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Patient advocacy: Japanese psychiatric nurses recognizing necessity for intervention

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Abstract

Background: Advocacy is an important role of psychiatric nurses because their patients are ethically, socially, and legally vulnerable. This study of Japanese expert psychiatric nurses' judgments of interventions for patient advocacy will show effective strategies for ethical nursing practice and their relationship with Japanese culture.

Objectives: This article explores Japanese psychiatric nurses' decision to intervene as a patient advocate and examine their ethical, cultural, and social implications.

Research design: Using semi-structured interviews verbatim, themes of the problems that required interventions were inductively summarized by a qualitative analysis and their contexts and nursing judgments were examined.

Participants and research context: The participants were 21 nurses with 5 or more years of experience in psychiatric nursing.

Ethical considerations: The research was approved by Institutional Review Board of research site and study facilities. The participants gave written informed consent.

Findings: Analysis of 45 cases showed that nurses decided to intervene when (a) surrounding people's opinions impeded patients' safety, (b) healthcare professionals' policies impeded patients' decision-making, (c) own violent behaviors impeded treatment and welfare services for patients, (d) own or families' low acceptance of illness impeded patients' self-actualization, (e) inappropriate treatment or care impeded patients' liberty, and (f) their families abused patients' property.

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Discussion: To solve conflicts between patients and their surrounding people, the nurses sought reconciliation between them, which is in accordance with Japanese cultural norms respecting harmony. When necessary, however, they protected patients' rights against cultural norms. Therefore, their judgments cannot be explained by cultural norms alone.
Conclusion: The findings indicate that the nurses' judgments were based on respect for patients' rights apart from cultural norms, and they first sought solutions fitting the cultural norms before other solutions. This seems to be an ethical, effective strategy if advocates know the culture in depth.

Keywords
Expert nurse, mental disorders, nursing judgment, patient advocacy, patient's right, psychiatric nursing

Introduction

To promote the well-being of persons with mental illness, it is crucial to protect their basic human rights, as indicated by the United Nations[1] Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care adopted in 1991 (hereinafter, UN Principles). Psychiatric nurses, more often and more directly than nurses in other fields, have to deal with legal and complex ethical matters that require nurses' advocacy for the protection of patients' rights. A search of CINAHL database for original articles and reviews with abstracts on nurse's advocacy published during 1985–2012 yielded 70 articles but only two of them[2,3] were in the field of psychiatric nursing. This research reports on the situations of psychiatric nurses' advocacy in Japan.

Psychiatric nurses' advocacy for patients may vary according to the medical, legal, social, and cultural environment of each country. Japanese psychiatry has dealt with issues related to human rights, such as hospitalization, isolation, and physical restraint criteria. Japanese government has put importance to public security and preferred institutional mental health services; involuntary hospitalization had been allowed before 1988 when the Mental Health Law was enforced.[4] Such policies are under reform to find culturally appropriate and effective ways for realizing international standards of care.[5] The goal, however, cannot be attained by only reforming the forensic system and related policies without practice of care providers' advocacy for patients.

Since the revision of the Mental Health and Welfare Law in 1995, the focus has been shifting from inpatient to community healthcare.[6] However, the emphasis is still stronger on hospitalization than in Western countries. The mean period of psychiatric hospitalization in 2012 was 291.2 days (6.2 days shorter than in 2011).[7] In 2011, there were about 3 million inpatients, of whom 59% had schizophrenia, 64% had been there 1 or more years, and 54% for 5 or more years.[8] In the 1970s, the Japanese government encouraged private sectors to open psychiatric hospitals. As a result, 91% of psychiatric hospitals are owned by private sectors in 2011,[8] which may be a factor for long hospital stay. Support for rehabilitation is provided as day-care, home-help, and home-visit nursing care services, as well as daily-activity-training facilities, group homes, and factories. People who have not consulted psychiatrists or discontinued treatment can receive psychiatric health and welfare consultation services provided by public health nurses at regional health centers.[8,9]

