Title: New legislation for offenders with mental disorders in Japan

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Abstract

This article describes the recent law reform on forensic mental health and its background in Japan, focusing on the enactment of the Medical Treatment and Supervision Act in 2005. The new system—under which a person who commits a serious criminal offence in a state of insanity or diminished responsibility shall be referred by the public prosecutor to the District Court—aims to provide intensive psychiatric treatment to offenders with mental disorders, attaching great importance to their reintegration into society. The court panel, which consists of a judge and a specially qualified psychiatrist, plays a key role in the treatment procedure. Upon the agreement of the two panel members, the panel delivers a verdict that takes into account the outcome of psychiatric evaluation; possible verdicts are inpatient treatment order, outpatient treatment order (mental health supervision), and no treatment order. Designated facilities are currently being established for inpatient and outpatient treatment. Referring to the published data on outcomes of enforcement, this article discusses particularities, current problems, and future prospects of the system, drawing comparisons between the German and Japanese systems.

1. Introduction

The management system for offenders with mental disorders varies among countries with different legal and psychiatric frameworks. Until recently, Japan was unique in that no special management system had been implemented for offenders with mental disorders; most were simply treated with general psychiatry. However, the enforcement

of a new law, called the Act for the Medical Treatment and Supervision of Persons with Mental Disorders Who Caused Serious Harm (hereafter "Medical Treatment and Supervision Act"), in July 2005 has brought about fundamental changes surrounding forensic mental health in Japan. This article describes the background of the reform, the aims and provisions of the new law, the outcome of enforcement, and future prospects.

2. Background

2.1 The traditional system

The history of law and psychiatry in modern Japan has been reviewed in a previous report (Nakatani, 2000). Therefore, only an outline of how offenders with mental disorders have been managed is given here.

In early 20th-century Europe, one of the predominant trends in criminal politics was to establish special measures for highly dangerous offenders, including those with mental disorders. The basic idea was that the inclination for criminal behavior could be eliminated by pedagogic or psychiatric interventions. The trend resulted in a series of new legislative enactments, including the 1928 Detention by the Government's Pleasure (*Ter beshikkingstellung*) in the Netherlands, the 1930 Measures for Security (*le Misure di Sicurezza*) in Italy, and the 1933 Law Against Dangerous Recidivists (*das Gesetz gegen gefährliche Gewohnheitsverbrecher*) in Germany.

Since the latter half of the 19th century, Japan has energetically embraced western legal ideas and systems. Article 39 of the current Japanese Penal Code, enacted in 1907, states that insane offenders shall not be punished, and that offenders with a diminished responsibility shall be given a mitigation of punishment. At that time, the concept of special measures for dangerous offenders had not yet materialized in Europe, and consequently Japan did not incorporate such ideas into the Penal Code. Unlike the laws of most western countries, then, the Japanese Penal Code does not provide any procedures for the management of persons acquitted due to mental disorders.

The first law for people with mental disorders, the Custody of Mentally Ill Persons Act, was enacted in 1900. The Act set up regulations with regard to the confinement of the mentally ill. In accordance with this law, an insane person who committed an offence could be confined to an ordinary psychiatric hospital.

The Mental Health and Welfare Act, which regulates the current mental health system in Japan, provides several forms of hospital admission. One of these is involuntary admission on an order of the prefectural governor, which is applied to persons considered likely to cause injury to themselves or others. Before the Medical Treatment and Supervision Act was enacted, most offenders with mental disorders were hospitalized by involuntary admission. For example, 702 persons were judged to be

insane or to have a diminished responsibility in 2001. Of them, 71.4% were admitted to hospital on an order of the prefectural governor, 8.7% were hospitalized in other forms of admission, and 12.7% were convicted (Ministry of Justice, 2006).

Thus, in the traditional system, a number of offenders with mental disorders were treated within general psychiatry as involuntarily admitted patients—there was no special facility for these patients. Even more troubling, more than 80% of psychiatric hospitals are private hospitals that are not equipped with special staff and security required to handle patients with criminal records.

2.2 Attempts at reform

Perceiving the lack of provisions for the management of offenders with mental disorders as a flaw in the legal system, the Japanese government aimed to improve legislation surrounding such offenders in the revised Penal Code (Nakatani, 2000). Early attempts at legislative revision included one in 1926, which contained Measures for the Safety of the Public (*hoan-shobun*), and the plan proposed by the Ministry of Justice in 1940, which grouped targeted offenders into four categories: offenders with mental illnesses, offenders addicted to alcohol or drugs, lazy recidivists, and persons at high risk of repeating a serious offence.

