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メタデータ	言語: en 出版者: Wolters Kluwer Health, Inc. 公開日: 2022-06-16 キーワード (Ja): キーワード (En): 作成者: 恒松, 佳代子, 福本, 優子, 柳井, 圭子 メールアドレス: 所属:
URL	https://jrckicn.repo.nii.ac.jp/records/824

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Original Article

OPEN

Ethical Issues Encountered by Forensic Psychiatric Nurses in Japan

Kayoko Tsunematsu, RN, MSN[1], Yuko Fukumoto, RN, MSN[2], and Keiko Yanai, RN, PhD[2]

Background: Criminals in Japan with mental disorders face penal servitude in prison or treatment under the Medical Treatment and Supervision Act, depending on their ability to take responsibility for their criminal acts. Forensic psychiatric nurses caring for this group may face various ethical issues.
Objective: This study aimed to identify ethical issues forensic psychiatric nurses in Japan encountered.
Method: We used the Ethical Issues Scale to conduct a survey among forensic healthcare ward nurses and analyzed the data using descriptive statistics. We also conducted semistructured interviews with individual nurses who provided signed consent and responded to the initial survey on ethical issues they encountered. These data were analyzed using Berelson's content analysis.
Results: Of 175 nurses, 131 answered our survey. The most frequently encountered ethical issue was "protecting patients' rights and human dignity," and the most disturbing ethical issue was "providing nursing care with possible health risks." Seventy-seven percent of the nurses chose to discuss with peers when resolving the ethical issues. Seventeen nurses who were interviewed described these forensic psychiatric nursing-related ethical distresses and conflicts: difficulty in discharge management, prevention of violence and self-harm, compulsory treatment, patient care, and negative emotions toward patient.
Conclusion: Forensic psychiatric nurses in Japan face difficulties regarding respecting patients' rights. They strive to respect patients' rights by using their expertise as nurses while sharing their difficulties with colleagues. It is important to develop a support system for social reintegration to solve ethical issues.

KEY WORDS:
Ethical conflict; ethical distress; ethical issues; forensic nurses; forensic psychiatric nursing

Between 2006 and 2016, the Japanese arrest rate decreased by approximately 1,400,000. Among the total arrest cases, the proportion of people with diagnosed and suspected mental disorders increased from 0.8% to approximately 2% (Ministry of Justice, 2008, 2017). The treatment of individuals diagnosed with mental disorders who have committed criminal acts differs greatly, depending on a prosecutorial psychiatric assessment's determination of their capacity for liability. Some may be prosecuted and sentenced to prison if it is determined they possess the capacity for liability. Otherwise, people assessed to be in a state of mental insanity, or who had diminished capacity at

Author Affiliations: *[1]Kumamoto Health Science University and [2]Japanese Red Cross Kyushu International College of Nursing.*

The authors declare no conflict of interest.

Correspondence: *Kayoko Tsunematsu, RN, MSN, Kumamoto Health Science University, 325 Izumimachi Kita-ku, Kumamoto 861-5598, Japan. E-mail: buzzurg1995@gmail.com.*

Supplemental digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal's website (www.journalforensicnursing.com).

This work was supported by a JSPS KAKENHI Grant Number 26463228.
Received November 1, 2019; Accepted March 31, 2021

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DOI: 10.1097/JFN.0000000000000333

the time of the crime and have been proven to have no capacity for liability, are subject to nonprosecution (Penal Code Article 39).

The Medical Treatment and Supervision Act (MTSA) was enforced to prevent the recurrence of other harmful acts and promote social reintegration by administrating treatment rather than punishment. The MTSA enabled the growth of forensic psychiatric nursing as a specialized field of practice and an expansion of relevant literature. Forensic psychiatric nursing has developed over the last 30 years worldwide but only over the past 10 years in Japan (Kodama et al., 2012). In our study, nurse participants had provided care to patients with mental disorders that did not allow them to distinguish between good and evil and who had committed serious harmful acts (e.g., murder, arson, robbery, rape, indecent assault, and injury). The development of Western forensic psychiatric/correctional nursing has aimed to provide health and rehabilitation support for sentenced individuals, and experts' practice has significantly benefited the patients (Byrt et al., 2018; Holmes et al., 2015; Hufft, 2013). Similar attempts have been made in Japan to introduce an evaluation scale that serves as evidence of nursing (Shimosato et al., 2007), but the evaluation has not been standardized. Many previous studies in Japan have reported the adverse effects of nurses' emotional experiences and the difficulty of intervention and therapeutic rehabilitation, but specific interventions and support measures have not been established (Matsui, 2009, 2011; Sato et al., 2018). Furthermore, in correctional nursing, there are few recommendations regarding the need for specialized nursing (Nakatani et al., 2018; Yanai, 2013).