Tanaka et al.[10] suggested the following ethical problems experienced by Japanese psychiatric nurses: (a) infringement of the rights of patients to know and make self-decisions due to paternalism, (b) infringement of the rights of patients to live in the community to reduce the burden on family members, (c) disrespect of the dignity of patients and their right to control their own body by prioritizing the safety of the hospital and dignity of physicians, (d) dignity of physicians and hospital culture that keeps nurses from providing care based on nursing ethics, and (e) interferences with patient care and education for family

members due to enforced confidentiality. They cited the following as their causes: (a) inability of patients to make decisions, (b) social values, (c) shortage of social resources in intermediate facilities, (d) shortage of human resources, and (e) shortage of competent physicians. According to Usami,[11] psychiatric nurses feel guilty and helpless because they are unable to adequately cope with ethical problems. A large number of psychiatric nurses have concerns about physical restraints, isolation, and long-term hospitalization in particular.

We searched the Ichushi Web database for relevant literature in Japan. Since the concept of advocacy used to be uncommon in Japan, we used keywords related to patients' rights and found 483 nursing articles published in Japan from 1983 to 2012. The major themes they involved were the following: (a) patients' decision-making ability, (b) behavioral restrictions, (c) informed consent, (d) respect for human rights, and (e) information disclosure. Only a few, however, directly examined situations of nurses' advocacy, including a pilot study by Davis et al.[12] and two studies regarding adult nursing by Takemura,[13,14] but no study has been conducted in psychiatric nursing.

This study explores experienced psychiatric nurses' clinical judgments leading to interventions as patients' advocates with a focus on the clinical environment relevant to these judgments.

Objective

We intend to explore psychiatric nurses' judgments regarding the necessity to act as patient advocates. Our objectives are the following:

(a) to provide basic data regarding nursing interventions as patient advocates in psychiatry;
(b) to clarify when and why they judged their intervention to be necessary, which includes identifying components of the situations and considerations when judging their interventions to be necessary;
(c) to discuss the strategy they used when intervening.

Methods

As shown above, very little is known about patient advocacy in psychiatric nursing. Therefore, we employed a qualitative method to describe the phenomena themselves.

The subjects were nurses with experience of 5 years or more in psychiatric nursing. To collect rich episodes, they were selected using two additional criteria which their superiors recognized them as (a) having high-level ethical sensitivity and (b) providing patient-oriented care. They were 21 nurses in eight facilities located in two prefectures of Western Japan. Of them, 17 belonged to middle-scale (100–250 beds) psychiatric hospitals, 3 belonged to home-visit nursing stations affiliated to hospitals, and 1 belonged to a transitional facility (between hospitals and homes). The two home-visit nurses and one working in the transitional facility had bachelor's degree in nursing, and the other 18 had diploma's degree in nursing.

As thus selected, they do not represent Japanese psychiatric nurses in general. Their rich experience, however, will illustrate the situation of advocacy in psychiatric nursing in Japan and show the possible experiences of psychiatric nurses working there with ethical sensitivity.

We employed semi-structured interviews starting with a question "Have you experienced any case where you judged that you needed to act to protect human rights or promote well-being of a patient? If so, please tell me about it." Questions for clarifying details such as "What made you think so?" were sparingly used to avoid disturbing the flow of speech. They provided the interpretation of the situation, bases of judgments, and the strategies planned to be used in approximately an hour. The data were collected between August 2011 and December 2011.

The interviews were digitally audio-recorded with consent, transcribed verbatim, and analyzed qualitatively and inductively. The cases of judgment regarding advocacy were extracted and the environmental factors (including major players there) and the basis for judgment were identified for each case. Then, the cases were classified into groups according to relevant environmental factors and the bases of judgment. Finally, the theme was identified for each group.