After a suspension during World War II, the Ministry of Justice resumed its work, and the Council for Legislation devised a new scheme for the Measures for the Safety of the Public in 1961. Aiming to focus legislation on mental disorders rather than repeat offences, the third and fourth categories of the previous scheme were eliminated; subjects were limited to offenders with mental illness or substance addiction who committed an offence usually punishable by imprisonment and needed to be confined for the safety of the general public. This scheme was apparently modeled after the German law (*die Maßregeln*).

The Ministry of Justice's reform plan was soon confronted with harsh criticism from psychiatrists and advocates of human rights, who began to campaign against the plan, arguing that it was based on the discriminatory idea that all people with mental disorders are potential offenders, and that the plan would inevitably infringe upon human rights and dignity. In 1971, the Japanese Society of Psychiatry and Neurology (JSNP), the largest academic circle of psychiatrists in Japan, almost unanimously adopted a resolution to oppose the plan (JSPN, 1971). The Japanese Bar Association also campaigned in league with JSPN. After many disputes, the government suspended the plan.

The major cause of the collapse of the reform attempt was that the scheme appeared to be oppressive in view of contemporary psychiatry, which was adopting an open-door

policy. Opposition groups perceived the reform as an unfair judicial intervention into psychiatry.

The controversy had a serious effect, leaving long-term sequelae. From that time on, most psychiatrists remained distant from judicial problems, and even regarded any discussion on that matter as something that should be avoided. Distrust of judicial intervention prevailed. The word *hoan-shobun* (Measures for the Safety of the Public) became taboo, and the problem was no longer overtly discussed. In turn, the government lost the motivation to pursue further reforms.

Interestingly, criminal justice came into conflict with psychiatry in France during the 1970s as well. The French Ministry of Justice intended to introduce new legislation for "abnormal delinquents," but the syndicate of psychiatrists who were oriented to community-based psychiatry (*sectorisation psychiatrique*) strongly objected to the plan, arguing that it went against current ideas of psychiatric treatment. They expressed their concern about the "*judicialisation*" of psychiatry (Ayme, 1997). As happened in Japan, psychiatry as a whole turned its back on the forensic problem.

However, it should be noted that many Japanese psychiatrists were ambivalent towards the problem. Psychiatrists, especially those who were obliged to treat patients with criminal records in their hospitals, continued to call for effective measures. The Japanese Association of Psychiatric Hospitals, a large organization of psychiatrists working in private hospitals, appealed again and again to the government to allow patients who had committed crimes to be treated in public facilities; however, the situation did not change until an awful criminal act shocked the government into considering new legislation.

2.3 Towards new legislation

In June 2001, a former patient of a psychiatric hospital broke into an elementary school and stabbed eight children to death. Although a psychiatric evaluation revealed that the perpetrator had a personality disorder and could be held fully responsible for his actions, the atrocious and seemingly motiveless nature of the murders triggered a strong fear of crimes that could be committed by people with mental disorders. Driven by public opinion, the government began to make serious efforts to improve legislation regarding criminals with mental disorders, eventually introducing a new bill to the Diet in March 2002.

During the Diet session, many subjects ranging from forensic psychiatry to general psychiatry were discussed (Nakayama, 2005). One of the most controversial themes related to the risk of re-offending—the government's original plan stated that the court shall give a hospital treatment order "if a person is deemed to have a risk of committing a

similar act." Opposing parties argued that this provision erroneously assumed that multiple offences could be accurately predicted, inevitably leading to false positive cases. The government deflected this criticism, maintaining that predicting dangerous behavior is justifiable because it is a part of the ordinary work of psychiatry.

Another important theme of the debate concerned the extent to which the new plan differed from the Measures for the Safety of the Public, which the government had since abandoned. The government insisted that the new plan was substantially different from the previous one because it was conceived independently of the Penal Code. Then, answering the question of why a special management system was required, the government explained that offenders with mental disorders require intensive care—not because they are dangerous to the general public, but because they suffer from "double handicaps"; that is, being both mentally ill and an offender. This "double handicap" scheme, which put an emphasis on patient benefits, continued to be a main source of the government's justification for the new plan, allowing a repeat of the controversy of the 1970s to be avoided.