Sentenced individuals with difficulties in receiving psychiatric care at ordinary prisons are held in a medical prison specializing in psychiatric care. Most of the incarcerated persons in such prisons have diagnoses of schizophrenia, drug-related toxic psychosis, and other mental disorders. When individuals with mental disorders are detained, symptoms related to situational judgment ability, ability to seek help, intense emotional changes, confusion, delusions, feelings of persecution, violent behavior, food refusal, incontinence, and suicide attempt overlap and rapidly worsen (Sato, 2011). Furthermore, such prisons' closed environments reportedly have negative impacts on mental health, leading to the emergence of dissatisfaction and violence concerning behavioral restrictions, decision making, and freedom (Hufft, 2013). Sentenced individuals are exposed to suicide risks because they experience social isolation and lack personal privacy (Hufft, 2013). They are always under surveillance to ensure their safety. Nursing care is required to improve their comfort, autonomy, and safety in environments without freedom.

After receiving the district court's judgment under the MTSA, patients must receive a treatment decision regarding hospitalization, outpatient treatment, or nontreatment (MTSA Article 43). Such individuals have mental disorders, and it is imperative to treat their disorders, including schizophrenia, mood disorder, and drug dependence. A person with a mental disorder receiving a treatment decision is obliged to obey the judgment, regardless of personal desires, and is subject to impaired autonomy under legal enforcement. However, nurses must respect autonomy, as per the Code of Ethics for Nurses (International Council of Nurses [ICN], 2012). Western countries have also reported problems concerning respect for patients' autonomy as an ethical issue in forensic nursing (Gustafsson et al., 2013; Rose et al., 2011).

Under MTSA guidelines regarding medical care, the medical worker is obliged to provide sufficient explanation for the treatment provision after gaining the patient's consent. Because forensic nursing is subject to medical provisions under legal enforcement, the informed consent and information disclosure, which are standard principles in modern healthcare, are restricted, and situations where the patient can make decisions are limited. Furthermore, unlike in prisons and general psychiatric wards, treatment and care include many specialists and staff workers (Ministry of Health, Labor and Welfare, 2008, 2013). However, prisons housing patients and security facilities in psychiatric wards are closed environments and often hidden from society. Consequently, such social isolation significantly reduces the individual autonomy in those who are committed.

Furthermore, in a forensic and remedial environment, some nurses have difficulty perceiving crime-accused subjects as "patients," feeling fear, distrust, and disgust toward them (Matsui, 2010; Peternelj-Taylor, 2004). Isolated patients may also have many negative experiences because of their emotional and sensory functions as well as feeling invisible and abandoned by nursing staff (Holmes et al., 2015). Patients tend to perceive that they are not being treated or cared for properly, which may be related to the negative emotions nurses may be projecting. Only nurses with criminal psychology and violence management-related expertise and skills can properly handle such negative emotions (Palmstierna & Barredal, 2006). It is important to identify, and try to resolve, ethical problems both prison nurses and forensic psychiatric nurses encounter working in medical institutions. This relates to the aim of our study to examine the pressing need for ethical problems to be resolved in Japanese forensic nursing practice.

Methods

Study Design

A mixed method design using quantitative and qualitative approaches was employed to understand the frequency

and extent of ethical issues nurses encountered and to understand the ethical conflicts and sufferings individual nurses experienced.

Population and Sample

This study's selected nurse participants were working with patients with mental disorders in forensic healthcare wards and medical prisons. Using purposive sampling, we selected the participants from medical institutions with forensic healthcare wards and medical prisons; we approached nine public healthcare facilities and one medical prison. Five facilities consented to cooperate in the study; 175 nurses working in their forensic healthcare wards were eligible to participate in the study.