Definition of terms

1. Patient advocacy refers here to nurse's practice to protect a patient's rights and benefits. It is distinguished from paternalism as the advocate respects the patient's values stated explicitly or discerned through nurse's interaction with the patient. This definition does not exclude the possibility of nurse's decision making on behalf of patients and hence expands the concept of advocacy indicated by the Code of Ethics for Nurses of the Japanese Nursing Association (JNA),[15] which orders nurses to protect the rights to information and self-determination of patients (clause 4) and protect and safeguard clients, when their care is inhibited or their safety is threatened (clause 6). This JNA Code puts importance on patients' self-determination and does not refer to patients' benefits. However, psychiatric patients sometimes lack the competency for self-determination because of mental illness and, especially in Japan, the long hospital stay that creates an indifferent attitude toward the outside world and discourages the patients to think of community life, as Wing[16] cautioned in 1962. Therefore, when there exist conflicts of interest between the patients and their families, nurses' decision making on behalf of patients can be inevitable to protect the patients' basic human rights as directed by the UN Principles.[1]
2. Clinical judgment for patient advocacy (CJPA) means the process of assessing situations and the problems that led to the recognition of the necessity for intervention as a case of patient advocacy.

Ethical considerations

This study was conducted with the approval of the institutional review boards of Kochi Medical School (Kochi University) and study facilities. The participant nurses were provided with written and oral explanations of the study objective, methods, privacy protection, data usage restrictions, and their right to withdraw from interviews.

Results

Participants and patients

The 21 interviewees were 6 male and 15 female psychiatric nurses with a mean age of 44.5 years (standard deviation (SD) = 7.5 years) and a mean working period of 14.1 years (SD = 6.3 years). The data consisted of 45 cases of CJPA. These cases involved 45 patients (26 males and 19 females) consisting of patients with schizophrenia (37), emotional disorders (4), developmental disabilities (3), and eating disorder (1). Their residences included hospital (33), home (10), and other care facilities (2).

Circumstances requiring patient advocacy

The data included (with overlaps)13 cases of conflicts between patients and their families, 2 cases of conflicts between patients and community residents, 6 cases of conflicts between patients and community-based supporters, 8 cases of conflicts between patients and healthcare professionals, 6 cases related to

Table 1. Themes identified as the major problems in psychiatric nurses' CJPAs.

Theme 1: Conflict with surrounding people impeding patients' rights to life and safety
Theme 2: Healthcare professionals' policies impeding patients' self-determination
Theme 3: Own violent behaviors impeding appropriate treatment and welfare services
Theme 4: Own or families' recognition impeding patients' self-actualization
Theme 5: Inappropriate medical treatment or nursing care impeding patients' liberty
Theme 6: Kin's heartless conduct impeding patients' property rights

CJPA: clinical judgment for patient advocacy.

isolation/physical restraints (including behavioral restrictions and personal property management), 3 cases of problems with receiving medical care at other departments, 8 cases of problems with medical treatment, and 7 cases of patients' refusal of treatment.

Psychiatric nurses' CJPA

The themes identified as the major problems in respective CJPAs are shown in Table 1. Typical cases for each theme are reported below, where nurses' statements were modified for privacy protection without changing their meaning.

Theme 1: Conflict with surrounding people impeding patients' rights to life and safety (13 cases). In these cases, conflicts occurred between patients to be discharged to the community and the community members (including the patients' families) who disagreed to accept the patients because of their past violent behaviors. The nurses' CJPAs were based on consideration of the patients' right to community life and the community members' right to (feeling of) security.

Case 1.1. A patient with schizophrenia who had auditory hallucinations and delusions wanted to return home, while his father was unwilling to accept him.

The nurse considered the possibility of his discharge, focusing on the absence of violent behavior and the increasing difficulty in discharging the patient with his father's aging or death. She intervened for discharge with the doctor's approval. The patient was finally able to return home after this nurse's repeated requests to his father coupled with provision of information about the patient's condition and available support services. (Female hospital nurse)

Case 1.2. A patient with schizophrenia and history of violence and drug abuse wanted to live at home, while his siblings refused to accept him.