During debate in the Diet on the Bill for the Medical Treatment and Supervision Act, the word "*osore*" (risk) was deleted from the text, and the conditions necessary for a treatment order were defined in more euphemistic terms, which will be discussed later. The Diet finally passed the bill in August 2003; however, it is doubtful that the plan was thoroughly examined, and it was another two years before the Act was put into effect.

3. The Medical Treatment and Supervision Act

3.1 Aim

Article 1 of the Medical Treatment and Supervision Act states that the law aims to "promote the rehabilitation of persons who have committed serious harm to others in a state of insanity or diminished responsibility. In accordance with this aim, the law establishes rules for proper management of cases, and provides offenders with continuous and appropriate medical treatment and supervision in order to improve his/her mental conditions and to prevent recurrence of similar acts."

3.2 Referral

Figure 1 illustrates the processes involved in the Medical Treatment and Supervision Act. When a person with a mental disorder commits a serious criminal offence in a state of insanity or diminished responsibility, the public prosecutor shall refer him or her to the District Court. There are two channels for referral: first, a person for whom the public prosecutor withdraws a charge on the grounds of insanity or diminished responsibility; and, second, a person who is acquitted or given a mitigated sentence without imprisonment on the grounds of insanity or diminished responsibility. A

psychiatric evaluation is carried out in order to make decisions regarding the appropriate course of action.

One of the particularities of the law is that it can only be applied to offenders who have committed a “serious” offence—homicide, robbery, bodily injury, arson, or a sex crime (rape and indecent assault). All categories, except bodily injury, include an attempt of the act. In the case of minor bodily injury, the public prosecutor may decide not to make a referral.

3.3 Court process

The District Court plays a key role in the procedure. Following a referral by the public prosecutor, the Court orders a psychiatric evaluation during a period of up to three months. In parallel with this, a specialist panel is set up inside the Court to make a decision. This panel is very unique as a court process. Unlike a normal criminal court, the panel consists of two members: a judge and a specially qualified psychiatrist. Both are equally qualified to make a decision. Based on the result of psychiatric evaluation, they exchange opinions from legal and medical viewpoints. A lawyer must be appointed to assist the referred person. The panel interviews the person and seeks comments from his or her lawyer, the public prosecutor, directors of the designated inpatient facility and the probation office. Although it is not stipulated by law, some District Courts organize informal conferences attended by concerned parties (except the referred person) (Miyoshi, 2008). Finally, the panel brings in a verdict upon agreement of the two panel members.

There are three possible verdicts: inpatient treatment order, outpatient treatment order, and no treatment order. If the District Court considers that a prerequisite for referral has not been fulfilled, the referral must be dismissed. In the case of dismissal, the referred person can be indicted at the discretion of the public prosecutor. The referred person, his or her guardian or attendant, and the public prosecutor can also appeal the decision to a higher court.

Article 42 of the Act states that the Court shall order treatment “if it is deemed necessary to provide the person with treatment under the law in order to improve the person’s mental conditions at the time of the act and to promote his/her rehabilitation without recurrence of a similar act.” Thus, the decision criteria for a treatment order are expressed in somewhat euphemistic terms.

The main purpose of psychiatric evaluation ordered by the District Court is to clarify whether treatment under the Act is necessary for the offender. The commonly used Guidelines for Psychiatric Evaluation specify three axes on which the necessity of treatment should be assessed: the first is the nature and severity of the mental disorder

and its relationship with the act; the second is the "treatability" or responsiveness to psychiatric treatment; and the third is factors expected to hinder the person's rehabilitation without re-offending. An offender is regarded as a candidate for a treatment order if he or she meets all three criteria (Research Group, 2005). In order to formulate a treatment program for each patient, Common Assessment Items have been developed (Research Group, 2005). This 17-item checklist, based mainly on HCR-20 (Historical, Clinical, Risk Management-20), is designed for the assessment at various stages of management (Murakami, 2006), but its reliability and validity have not been determined yet.

3.4 Inpatient treatment order

The inpatient treatment order is carried out in a "designated inpatient treatment facility" established by the state, local government, or a public corporation. The facility must meet the standards set by the Ministry of Health and Welfare. Within six months of admission, the director of the facility must apply for continuation of the inpatient treatment order to the District Court if the patient is considered to need further hospitalization. When inpatient treatment is no longer necessary, the director of the facility must apply for the patient's discharge to the District Court without delay.