Data Collection

The survey included two parts: a self-administered questionnaire and an interview. Respondents received an interview cooperation request document describing the study's purpose, methods, and benefits; disadvantages resulting from study cooperation; freedom regarding study participation; poststudy participation refusal process; and an assurance of anonymity. Consenting participants received the interview questionnaire. Survey data were processed using code numbers to avoid specifying individuals; furthermore, the data were safeguarded inside a locked cabinet. The Kumamoto Health Science University's institutional review board approved this study (approval number: 2015-31).

Questionnaire

The anonymous self-administered questionnaire was distributed between November 2015 and May 2016. The questionnaire comprised the Japanese version of the Ethical Issues Scale (EIS; Fry & Duffy, 2001), which was translated by Iwamoto et al. (2005), and questions concerning personal demographic characteristics (i.e., gender, age, clinical experience [years], nursing education, job title). The devisers of the EIS have verified this measurement's reliability and validity through nurse surveys (Fry & Duffy, 2001). We obtained email permission from the scale's creators and translators. EIS is designed to measure frequency and concerns encountered about three ethical-issue-related components: end-of-life treatment decisions (13 items), patient care (15 items), and human rights (seven items). Respondents were instructed to circle the most suitable number in a 4-point evaluation scale (0 points = *not at all*, 1 point = *not much*, 2 points = *sometimes*, and 3 points = *frequently*). We also asked respondents to order the three most distressing ethical issue items (out of 35). We also presented 12 items dealing with ethical issues where respondents had to circle applicable items.

Interviews

Interviews were conducted with respondents, who provided written consent. The first and third authors conducted the interviews between January 2016 and November 2016. We created a semistructured interview guide to gauge what ethical conflicts and distressing subjects nurses experienced and what decisions they made. Specifically, (a) "What was the situation?" (b) "What conflict or distress did you experience?" (c) "Why was it distressing or conflictive?" (d) "How did you act during the conflict or distress?" and (e) "Why did you act on it?" Interviewers also asked the respondents about past ethical distresses and conflict situations they had encountered. All interviews were recorded (with the respondents' consent) using a digital voice recorder.

Data Analysis

Questionnaire data analysis was performed using Microsoft Excel 2010. Descriptive statistics were calculated for the demographic data. We calculated encounter frequency of the EIS 35 ethical issue items, mean values, and standard deviations for each item and the three constituent elements' mean points and standard deviations. Among the 35 ethical issue items, we scored the first-to-third highest ranked ethical issues in terms of distress as most distressing = 3 points, second-most distressing = 2 points, and third-most distressing = 1 point; each item's point was then tabulated. We also calculated the total responses regarding methods that were helpful in dealing with ethical issues; the total responses were calculated for each item.

The interviews' audio data were converted into a verbatim written record; the first and second authors read this record and performed Berelson's content analysis (Funashima, 2007). The third author checked for any differences between the interview and the results of the reading and content analysis performed by the second author. Item 1 summarized the conflict situations and categorized themes reflecting those situations. The answer content for Items 2–5 was then analyzed; the responses to the items were extracted as context units, descriptions that did not damage the context were extracted as recording units, and finally, researchers attached a category name reflecting the recording unit. All study authors confirmed and corrected the extracted categories and made efforts to ensure the category extraction's reliability.

Results

Demographics

One hundred thirty-one of 175 subjects (75%) responded to the questionnaire. Of these, six did not complete the demographic questions. All respondents were registered nurses and included 62 men and 63 women; the mean age was 40.4 ± 12 years, and the mean clinical experience duration was 9.0 ± 7.2 years. Respondents' educational levels were nursing diploma (104 [79%]), junior college (9 [7%]), university (6 [5%]), graduate school (master's degree; 3 [2%]), public health nurse course (2 [1.5%]), and midwifery

TABLE 1. Type and Frequency of the Ethical Issues (*N* = 131)