Although the doctor agreed to his discharge, the family decisively rejected it. Their reason for refusal was his previous violent behavior and drug abuse. The nurse took into consideration that his parents had died and his siblings were leading their own lives. The nurse expressed her acceptance of the family's difficult feelings and caringly recommended to use services to support community life of the patient and also informed them of available social resources such as dormitories and group homes. The patient was finally discharged to a group home by mutual agreement. (Female hospital nurse)

Case 1.3. Community residents were against discharge of a patient with delusions.

The patient's ability to self-care and the stability of his mental health were sufficient for discharge, but community residents were afraid that he would cause "trouble with the police." The nurse considered it necessary to get their understanding so she cooperated with the doctor to educate the patient regarding the

illness, sleep, daily self-care, medications, and social resources and also provided occupational therapy, such as handicraft making and cooking. These therapeutic approaches were explained to the residents, and the patient was finally discharged home with their enhanced understanding. (Female hospital nurse)

Theme 2: Healthcare professionals' policies impeding patients' self-determination (11 cases). In these cases, the patients were unwilling to receive treatment and nursing care provided without choice. CJPAs were based on consideration of patients' right to treatment and nursing options, as well as to self-determination.

Case 2.1. A patient withdrew from pharmacotherapy based on his own judgment.

This patient with schizophrenia regarded his symptoms as insomnia and hence refused medication other than sleeping pills and finally withdrew from pharmacotherapy based on his own judgment, resulting in repeated hospitalizations. The nurse considered it more appropriate to support the patient's attitude toward medication to improve the situation. Since the patient tended to secretly avoid the medication when forced, the nurse considered it necessary to establish a cooperative relationship that allowed the patient to be open about his withdrawal. With the doctor's approval, the nurse supportively observed the patient. This consequently improved his medication adherence and prevented his re-hospitalization. (Male home-visit nurse)

Case 2.2. Nurses' insufficient recognition delayed discharge of a patient with an eating disorder.

Although the doctor suggested her discharge, the nurses did no preparation for discharge, regarding it as unrealistic because she had been hospitalized over the previous 2 years without major changes. At a discharge review meeting, a nutritionist cautioned that the doctor was planning to discharge this patient and it could be fatal without preparation. The interviewed nurse considered it necessary to know and respect the patient's will. Having confirmed the patient's wish about discharge, the nurse organized a support team, invited the patient to join it, and led it to her successful discharge. (Female hospital nurse)

Case 2.3. The doctor restricted freedom of a patient with schizophrenia to communicate with his wife who was hospitalized due to depression.

The wife was considering divorcing him. Her doctor, supporting her, restricted their conversations regardless of the patient's wishes. Therefore, the patient was continuously worried about her condition without having ways to confirm it. The nurse considered this a marital matter to be discussed between the patient and his wife and decided to intervene to promote his communication with his wife. As an intervention, the nurse repeatedly pointed out the necessity for the doctor to arrange an environment for discussion between him and his wife. (Female hospital nurse)

Theme 3: Patients' own or families' behavior impeding appropriate treatment and welfare services (seven cases). In these cases, nurses' CJPAs were based on consideration of patient's right to appropriate treatment, nursing care, and welfare services.

Case 3.1. A patient with depression had difficulty with consultation about his cancer due to his mental illness.

All his family members disregarded his computed tomography (CT) results, and the psychiatrist was reluctant to refer him for cancer treatment. The nurse considered such an attitude as inappropriate and persuaded the doctor to refer him for outpatient examinations in a hospital. Although that hospital initially refused the patient's re-hospitalization due to his previous problematic behavior, he finally received cancer treatment there after repeated requests by the nurse and doctor supporting his decision. (Female hospital nurse)

Case 3.2. A patient with schizophrenia had difficulty in receiving home nursing care due to his family's negative attitudes.