According to the Guidelines for Inpatient Treatment, treatment is divided into three stages: acute, recovery, and rehabilitation (Ministry of Health and Welfare, 2005). Multi-disciplinary teams conduct treatment in line with the program designed for each patient. The program focuses on not only the improvement of mental conditions but also the enhancement of social skills and insight, using various therapeutic methods such as cognitive therapy and anger management. The average length of inpatient treatment is expected to be 18 months.

3.5 Outpatient treatment order (mental health supervision)

The outpatient treatment order, also called "mental health supervision," aims to maintain continuous treatment. The patient is placed under the supervision of the probation office and must obey rules such as living in a fixed place and appearing at the probation office when required. "Rehabilitation coordinators" with backgrounds in mental health and welfare issues are assigned to each probation office. Coordinators maintain contact with the outpatient and act as bridges connecting the various agencies involved. The length of outpatient treatment is usually three years; however, the District Court can prolong treatment for an additional two years. When outpatient treatment is considered unnecessary, the director of the probation office must apply for the conclusion of treatment to the District Court. If the patient's condition worsens, the District Court can order re-hospitalization. The Guidelines for Outpatient Treatment aim

to help patients live stable lives in their communities by promoting active collaboration between legal and administrative bodies (Ministry of Health and Welfare, 2005).

4. Outcomes of enforcement

On the basis of the published data, we present here the outcomes of the Medical Treatment and Supervision Act.

4.1 Court Decision

Data released by the Supreme Court reveal that 938 referrals were received by the District Court in the two-year period between 15 July 2005 and 31 July 2007 (Shimomura, Yoshida, & Tsuboi, 2008). A court decision has already been reached in 664 cases. Table 1 shows the decisions reached for each offence category. In 56.9% of cases, inpatient treatment was ordered, while no order was given in 18.5%, and the referral by the public prosecutor was dismissed in 2.7%. There were two reasons for dismissal: either the person was not considered to be insane or to have diminished responsibility, or the person's crime was not regarded as a "serious" offence in any category. 88% of offences were bodily injury, homicide and arson, whereas the numbers of sexual offences and burglary were relatively small (6.2% and 5.9% respectively). During this two-year period, 64 cases were discharged, and treatment was terminated in 23 cases.

4.2 Clinical characteristics

Wada et al. reported the personal and clinical profiles of 225 court decision cases in the ten-month period between July 2005 and May 2006 (Wada, Tamiya, Nakaya, Morisawa, Takada, & Oosawa, 2008). Of these 225 cases, 71.1% were male. The average age at the time of referral was 42.3 (S.D. = 13.7). At the time of the act in question, 73.3% were not married or divorced, only 10.2% had a permanent job, and 42.2% depended on family income. Only 17.8% had had arrest records prior to the act, and 11.1% had been previously imprisoned. 22.2% had never been treated, while 44.4% were receiving outpatient treatment at the time of the act; 25.8% had discontinued treatment prior to the act. 54.2% had a history of hospitalization. 39.4% of victims were members of the offender's family, while 38.5% were strangers. As indicated in Table 2, persons with a primary diagnosis of schizophrenia represented the majority of cases, especially in the categories of homicide and bodily injury. In contrast, only three cases of personality disorder were reported.

4.3 Facilities

In December 2007, there were 14 designated inpatient facilities in Japan. Twelve facilities were established by the state, and 2 were established by local governments. The number of beds in all 14 facilities totaled 354, revealing an obvious delay in the

establishment of inpatient facilities—enforcement of the Medical Treatment and Supervision Act was initially expected to provide 720 beds (Miyoshi, 2008; Namiki & Nishida, 2008).

By March 2008, there were 260 designated outpatient facilities, 81% of which were attached to private psychiatric hospitals (Matsubara, 2008).

5. Discussion

In Japan—where offenders with mental disorders were treated primarily with general psychiatry for many decades—the enactment of the Medical Treatment and Supervision Act has without a doubt ushered in a new era in forensic mental health. The role and function of the new law, however, remain unclear.

The new legislation puts the main emphasis on the improvement of mental conditions and rehabilitation of persons who have committed serious offences. Potential danger to others and risk of re-offending are taken into consideration as far as they are anticipated to hinder the patient's reintegration into society. The patient's "treatability" or responsiveness to psychiatric treatment is regarded as essential for entry into the system.