Ethical issues	Frequency	
	Mean	SD
Human rights issues	1.0	0.8
Protecting patient rights and human dignity	1.7	1.2
Providing care with a possible risk to your health (e.g., TB, HIV, violence)	1.3	0.9
Using/not using physical or chemical restraints	1.3	0.9
Protecting patients' rights when research subjects	1.1	1.1
Respecting/not respecting informed consent to treatment	0.9	0.9
Following/not following advance directive (e.g., living will, DPA)	0.2	0.5
Using experimental treatments or equipment without patient consent	0.2	0.5
End-of-life treatment decisions	0.5	0.7
Treating/not treating a patient against patient/family wishes	0.8	0.9
Acting against patient's personal/religious values	0.8	0.8
Not considering the quality of a patient's life	0.7	0.8
Acting against your personal/religious values	0.6	0.8
Treating/not treating severely disabled/handicapped infant, child, or adult	0.6	0.8
Ordering too many or too few procedures or tests	0.5	0.7
Overuse or underuse of pain management	0.3	0.6
Using or removing life support (including nutrition/hydration)	0.3	0.6
Resuscitating/not resuscitating patient without knowing his wishes	0.2	0.6
Prolonging the living/dying process with inappropriate measures	0.2	0.5
Participating/not participating in euthanasia or assisted suicide	0.2	0.5
Determining when death occurs	0.2	0.5
Procuring/distributing organs or issues for transplantation	0.1	0.3
Patient care issues	0.5	0.7
Conflicts in nurse–physician (or other professional) relationship	1.1	0.9
Staffing patterns that limit patient access to nursing care	1.1	0.9
Working with unethical/incompetent/impaired colleague(s)	0.8	0.8
Working with unsafe equipment and/or environmental hazards	0.8	0.8
Ignoring patient/family autonomy	0.6	0.7
Allocating scarce/costly resources (human, financial, equipment)	0.6	0.8
Caring for patients/families who are uniformed or misinformed about treatment, prognosis, or medical alternatives	0.5	0.6
Discriminatory treatment of patients	0.5	0.7
Implementing managed care policies that threaten quality of care	0.5	0.7
Reporting child/spousal/elderly/patient abuse or neglect	0.4	0.7
Not respecting patient confidentiality/privacy (e.g., HIV status)	0.4	0.6
Implementing managed care policies that threaten availability of care	0.3	0.5
Reporting of unethical/illegal practice of health professional/agency	0.3	0.6
Determining the rights of minors vs. parental rights	0.3	0.5
Participating in abortion/fertility treatment against your conscience	0.1	0.4

TB = tuberculosis; HIV = human immunodeficiency virus; DPA = Durable Power of Attorney.

course (1 [0.8%]). One hundred sixteen respondents were staff nurses (89%), six were assistant nurse managers (5%), and three were nurse managers (2%).

Frequently Encountered Ethical Issues

The six most commonly encountered ethical issues were (a) "Protecting patient rights and human dignity" (1.7), (b)

"Providing care with a possible risk to your health" (1.3), (c) "Using/not using physical or chemical restraints" (1.3), (d) "Protecting the rights of patients when they are research subjects" (1.1), (e) "Conflicts in nurse/physician (or other professional) relationships" (1.1), and (f) "Staffing patterns that limit patient access to nursing care" (1.1). Refer further to Table 1.

Among the three ethical-issue-related components nurses encountered, the highest average point total corresponded to human rights issues (1.0), followed by end-of-life treatment decisions (0.5) and patient care issues (0.5).

Most Disturbing Ethical Issues

The top five ethical-issue-related items causing high distress levels were (a) "Providing care with a possible risk to your health" (52), (b) "Using/not using physical or chemical restraints" (50), (c) "Protecting patient rights and human dignity" (47), (d) "Treating/not treating a patient against patient/family wishes" (36), and (e) "Ignoring patient/family autonomy" (36). Human rights issues constituted the top three reported ethical issues; the two fourth-ranked ethical issues were end-of-life treatment decisions and patient care issues. Refer to Supplemental Digital Content 1, http://links.lww.com/JFN/A61.

Ways to Manage Ethical Issues

Ways to manage ethical issues consisted of "Discussion with nursing peers" (77%), followed by "Discussion with nursing leadership" (64%), "Discussion with patient's physician" (44%), "Discussion with patient" (39%), and "Discussion with other professionals" (37%; see Table 2).

Actual Ethical Distress and Conflict

We interviewed 19 respondents who consented to be interviewed. Interviews were conducted in conference or meeting rooms of the facilities where respondents worked.

TABLE 2. Dealing With Ethical Issues

	Number *N* = 131	%
Discussion with nursing peers	101	77
Discussion with nursing leadership	84	64
Discussion with patient's physician	58	44
Discussion with patient	51	39
Discussion with other professionals	49	37
Discussion with family or friends	22	17
Discussion with patient's family	17	13
Discussing/consulting with nobody	12	9
Did not deal with the situation	12	9
Discussion with ethics committee	7	5
Discussion with nurse association	2	2
Discussion with religious counselor	1	1

The analysis excluded two interview respondents because they did not concern forensic psychiatric nursing-related practical situations; in all, 17 responses were analyzed.

