: Prison notes, 2003; POPLAR Publishing, Tokyo.
44. Yamamoto J: Handicapped repeated offenders, 2006; Shinchosha, Tokyo.
45. Hamai K: Prison scenes, 2006; Nippon Hyoronsha, Tokyo.
46. Itoi K: Psychiatric evidence as viewed from correctional institutions. In Criminal responsibility of persons with mental disorders (Nakatani Y, ed), 1993; pp 269–289, Kongo Shuppan, Tokyo.
47. Igarashi S: Treatment of mentally disordered offenders. In Lectures in clinical psychiatry, 19: 1998; pp 406–420, Nakayama Shoten, Tokyo.
48. Igarashi S: History and current situation in England. In Outline of forensic psychiatry (Matsushita M, editor in chief), 2006; pp 94–119, Nakayama Shoten, Tokyo.

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