However, although the new law expresses its intention of providing mentally ill offenders with medical treatment rather than protecting the general public from harm at their hands, the provisions of the law contain several complicated problems. Entry into the system is limited to those who have committed a crime that can be categorized as "serious"; however, those charged with minor offences never enter into the system, even if they suffer severe pathology, raising serious questions about the delivery of mental health services to people charged with summary offences (Weisstub & Carney, 2006). In addition, the probation office, which essentially serves to prevent crime, plays an important role in the outpatient treatment order. Some criminal law experts sarcastically point out that the new law has clandestinely inherited the essences of the plan based on the German model, which was ultimately abandoned by the government in the 1980s (Nakayama, 2005; Yamamoto, 2008).

In this respect, it is interesting to compare Japan's new system with that of Germany. According to the Section 63 of the German Penal Code, a hospital order shall be given "if the overall evaluation of the offender and his/her criminal act indicates that more severe criminal acts are to be expected as a result of his/her mental state and that, therefore, he/she presents a danger for the general public" (Müller-Isberner, Freese, Jockel & Cabeza, 2000). In contrast to the German law, the Japanese law carefully avoids outright use of words such as "risk" or "danger," which were targets of bitter criticism during the law-making process in the Diet. Such language modification may have unfavorable consequences—it is possible that the vague treatment order criteria

and the absence of a “least restrictive alternative principle” will lead to overuse of the law, giving treatment orders to persons who could have been treated in less secure settings (Weisstub & Carney, 2006; Kojimoto, 2007).

As described in the Background section, there were many disputes before the new law passed the Diet. As a result, the new law provides a “hybrid” solution, partly criminal and partly civil (Weisstub & Carney, 2006). The idiosyncrasy of the system is evident in terms of the decision-making process in the District Court. The panel delivers a verdict based on the agreement of a judge and psychiatrist, and other mental health and welfare professionals can express their opinions at the panel meeting, making the medical point of view more respected than in a normal criminal trial. Furthermore, the discussion is held not in a court of law but in a conference room with a less formal atmosphere. At present, this court process is approved by both the medical and judicial sides (Miyoshi, 2008). Although outpatients are placed under “mental health supervision” by probation offices, management is expected to be supportive rather than directive.

Available data on the outcome of enforcement are not sufficient at present, but some interesting tendencies seem to emerge, and they appear to reflect the particularity of the new system. At the time of enactment of the law, the vast majority of referred persons were expected to receive an inpatient treatment order; however, in reality, more than 40% of persons did not receive that order during the first two years. One reason may be that some of them had recovered to some extent before the verdict, having been treated during two or three months of psychiatric evaluation. Another reason may be that some panels of the District Court tended to avoid hospitalization unless absolutely necessary.

The distribution of offence and diagnosis also shows distinct features. The majority of offences are bodily injury, homicide, and arson, while the proportion of sexual offences is very small. More than 70% of offenders suffer from schizophrenia, while the number of persons with personality disorders is almost negligible. A small proportion of offenders had a previous criminal record, and the majority had received some sort of psychiatric treatment. Nearly 30% were female.

Turning to Germany, a study of the patients at the Haina Forensic Psychiatric Hospital in the State of Hessen shows following findings: only 5% of patients were female; 28% were in treatment at the time of the crime in question; 27% committed a sexual offence; 37% had personality disorder; and 41% had functional psychosis (Müller-Isberner, Freese, Jöckel & Cabeza, 2000).

Although the statistics from Haina directly relate only to the State of Hessen, they suggest interesting differences between Germany and Japan. The main clientele of the

treatment order in Japan are schizophrenic offenders, while those with personality disorders are hardly eligible for the system; this may be associated with the low rate of sexual offence and the relatively high rate of females in the Japanese system. The main reason for the exclusion of offenders with personality disorders from the Japanese system is that these individuals are conventionally assessed to have full criminal responsibility, so they are rarely referred under the Medical Treatment and Supervision Act.