The patient's mother repeatedly blamed him for waking up late, which made the patient scream, a sign of regression. Considering that he was able to appropriately communicate with the nurse, and that his family gradually interfered with home nursing care, the nurse decided to intervene; she began to visit the patient with another nurse to deal with him and his family separately. This resolved the problem. (Female home-visit nurse)

Case 3.3. A patient with schizophrenia and his supporters fell in a difficult situation due to aggravated delusions.

The patient suffered from increased delusions about other residents in his apartment. Consequently, he wanted to move, and his community-based supporters tried to help him. However, his large number of requirements made it difficult to find a satisfactory apartment. This increased his stress, resulting in his violent behaviors toward his supporters, such as throwing papers at them. While the supporters kept respecting the patient's wishes, the nurse considered this situation as non-beneficial to both parties. She informed the doctor in charge of their situation to resume the patient's oral medication to prevent further aggravation of his symptoms, thus protected the patient's right to appropriate medication. (Female home-visit nurse)

Theme 4: Own or families' recognition impeding patients' self-actualization (six cases). In these cases, the interventions included education of the patients and their families about their illness and living abilities.

Case 4.1. A patient had difficulty in self-care and daily-life behaviors without awareness of insufficiency of his own abilities.

An adult patient with a developmental disorder living at home had difficulties in managing oral medications, dealing with incontinence, changing underwear, and using day-care services. During a trial admission to a care facility, he had night-time incontinence, badly soiled the toilet bowl and its periphery, and slept with his lower half of the body naked, leaving soiled underwear without cleaning. The nurse explained the necessity of daily support to him. Although he answered that he could take care of himself, the nurse judged that his response indicated his insufficient understanding of his own condition and arranged for his admission to another facility for promoting social activities to protect his rights to real self-actualization. (Female nurse working in a transitional facility)

Case 4.2. A patient with schizophrenia was unwilling to live in the community after a long hospitalization.

When the doctor recommended his discharge, he refused. He had been hospitalized for over 20 years. However, the nurse considered that it might be possible for him to live in the community when his self-care ability improved. The nurse encouraged him to try to leave the hospital just one night to start with. After training to improve his self-care ability, the patient was discharged. (Female hospital nurse)

Case 4.3. A patient with schizophrenia repeated discharge and involuntary re-hospitalization.

In the hospital, he adhered to medication and controlled his behavior only to return home early. Because of this, a wide range of activities were permitted to him during hospitalization, including freely leaving the hospital. The nurse intervened to prevent such treatment in consideration of the possibility of his premature discharge leading to fatal consequence impairing his remaining life. The patient caused serious trouble after being discharged three times, resulting in involuntary re-hospitalization. The nurse explained the

importance of sufficient treatment before discharge to the patient for the first time. In line with this, educational and community-based supports were provided before and after discharge. (Male hospital nurse)

Theme 5: Inadequate medical treatment or nursing care impeding patients' right to freedom (seven cases). In these cases, CJPAs were to protect patients' right to freedom, which was being limited by treatment or nursing care which gave priority to safety.

Case 5.1. Dietary restriction of a patient with schizophrenia resulted in physical restraint.

Gastrostomy for preventing frequent aspiration pneumonia restricted oral intake of a patient with schizophrenia. This restriction increased his stress, which resulted in loud shouts and dangerous behavior such as leaving the bed. A physical restraint was applied. The nurse considered this a deprivation of freedom and pointed out the importance of meeting his needs when his condition was stable while considering the effect of such support on the improvement of his condition. The nurse and doctor examined appropriate methods of oral intake for the patient. (Female hospital nurse)

Case 5.2. A patient with schizophrenia was continuously put in isolation due to caregivers' fear of his violent behavior.

Because of his violent behavior toward staff members and other patients, the caregivers tended to strictly control him for their own safety. Their fear occasionally interfered with therapeutic procedures; they opposed the doctor's instruction to observe the patient all day. As there were only a small number of male workers in this hospital, two female caregivers were assigned to the night shift. They could be at risk of sexual harassment if he was released. Reflecting that the patient's right to liberty must not be restricted for the caregivers' benefit, the nurses changed their work shift system and released the patient from restriction. (Female hospital nurse)

Theme 6: Kin's heartless conduct impeding patients' property rights (one case). This occurred with an old patient when all his close family members had died after a long hospitalization.

