原　著

Support for Victims of Domestic Violence in Japan: Difference in Correspondence of Hospitals During Consultation Between Daytime and Nighttime Visit

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Abstract

Objectives: This study aimed to examine the issues of cooperation between police and health care systems against domestic violence (DV) in Japan and determine what measures can be taken for its improvement. Methods: This study employed a quantitative descriptive design. A survey using an anonymous self-administered questionnaire was conducted with 500 police officers of X prefecture in 2014.

Results: The number of respondents who reported having received sufficient cooperation from general hospitals and clinics totaled 184 persons (42 %) and 118 persons (27 %), respectively. The respondents indicated a lack of a DV reporting policy, also mentioning that medical staff took a non-cooperative attitude toward the police and attached little importance to DV cases. Compared with general hospitals, clinics did not have sufficient facilities to protect victims' privacy in either the afternoon or at night.

Conclusion: There were significant differences between general hospitals and clinics without hospitalization facilities concerning their responses to DV victims in both day and nighttime. An efficient measure for improving inter-institutional cooperation against IPV is the establishment of one-stop centers where victims can receive all the necessary police, legal, welfare, and health services in one location.

Keywords：domestic violence (DV), intimate partner violence (IPV), police, collaboration, hospital

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Introduction

Intimate partner violence (IPV) causes deep physical and psychological trauma to its victims, threatening their lives and well-being. According to a WHO report, abused women are more likely than non-abused women to undergo surgery and hospitalization[1]. In a Japanese study conducted by Yoshihama, et al.[2], the adjusted odds of hospitalization (2.44), use of sleeping pills or tranquilizers (3.30), and suicidal tendencies (5.04) were significantly higher for women reporting emotional, physical, and sexual abuse than those women reporting no abuse. "Adjusted odds" refers to the measure of the odds of an event happening in one group compared with the odds of the same event happening in another group. Konishi[3] reported that 99% of sexual abuse victims experience emotional shock, and 40% have to take a leave of absence from or quit their jobs. Campbell[4] suggested that IPV may lie at the root of smoking, poor nutrition, and other public health problems.

Strong cooperation between the police and health care system is required for effective victim protection and the elimination of DV. Comprehensive involvement, such as prevention, treatment (long-term care), and interpersonal relationship rehabilitation, is necessary. In the United States, for example, various programs have been launched to increase health care professionals' awareness and ability to recognize DV risk factors. A number of guidelines and manuals for medical professionals have been published, and screening tools for early DV detection are constantly being developed[5][8]. Many states in the US require health care providers to report instances of DV to the police or other government bodies. MacMillan[9] reported that screening may be effective for the health improvement of crime victims and that it inflicts no harm in health care settings. In Japan, however, situations regarding the cooperation between the police and medical service facilities remain unknown, and one-stop supporting systems including these two sectors are not yet well organized.

The present study aimed to investigate the issues of cooperation between the police and general hospitals/clinics regarding DV in Japan, and examine possible measures taken for improvement.

Participants and Methods

We chose X Prefecture as a research field because it has launched a private shelter for victims of domestic violence (DV), being among the earliest to do so in Japan. It has a number of support organizations, both administrative and private, and police involvement is also reputed to be appropriate compared with other prefectures. Moreover, as its Center for Sexual Victims' Support has recently started, after Osaka and Tokyo, active surveillance by female doctors is attracting attention.

First, we sent letters to the chief officers of X Prefecture Police Headquarters, Community Safety Division, First Criminal Investigation Division, Crime Victims Support Office, and other related divisions to request their cooperation. Each of the officers selected eligible participants: 503 police officers working in the headquarters and police stations of X Prefecture who had dealt with DV cases (physical, elder, disability, child, and sexual abuse, and stalking) from 2011 to 2014.

Second, we sent to the participants an anonymous self-administered questionnaire with a document of written explanation regarding the purpose and method of the research. Cooperation was totally voluntary. Each participant returned the questionnaire to the researcher via regular postal mail from June to July in 2014. Before the data collection, we obtained the approval of the ethical committee of Sapporo City University (1401-1, April 30, 2014).