Traditionally, the discretion of the public prosecutor has been strong in Japan's criminal justice system, which may influence the enforcement of the new law (Weisstub & Carney, 2006). An offender assessed to have diminished responsibility can be prosecuted rather than being referred under the Medical Treatment and Supervision Act, and this option rests with the public prosecutor. Hence, persons with mental disorders who commit very serious offences with diminished responsibility may not benefit from the new system and may be convicted in a criminal court. These individuals require mental health care, but psychiatric treatment currently available in correctional facilities has many problems (Kuroda, 2005).

The rehabilitation-oriented system of the new legislation has been generally appreciated by psychiatrists and other mental health professionals; however, its hybrid nature is likely to cause confusion in the interface between forensic psychiatry and general psychiatry, especially in terms of the relationship between the treatment order and involuntary treatment under the Mental Health and Welfare Act. In this regard, the decision of the Supreme Court in July 2007 has had a significant impact. A man with delusional disorder who committed arson was judged to be insane and referred to the District Court in accordance with the Medical Treatment and Supervision Act. The panel of the Court decided not to issue a treatment order because involuntary hospitalization under the Mental Health and Welfare Act was presumed to be sufficient. However, the High Court and the Supreme Court rejected the verdict, maintaining that a treatment order must be given without exception as long as the person's conditions meet the criteria (Namiki & Nishida, 2008; Yamamoto, 2008).

The Supreme Court's ruling implies a narrowing of the passage between forensic and general psychiatry. The system's considerable shortage of beds makes circumstances all the more serious. In August 2008, the Ministry of Health and Welfare, aiming to increase the number of beds, issued a regulation relaxing the standards for designated inpatient facilities. Designated outpatient facilities are also expected to become insufficient for the growing number of persons who are given outpatient treatment orders or discharged from inpatient facilities. Although the new legislation highlights

the reintegration of offenders with mental disorders into society, multi-disciplinary care, such as assertive community treatment, has not yet been developed (Matsubara, 2008). Inpatient and outpatient facilities as well as coordination between forensic psychiatry and general psychiatry are necessary to enable recovering patients to progress smoothly to ordinary treatment.

6. Conclusion

Japan's new legislation has introduced an innovative approach in the area of forensic mental health. So far, the court process and the inpatient treatment are said to have functioned well on the whole—but at the same time, a range of problems have emerged, standing as firm challenges to the scheduled revision of the law in 2010. Follow-up studies on the enforcement of the law are needed.

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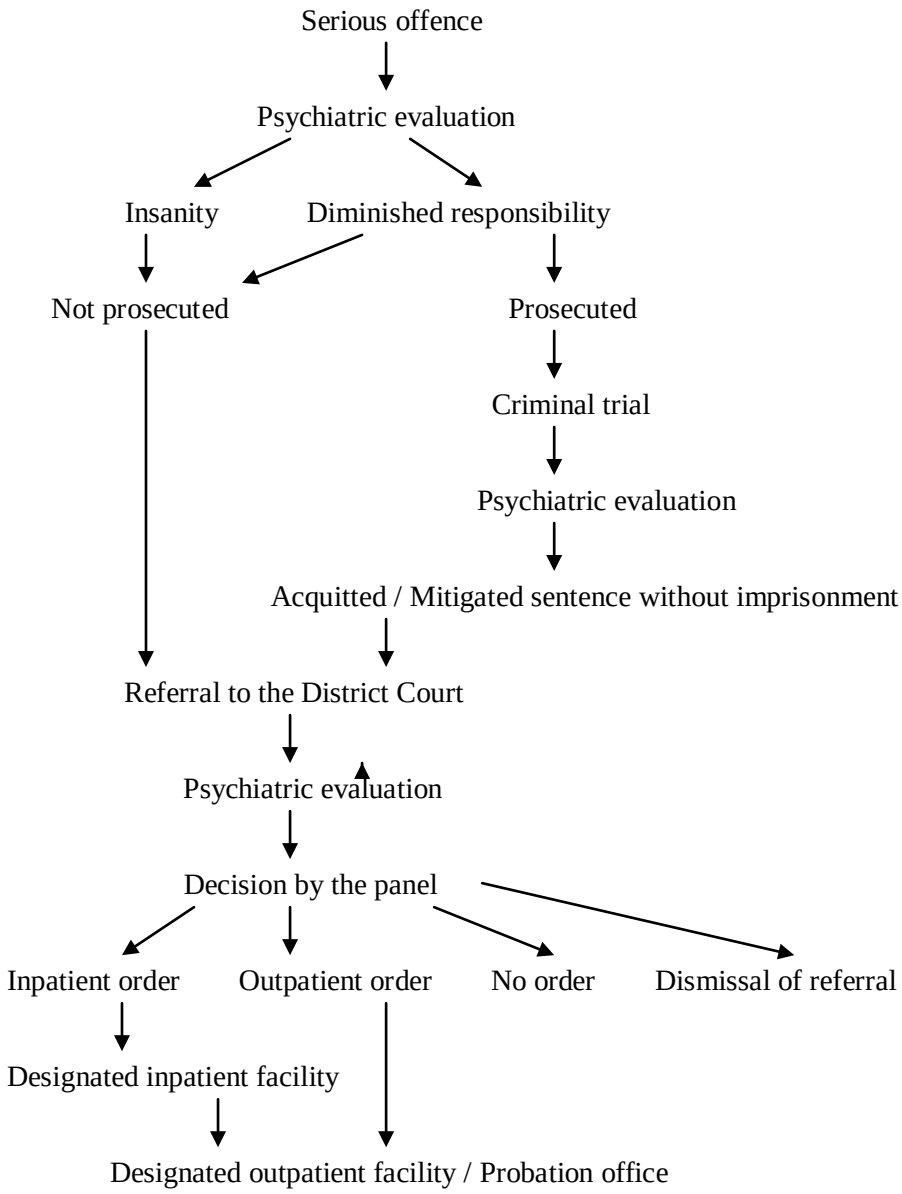