Case 6.1. The patient's pension was misappropriated by his nephew appointed as his guardian.

After the death of aged parents and siblings several years ago, the nephew became this patient's guardian and reduced his monthly allowance by a few thousand yen. Hospitalization costs decreased after he entered the late elderly stage, while he continued to receive the same amount of pension. The nurse regarded the nephew's use of the patient's money as unfair. In addition, when his admission to a private nursing home was considered, and was explained to the nephew at the hospital, he stated that he did not have sufficient money. Therefore, the nurse asked him to bring the patient's bank book for disability pension whereupon it was revealed that the balance was zero yen. From then on, the patient's bank book was maintained in the hospital to enable him to spend his money for his own benefit. (Female hospital nurse)

Discussion

In most cases we examined, the nurses' judgments resulted from their awareness of disregard or impediments of patients' rights by society, families, healthcare professionals including nurses themselves, or patients themselves. The nurses had to focus their attention on basic human rights of the patients to become aware of such disregard or impediments. Individuals with psychological disorder tend to suffer from mental, emotional, and behavioral disorders, in addition to communication difficulty, and consequently, their human dignity is disregarded on some occasions. Ertugrul et al.'s[17] study on patients with schizophrenia

found that perception of stigmatization and symptoms make a vicious circle. Our results indicate that such disregard or stigmatization is the major obstacle for protection of patients' rights and benefits, and not only sensitivity but also reflection is required to be aware of such disregard. Our data also indicate that strength and strategies are required to act as an advocate against violation of patients' rights.

The situations of CJPAs can be classified into three categories: (a) protecting patients from inappropriate actions of their families and the community residents surrounding them, (b) protecting patients from inappropriate actions of healthcare and welfare professionals, and (c) protecting patients' future. The factors affecting CJPA in situations of each category are discussed below.

Protecting patients from their families and community residents surrounding them

The conflicts, which impeded patients' rights to life and safety (theme 1) or property (theme 6), seem to have arisen not only from prejudice of community residents but also from the decline in patients' ability for social relationships and disease-specific behaviors, resulting in difficulty in appropriately communicating with surrounding people. The nurses thought the families and community residents tended to perceive the presence of patients as a threat to their safety because of their traumatic experiences. When their perception was justifiable to some extent, nurses struggled with an ethical dilemma in making judgments. Another factor is the group-centered tendency in Japanese culture. According to Iwamoto et al.,[18] Japanese nurses frequently experience a dilemma as they observe a tendency of decision making based on families' will, rather than patient's will. On the other hand, a comparative questionnaire survey[19] showed that the extent of moral distress felt by psychiatric nurses when they prioritized the family's wishes was lower in Japan than in England. These two findings may look inconsistent. Our results seem to indicate, however, that the reality has multiple aspects; prioritizing family's wishes is in accordance with Japanese group-centered cultural norms, and psychiatric nurses frequently observe such examples and feel difficulty when they try to advocate for patients. Konishi et al.[20] pointed out the benefits and problems resulting from respect of harmony in Japanese nurses. Therefore, the dilemma is between patients' rights and community residents' perception of security at the level of implementation and between the professional and cultural norms at the level of morality. The nurses interviewed in our survey had to solve such a twofold dilemma for their CJPAs.

As declared by the UN[1] Principles, all people with mental health problems have rights to live and work in the community, and arrangements should be made for it in accordance with their capability. Cultural norms must not be used as an excuse for inaction of proper practice.[21] At the same time, the patients' families' and community residents' sense of security must be respected. Our interviewees solved this dilemma by focusing on the relationship between the patients and community. They tried to protect the patients' rights by establishing a trusting relationship between the patients and their support groups and improving it.