Questionnaire

The questionnaire consisted of gender, age, and types of tasks as the participants' background information, and what the officers expected hospitals and health care facilities to do when they see DV victims. Possible choices for the answer were "separate places/facilities for examining victims," "entrances specified for victims," "spaces with a relaxed atmosphere," "leaflets encouraging victims to file damage reports with the police," "leaflets encouraging victims to turn to administrative bodies for support," "professional staff trained to work with DV victims," and "others." Another question was on the sufficiency level ("sufficient," "mostly sufficient," "not quite sufficient," or "insufficient") of health professionals' support, regarding the case where a DV victim and a police officer meet separately for the first time at a general hospital or a smaller-sized facility (19 beds or less) in the daytime or nighttime. Additionally, the subjects were asked to write down freely and in detail what they perceived as insufficient.

Data analyses

Responses regarding level of cooperation were tabulated by the type of medical facilities (general hospital and clinic). Responses to the open ended questions were sorted into several categories based on their similarities and differences.

Statistical Analysis

The Student unpaired t-test was carried out for statistics obtained in our analyses, which were conducted with SPSS version 24. A p value <0.05 was considered statistically significant.

Results

Among a total of 503 questionnaires distributed, 438 questionnaires were returned (return rate of 87.1%), and all of them were valid.

Basic attributes of the participants

The participants consisted of 383 males (87.4%) and 55 females (12.6%), as shown in Table 1. As for workplace, 279 participants (63.7%) worked in police stations, and 151 participants (34.5%) were stationed at Police Headquarters. Assignment-wise, 205 participants (48.6%) belonged to the Criminal Investigation Division, and 204 (48.3%) belonged to the Community Safety Division.

A total of 185 participants (42.2%) had experience of dealing with DV cases that health care facilities had failed to report to the police, although the victims had received medical treatment. Of them, 131 participants (70.8%) had dealt with no more than five such cases, 18 participants (9.7%) reported 6 to 10 such incidents, and 30 participants (16.2%) reported 11 or more cases.

As regards the question of whether or not measures should be taken to encourage health care facilities to report DV, 351 participants (80.1%) replied "Yes." Among such measures to be taken, the participants mentioned "regular opinion exchange between the police and health care institutions" (155 participants), "providing a better understanding of the legal framework in respect to DV" (132 participants), "on-the-job training to raise shared awareness of intimate partner violence" (126 participants), and "training programs for health care professionals to learn appropriate techniques for treating DV victims" (93 participants).

Concerning general hospitals, the participants indicated the need for "separate places/facilities

to examine victims" (241 participants), "leaflets encouraging victims to file damage reports with the police" (199 participants), and "professional staff trained to work with DV victims" (172 participants). "Centralization of information gathering" and "providing separate rooms for police questioning" were also deemed necessary. General hospitals were also expected to "provide necessary education for doctors concerning DV."

As for smaller-sized hospitals, the following items were indicated by the participants as necessary: "leaflets encouraging victims to file damage reports with the police" (223 participants), "separate facilities for examining victims" (217 participants), "leaflets encouraging victims to turn to administrative bodies for support" (165 participants), "spaces with a relaxed atmosphere" (134 participants), "professional staff trained to work with DV victims" (67 participants), and "entrances specified for victims" (51 participants).

Level of cooperation with the police in dealing with DV cases

The number of respondents who reported having received "fully sufficient" or "fairly sufficient" cooperation from general and smaller-sized hospitals during the daytime were 184 (42.4%) and 118 participants (26.9%), respectively, as shown in Table 2. Sufficient cooperation from emergency staff during the nighttime hours at general and smaller-sized hospitals was reported by 177 (42.8%) and 102 participants (24.6%), respectively. Most of the participants who reported "somewhat insufficient" or "insufficient" cooperation from health care institutions indicated an absence of isolated rooms or rooms where victims could relax and calm down. The following opinions were given regarding the lack of cooperation from general hospitals: "Doctors' attitude toward the police was not cooperative," "Medical staff attached little importance to DV cases," "Many hospitals strongly preferred the questioning of victims be held at police stations and not in hospital rooms," and "Hospitals had no DV reporting policy." The participants also mentioned non-cooperative attitudes and a lack of DV reporting policies at smaller-sized hospitals.