Respondents included 11 men and six women, with a mean age of 41.5 ± 6.3 years and a mean clinical experience duration of 9.0 ± 7.2 years. Mean interview time was 23 ± 13 minutes. Supplemental Digital Content 2, http://links.lww.com/JFN/A62 depicts ethical conflicts, themes of scenes of distress, and behaviors to cope with distress and their reasons. Themes of conflict and distressing situations were classified into five groups: (a) difficulty of discharge management (n = 5), (b) prevention of violence and self-harm (n = 5), (c) compulsory treatment (n = 4), (d) patient care (n = 2), and (e) negative emotions toward patients (n = 1). The illustration of the different types of, and reasons for, each conflict/distress and the coping behaviors nurses used in these situations are further summarized in Supplemental Digital Content 2, http://links.lww.com/JFN/A62.

Difficulty of Discharge Management

Three types of conflicts or distress were part of this conflict/distressing situation. One of the most frequently mentioned was "uncertainly of the patient's postdischarge destination." One nurse (R6) described this conflict as follows:

> As acceptance by certain facilities is difficult even if patients who want to enter the facility, the patient cannot be discharged even though they are in good condition…. The patient's condition has improved, and although the patient has made an effort to fulfill the entrance conditions presented by the facility, acceptance by the facility is difficult…. I have heard patients say that they would like to wait until their preferred facility is available…. There is no positive impact on the patient if we force them to engage.

Prevention of Violence and Self-Harm

Two types of conflicts or distress were part of this conflict/distressing situation. One corresponded to "treatment without obtaining the patient's consent," as one nurse (R14) mentioned:

> Despite the patient's right to refuse treatment, we forcibly carried patients who were violent… patients were incapable of self-awareness because they have not been treated. And if the patient was not taking their medication, the condition of the patient will not improve with treatment.... I observed the patient according to the team policy.... I am not a team member; I am in a position to provide care according to the policy of the team.

Compulsory Treatment

Two types of conflicts or distress were part of this conflict/distressing situation. The most frequently mentioned was "treatment without obtaining the patient's consent," which one nurse (R1) described:

> Compulsory treatment is required for the patient, but the treatment should be done with the consent of the patient…. This is because there is a difference between my desire to respect the patient's right to self-determination and the situation in which the patient has to undergo compulsory treatment…. I repeatedly explained the necessity of treatment in order to obtain the consent of the patient...because increasing the motivation of the patient enables the patient to continue the treatment.

Patient Care

Nurses mentioned two types of conflicts or distress that were part of this conflict/distressing situation. One corresponded to "treatment does not benefit the patient," as one nurse (R13) discussed:

> I thought it was best to keep the patient under observation at all times, but the treatment did not improve the patient's condition…. This was because the patient's condition was known to be incompatible with MTSA treatment, so I knew that the treatment would not have any effect when they were hospitalized…. Each time, I was involved with the immediate goal so that the patient would not be forced…. I want the patient to do what they can and then finish the MTSA-prescribed treatment.

Negative Emotions Toward Patients

Only one type of conflict or distress was mentioned as part of this conflict/distressing situation: "inability to ask patients to reflect on causing harm to others." As one nurse (R19) discussed:

> I want to encourage the patient to reflect on the vulnerable children (their victims), but I could not become involved with the patient in that way…. The patient's condition was not incompatible with MTSA treatment…. As I was not the patient's primary nurse, I could not make the patient aware of the harmful act they had done. Patients may not accept staff other than their own team.

Discussion

Distress From Not Respecting Patient Rights

This study revealed that the participating nurses were most concerned about human rights issues of patients because they did not consent to patient isolation, detention, or compulsory treatment and focused on the safety of not only patients but also healthcare staff. However, the MTSA requires patients to undergo a program aimed at social reintegration while receiving appropriate medical care, so that they will not exhibit harmful behavior again. Patients must receive inpatient or outpatient treatment based on court orders, and there is no flexibility concerning their medical treatment. Therefore, such patients undergoing treatment under the MTSA may find it difficult to have the "right to freedom of choice" and the "right of self-determination" (World Medical Association, 2005) protected.