Their approach may appear paternalistic from a Western point of view. However, the nurses respected patients' will, and it was the only way to effectively protect patients' rights. As ethical practices are rooted in moral sense of nurses, the psychiatric nurses had to first solve the dilemma between their professional and cultural norms. Their strategy was that they first focused on their professional norm, that is, respect of the human rights of patients, and then pursued solutions between the two norms. Respect of cultural norms would be necessary for not only their effective practice for protection of patients' rights but also their own morality.

On the other hand, there is evidence that the burden felt by the family carers for mental illness can be rather universal across cultures. A systematic review of literature by Rowe[22] revealed that family carers of psychiatric patients in the United Kingdom are struggling with impossibly heavy obligation, which makes their support ineffective, and therefore recommended professional service for carers and more empathic professionals' communication with carers to make their support effective.

Protecting patients from healthcare and welfare professionals

The conflicts impeding patients' right to making their own decisions (theme 2), appropriate treatment and welfare services (theme 3), or liberty (theme 5) were caused by the patients' lack of awareness of their illness (LAI) or disregard of patients' wishes by health professionals or both of these. Psychiatric patients' LAI frequently leads to treatment withdrawal. A systematic literature review of medication adherence in schizophrenia[23] found that the most frequently reported driver and consequence were lack of insight and greater risk of hospitalization, respectively. When they unwillingly receive treatment, they tend to secretly withdraw from treatment, resulting in the aggravation of symptoms and re-hospitalization. Such a vicious circle corresponds with a trustless relationship between the patient and healthcare professionals. A prospective study on adherence of patients with schizophrenia to neuroleptic treatment[24] showed that compliant patients were more cooperative with physicians and had higher positive treatment expectations from the first. The nurses, as advocates for patients, approached doctors in charge to establish cooperative relationships to protect patients' rights. As Sawada[25] reported, cooperation between nurses and doctors may be a core factor of patient advocacy.

These interventions were considered as necessary when the patient's liberty was restricted to facilitate treatment or nursing care (e.g. Case 5.1), healthcare professionals paternalistically dealt with the patient (e.g. Case 2.3), and the patient's wish was denied based on the nurse's preconception (e.g. Case 2.2). All these seem to be caused by some collective prejudgment preferring safety to liberty. This is in accordance with a report[26] that paternalism and police power have been major factors restricting psychiatric patients' rights in Japan. Nurses attending most closely to the patients might have been aware of the negative influence of such a tendency and intervene to resolve it. The Lisbon Declaration[27] proclaims the right to self-determination and that even a legally incompetent patient's decision must be respected as far as it is rational. Ikegami[28] as a lawyer stressed the importance of health professionals' informational support in patients' decision making. Psychiatric nurses may need to understand patients' wishes more accurately, than those in other fields, to provide effective support in their decision making.

Patients' problematic behaviors, such as violent acts and statements, threaten healthcare professionals' safety in some cases. In this study, such a threat led to the deprivation of patients' rights to treatment and liberty. In such a situation, the nurses tried to secure both patients' rights and their own safety by involving other healthcare professionals and improve the situation for protecting patients' rights.

Protecting patients' future

In these situations, the patients' right to self-actualization (theme 4) and property (theme 6) were impeded due to their own or families' attitudes based on inappropriate recognition about their illness. The nurses made a CJPA when they considered the patients' future lives. The possible obstacles they considered were patients' LAI, insufficient daily living abilities and resultant fear of discharge, and disregard by or negative attitudes of families and community residents. When the nurses considered the patients' recognition inappropriate, their CJPA may appear to infringe on the patients' right to self-determination and liberty. However, such CJPAs were based on a consideration of patients' future with a secure perspective obtained by sincere interaction, despite their occasional resistance and refusal, and close assessment of their pathological conditions and living abilities.