Figure 1. Flaw chart of the Medical Treatment and Supervision Act

Table 1

Court outcomes and offences of persons referred to the District Court between July 2005 and July 2007

	Court outcomes								Total	
	Inpatient order		Outpatient order		No order		Dismissal			
Arson	98	(51.0%)	49	(25.5%)	44	(22.9%)	1	(0.5%)	192	(100.0%)
Sexual offence	25	(61.0%)	8	(19.5%)	7	(17.1%)	1	(2.4%)	41	(100.0%)
Homicide	111	(65.3%)	33	(19.4%)	23	(13.5%)	3	(1.8%)	170	(100.0%)
Bodily injury	126	(56.8%)	48	(21.6%)	40	(18.0%)	8	(3.6%)	222	(100.0%)
Burglary	18	(46.2%)	7	(17.9%)	9	(23.1%)	5	(12.8%)	39	(100.0%)
Total	378	(56.9%)	145	(21.8%)	123	(18.5%)	18	(2.7%)	664	(100.0%)

Source: Shimomura, Yoshida, & Tsuboi (2008)

Table 2

Primary diagnoses and offences of persons given verdict between July 2005 and May 2006

	ICD-10*																Total	
	F0		F1		F2		F3		F4		F6		F7		F8			
Arson	4	(8.5%)	4	(8.5%)	31	(66.0%)	7	(14.9%)	1	(2.1%)	0	(0.0%)	0	(0.0%)	0	(0.0%)	47	(100.0%)
Sexual offence	1	(6.3%)	0	(0.0%)	12	(75.0%)	1	(6.3%)	0	(0.0%)	0	(0.0%)	1	(6.3%)	1	(6.3%)	16	(100.0%)
Homicide	2	(3.3%)	3	(4.9%)	49	(80.3%)	6	(9.8%)	0	(0.0%)	0	(0.0%)	1	(1.6%)	0	(0.0%)	61	(100.0%)
Bodily injury	3	(3.5%)	9	(10.6%)	62	(72.9%)	6	(7.1%)	1	(1.2%)	1	(1.2%)	3	(3.5%)	0	(0.0%)	85	(100.0%)
Burglary	0	(0.0%)	2	(13.3%)	7	(46.7%)	3	(20.0%)	0	(0.0%)	2	(13.3%)	1	(6.7%)	0	(0.0%)	15	(100.0%)
Total	10	(4.5%)	18	(8.0%)	161	(71.9%)	23	(10.3%)	2	(0.9%)	3	(1.3%)	6	(2.7%)	1	(0.4%)	224	(100.0%)

Source: Wada, Tanaka, Nakaya, Morisawa, Takada & Osawa (2008)

*ICD-10 diagnostic categories: F0=organic disorders. F1=substance use. F2= schizophrenia. F3=mood disorders. F4=neurotic disorders. F6=personality disorders. F7= mental retardation. F8=disorders of psychological development