Furthermore, many patients undergoing MTSA-prescribed hospitalization have schizophrenia or schizophrenic disorder and delusional disorder (Ministry of Health, Labor and Welfare, 2018), and there are times when they lack any knowledge or understanding concerning the necessity for treatment. In such cases, nurses are obliged to provide compulsory treatment. In particular, patients rejecting medications can be highly aggressive and impulsive and may perform violent acts against others or engage in self-harm acts. In such dangerous situations, nurses must protect the patient who is violent, other patients, and themselves. The Code of Ethics for Nurses (ICN, 2012) lists respecting patients' human rights and promoting acquisition of informed consent for nursing and medical care as part of a nurse's ethical role. However, patients who receive an MTSA-prescribed hospitalization decision must undergo inpatient treatment regardless of their desire (MTSA Article 43, Paragraph 1); under the MTSA legal directives, nurses must thus provide the prescribed care. Nurses' responses suggest their uncertainty about respecting patients' human rights versus carrying out their duties. Nurses felt distressed that they could not respect the patients' right to choose treatment, as there were some situations where nurses did not obtain their consent.

MTSA-prescribed inpatient care is promoted by hospitalization treatment guidelines (Ministry of Health, Labor and Welfare, 2012). Under these guidelines, treatment targets are set by classifying patients' treatment stages into acute, recovery, and social reintegration phases; furthermore, standard treatment content is shown alongside the treatment course. These guidelines indicate that patients' treatment should, ideally, be based on their consent. However, if patients' consent to therapy cannot be obtained, it is necessary to consult with them concerning the possibility of alternative treatment actions; a multidisciplinary team (MDT) should make efforts to elicit the motivation for their treatment (Ministry of Health, Labor and Welfare, 2012). If consent cannot be obtained despite these efforts, a decision to implement compulsory treatment can be made at ward ethics meetings. In addition, the MTSA requires that only a designated psychiatrist working at a designated inpatient

medical institution can prescribe isolation of patients and enforce other behavioral restrictions (Article 92, Paragraph 3 of the MTSA).

Accordingly, compulsory treatments given to patients have been based on MDT decision making and a designated psychiatrist's judgment; however, we presume that nurses were often unconvinced of the reasons for the judgment. Previous studies have reported that there is typically no exchange of views between professions within the MDT and the original multidisciplinary function has not been fulfilled (Orovwuje, 2008). There are reports of interprofessional hierarchies within the MDT that have made it difficult for members to exchange opinions based on their expertise (Haines et al., 2018). In the current study, many nurses indicated that they were unable to preserve the patient's autonomy, suggesting that these nurses were not convinced of the decision making by MDTs. The implementation of MDT decision making in forensic psychiatry is often the responsibility of nurses (Haines et al., 2018), and if acceptable results are not achieved, nurses may apply their own approaches. As such, it is important that nurses participate in the decision-making processes regarding forced treatment of patients and are convinced of the reasons for the decision.

Difficulties Dealing With Patient Violence

Forensic psychiatric patients are often aggressive and violent, and dealing with such patients can be a threat to the physical and mental health of nurses (Holmes et al., 2015). Nurses who encounter patients' abusive or rejecting behavior experience distress, and conditions characterized by patients' abuse and violence continue to cause physical and mental disorders among nurses (Lanza et al., 2006). Similarly, nurses in our study often encountered distressing potential risks to their health from providing care. Thus, conflict and distress arose not only from the issue of obtaining patient consent to deal with violence but also from the desire to protect staff.

Furthermore, patients' violence tends to be underreported to hospital managers (Arnetz et al., 2015) because hospital managers do not take action even if it is reported (Kaya et al., 2016). Violence is more likely to be reported if its symptoms or effects are more severe (Arnetz et al., 2015). There are also reports that psychological violence is less frequently reported than physical violence (Lanza et al., 2006). Underreporting to hospital managers may render them unaware of employees who are victims of violence, leading to a loss of occupational performance among these victims (Kaya et al., 2016). Visualizing violence toward nurses is difficult and thus difficult to address. There are reports of interventions in individual hospital units that were effective in reducing violence toward workers and related injuries (Arnetz et al., 2017). Hospital managers must monitor the presence of violence and work to prevent violent acts from occurring.