The nurses also considered the necessity of protecting patients' properties. The UN Principle 1 (Fundamental Freedoms and Basic Rights) describes the right to be protected from economic exploitation. In Japan, the average psychiatric hospital stay in 2012 was 291.9 days,[3] and 70% of the patients stayed in the hospital for 1 year or more and 36.8% stayed for 5 years or more in 2011.[4] While such patients are repeatedly hospitalized from their youth, their property tends to be managed by their families. In this study, the

nurse considered it a necessity to establish an economic base for a patient and intervened with future perspectives after becoming aware of his family's inappropriate management of his pensions.

Oya[29] pointed out that Japanese psychiatry needs to be improved to enable patients to pursue happiness. Most cases of CJPA in this study included a viewpoint on quality of life (QOL), and the nurses regarded it as indispensable for ensuring patients' right to the pursuit of happiness.

Limitations and future perspective

The following limitations exist and further studies are required to overcome them:

1. Our data did not include cases of CJPA regarding patients' rights to information, privacy, or health education.
2. Our data did not include cases of patients living in transitional facilities or with their families.
3. Since we focused on successful cases of interventions for patient advocacy by nurses recommended as having a high ethical sensitivity, the results would not represent the general situation of CJPAs in Japan.
4. Social preference could bias the data because patient advocacy is regarded as ethically preferable although interviewees must at least have wanted to act in a way they indicated.

Conclusion

The following three points characterize CJPAs in psychiatric nursing in Japan.

1. *Conflicts with families and community residents*.

Literature review by Toda[30] suggested the vulnerability of patients, conflicts with patients, and requests/demands from patients as prerequisites for advocacy by nurses. These were also the prerequisites for CJPAs in this study. In addition, our data included conflicts with families and community residents. These conflicts are associated with decreases in the daily-life and interpersonal skills of patients and the existence of specific behaviors and are unique to CJPAs by psychiatric nursing. The nurses paid attention to the rights to community life of not only patients but also their families and community residents. Maintaining a balance between them, the nurses provided support for the well-being and benefits of patients. This reflects the characteristics of Japanese culture, emphasizing harmony in a group rather than focusing on individuals, although nurses took the side of patients. However, their decisions were not always in accordance with the traditional cultural norm. For example, when a patient wanted to withdraw from treatment and argued with the physician, the nurse respected her decision. This can be interpreted that the nurses attempted to protect and promote the well-being and benefits of patients under the given social and cultural restrictions.

2. *Patients tend to be unaware of infringement of their rights*.

The patients' daily-life disability and unawareness of own disorders make it difficult for them to receive necessary supports. As a result, their basic human rights can be infringed on. They may also be unaware of violation of their rights.

The nurses, coordinating the professionals of other facilities and supporters in the community, interacted with patients and their families to advocate. As the majority of psychiatric patients have schizophrenia with impaired cognitive function, nurses must have ethical sensitivity because the patients tend to be unaware of infringements of their rights.

3. *Patients tend to be unassertive about their rights*.

Except for requests or demands related to patients' community life and withdrawal from treatment, the advocacy-related decisions were made based on nurses' consideration, rather than requests/demands from patients. According to Minami,[31] Japanese people do not openly talk about themselves and tend to be unassertive to maintain harmony with others. In particular, psychiatric patients with disabilities related to communication skills refrain from asserting themselves. Their families seldom request or demand something on their behalf. In order to protect the well-being and benefits of patients in such a situation, it is essential for nurses to recognize or be sensitive to the feelings of patients. This type of nurse–patient interaction has some similarities to paternalism in that nurses act for well-being of patients without requests or demands from them. In this case, however, nurses are required to be sensitive to the rights and will of patients and interact while collaborating with and disclosing information to them, which is significantly different from what is required in paternalism.

The expert nurses' CJPAs we examined were based on respect for patients' rights apart from cultural norms, but the nurses first sought solutions fitting the cultural norms before other solutions. Such strategies of advocacy should be ethical and effective if the advocates have ethical sensitivity, respect professional norms, and know their society and culture in depth.

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Conflict of interest

The authors declare that there is no conflict of interest.

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