Nurses must also directly cope with patient violence, especially when managers do not take action. The ICN released guidelines regarding coping with workplace violence in 1999; increasing abuse and violent incidents in healthcare practice hinders high quality care provision and threatens individual dignity and self-esteem (ICN, 2007).

Guidelines for measures against violence in healthcare and welfare facilities have been issued in Japan (Japanese Nursing Association, 2006). According to these guidelines, patient isolation and other behavioral restrictions may only be implemented if there are no other ways to respond to the perpetrators and if the designated psychiatrist deems that patient restraint is necessary (Japanese Nursing Association, 2006). Behavioral restrictions under the MTSA are also implemented at the discretion of a designated psychiatrist (MTSA Article 92, Paragraph 3). However, the symptoms of people with mental illness in forced detention are expected to rapidly worsen because of violence (Sato, 2011). Healthcare professionals need to create situations that do not require isolation because this is harmful to the patient.

The Comprehensive Violence Prevention and Protection Program trains Japanese forensic healthcare ward staff in physical intervention and communication skills and debriefing skills (psychological support) for patients and staff involved in violence. Nurses can use Comprehensive Violence Prevention and Protection Program skills to protect people involved with patients, prevent the next violent occurrence, and reduce subsequent stress and unpleasant emotions (National Institute for Health and Care Excellence, 2015; Shimosato & Matsuo, 2008). Research has found various interventions and related staff education associated with the successful reduction of seclusion, without increasing patient violence (Smith et al., 2015). Assessing and managing violence is important in forensic psychiatric nursing and requires both hospital management and healthcare staff to work collaboratively on preventing patient violence.

Nurses' Strategies for Ethical Issues

Nursing conflicts and distress can affect nurse morale and increase turnover if not properly addressed (Losa Iglesias & Becerro de Bengoa Vallejo, 2012). The ethical issues respondents encountered in our study included human rights issues that threatened the dignity and self-esteem of patients under the MTSA as well as individual nurses caring for patients. Several circumstances posed difficulties in solving such human rights issues through individual efforts. There are multiple conflict resolution strategies in nursing; among them is good collaboration, which can improve patient outcomes (Ylitörmänen et al., 2019). Similar to our results, previous studies revealed many cases of consultation with colleagues and superiors (Johnstone et al., 2004). Thus, discussion with colleagues and superiors may be a shared coping method among nurses.

Many interviewees mentioned the "discussion with other professionals" option: citing the medical team's responsibility for the patient, the necessity of issue sharing, considering what is best for the patient as a team, and utilizing team medicine (see Supplemental Digital Content 2, http://links.lww.com/JFN/A62). In MTSA-prescribed inpatient treatment programs, each patient is assigned an MDT—including physicians, nurses, clinical psychologists, occupational therapists, and psychiatric social workers—that formulates a treatment plan. Patients collaborate with MDT members in treatment planning, and obtaining patient consent is a part of the treatment plan. A weekly meeting evaluates the therapeutic effects and facilitates discussion among medical staff. With its various professional perspectives, discussions among an MDT could resolve ethical challenges.

Approximately 40% of nurses responded that discussion with patients was a useful countermeasure for dealing with ethical issues. They felt patients should be autonomous, and discussing ethical issues with them both builds relationships and improves patient motivation; thus, interacting with them as much as possible is necessary (Supplemental Digital Content 2, http://links.lww.com/JFN/A62). In this study, nurses struggled with medication guidance regarding patients who lacked knowledge of their illness and need for medication. "They had problems with the breakdown of trust with patients but also continued to assess patients while simultaneously considering it with other professions" (R5). As noted in other research, the staff's ability to form beneficial therapeutic relationships with patients aided in developing a safe foundation and care direction that promoted growth and changes in the patient population (Doyle et al., 2017). The nurse–patient therapeutic relationship could enable patients to become more motivated to accept treatment.

Difficulties in Terminating Hospitalization Treatment Under the MTSA

Inpatient treatment guidelines state that the major goal is social reintegration, and the standard period until discharge is 18 months (approximately 540 days). However, Kawano and Ando's (2017) investigation on inpatient treatment periods showed that the estimated mean duration was 562 days in a group where inpatient treatment was initiated in 2005. However, for several years since 2009, it has been over 800 days, and the length of inpatient treatment continues to increase. Of these patients, 4% were long-term patients hospitalized for 5 years or longer (Kawano & Ando, 2017). In our interviews with nurses, it was evident that they struggled with the difficulty of managing the patient's discharge because of the lack of a social support system and the incompatibility of the patient's needs and the MTSA. Reasons underlying discharge management difficulties were classified into two groups: (a) cases where, despite the patient's stable condition and hospital treatment termination, it was difficult for them to be accepted to a facility, and (b) cases where the condition was not ameliorated because of treatment refusal. In addition, it was revealed that, because of overlapping physical disorders, treatment of mental health conditions targeted by the MTSA did not progress, and evaluations were not made, making it impossible to finish inpatient treatment. Prolonged hospitalization resulted in cases where there was a lack of understanding regarding patients' conditions and refusal of treatment, difficulties in attaining the treatment stage required for the progress of inpatient treatment, and poor amelioration of social factors (Kawano & Ando, 2017). Many patients reject returning to their family members and even commit offenses, including criminal acts, against them. However, it is difficult to secure accommodation at receiving institutions and inpatient residencies for various reasons, including the inability of people with mental disorders to use group homes; there is thus a tendency to hesitate to accept such patients, and it is difficult to secure guarantors when patients are using rental housing alone (Ministry of Justice & Ministry of Health, Labor and Welfare, 2012).

This study's respondents examined and respected the patient's wishes and intentions as a problem-solving response to social reintegration and examined them with other professions including the MDT. These actions alone are not intended to encourage problem solving. In addition, when patients transition to outpatient treatment after completing inpatient treatment, it may be difficult to confirm that the hospital is providing outpatient treatment. It is necessary to ensure that as many patients as possible can easily access medical institutions designated by the national government in a familiar area; however, there is a shortage of medical institutions in large cities (Ministry of Health, Labor and Welfare, 2012). Harada et al. (2016) identified regional disparities in the development of designated medical institutions, which resulted in some areas supporting many patients, whereas other areas did not have any such patients. These findings indicate that discharge adjustment difficulties are related to the relationship between criminal behavior and family members, lack of social restoration facilities for people with mental disorders, and local prejudice. Although nurses support patients in aiming for social reintegration, lack of a local community-based acceptance support system reduces motivation for treatment and nursing care. In Japan, because of a partial revision in the Services and Supports for Persons with Disabilities Act (2012), regional consultation support systems are being developed to promote the discharge of hospitalized patients, including MTSA targets, from psychiatric hospitals (Ministry of Health, Labor and Welfare, 2012). Enhancing support systems for social reintegration remains an urgent task for solving ethical issues.

Limitations

On the basis of the number of beds and the placement criteria for nurses (Ministry of Health, Labor and Welfare, 2008,

2013), there are about 1,000 nurses working at Japanese forensic healthcare wards. This study had 131 nurse participants (about 13% of the total), limiting the study results' ability to generalize. However, with few reports regarding ethical issues Japanese forensic psychiatric nurses face, this study offers valuable data for Japanese forensic nursing practice.

Implication for Forensic Nursing Practice

Forensic psychiatric nurses found the roles of judicial medical care and patient care conflicting. This study clarified the ethical difficulties nurses experienced when advocating for patient rights and coping with patient violence and provided suggestions on how Japanese forensic nurses might overcome them. To resolve the conflicts nurses experience, it is important for them to actively participate in the MDT approach, for hospital managers and nurses to devise interventions, and for a system for social reintegration of patients to be established.

Conclusions

Japanese forensic psychiatric nurses struggle to balance their desire to respect patient rights and dignity, with their need to avoid distress. Nurses hesitate to use physical restraints, isolation, or sedation in treatments to deter violence and other harmful behavior. Furthermore, medication refusal or lack of participation in treatment can result in forced treatments. However, this study showed that nurses strived to respect patients' rights by using their nursing expertise and skills and sharing their conflicts and distresses with others. The root of the conflict was the disparity between nurses' responsibilities as professionals and their MTSA obligations; treatment methods where nurses do not obtain patient consent are an ethical issue for forensic psychiatric nursing. Furthermore, although nurses support their patients in social reintegration, they face moral conflicts and distress because of the lack of regional support systems. Enhancing support systems for social reintegration remains an urgent task for solving ethical issues.

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