The attitude of emergency staff at both general and smaller-sized hospitals during nighttime hours was also described as not cooperative, attributed to their busy schedule. The participants indicated that emergency rooms were extremely crowded. DV victims often had to wait for a long time to be examined and were unable to change their clothes. In nighttime hours, hospital staff members preferred that police officers not interview victims in the hospital. They also did not offer any place for interviews. Often, hospital staff members do not report to the police that DV victims came and saw health care professionals. The differences between smaller-sized and larger hospitals included "Victims of DV being interviewed in the same waiting space as other patients" and "A lack of an accommodating place where DV victims can talk to police officers without being seen by other people." They stated their opinions as "having no liaison system established for hospital staff members to report to the police" because "many hospitals are basically not cooperative with investigative police activities." There were significant differences in attitudes between general and smaller-sized hospitals regarding the issues of daytime or nighttime hours as well as sex and ages of police officers.

Victim information needed to be provided by health care institutions

The most frequently mentioned information items were "medical examination results" (258 participants, 58.5%), "the date, time, and place of the injuries" (249 participants, 56.8%), "the cause of the injuries" (206 participants, 47%), and "personal identification information, family composition" (197 participants, 45%). Health care providers were expected to record the exact words of a victim during an examination, as any changes or exaggerations could hinder police investigation. Many participants considered it important that doctors provided their opinions on victims' physical and emotional states as well as attitude toward police involvement. This and all the other information acquired by health care providers (MRI and CT images, information on the person who brought the victim to hospital, the victim's relation with the offender, etc.) can help the police avoid unnecessary questioning of the victim.

Measures necessary to strengthen cooperation between the police and health care providers

Among the necessary measures the participants indicated were "regular opinion exchange and study meetings" (233 participants, 53.2%), "educational programs for health care professionals" (191 participants, 43.8%), and "liaison meetings and system development" (146 participants, 33.3%). Establishing "new systems such as one-stop support centers and consulting services," developing "guidelines for personal data disclosure," and "programs to teach medical staff

Table 1: Basic attributes of the subjects

n=438

			Number of responses	%
Current Work	Criminal department		205	48.6%
	Life safety department		204	48.3%
	Others		13	3.1%
workplace	Police Headquarters		151	34.5%
	police stations		279	63.7%
	Others		8	1.8%
Report from the hospital to the police	Respondent	n=438		
	Although the victim visited the hospital,there was no report		185	42.2%
		1〜5 cases	131	70.8%
		6〜10 cases	18	9.7%
		11 cases over	30	16.2%
		unknown	5	2.7%
	The victim consulted and had a report		251	57.3%
	unknown		2	0.5%
The most frequently mentioned information items	medical examination results		258	58.5%
	time and place of the injuries data		249	56.8%
	the cause of the injuries		206	47.0%
	personal identification information		197	45.0%
	Others		11	2.5%
“What the police are seeking at the hospital (Multiple choice)”	Conservation of evidence of investigation		306	69.8%
	Quick response		304	69.4%
	Cause of injury		244	55.7%
	Mental care		113	25.8%
	isolation from the surroundings		99	22.6%
	Others		15	3.4%
Measures necessary to strengthen the cooperation between the police and health care providers	regular opinion exchange and study meetings		233	53.2%
	educational programs for health care professional		191	43.8%
	liaison meetings and system development		146	33.3%
	new systems such as one-stop support centers and consulting services		5	1.1%
	guidelines for personal data disclosure		4	0.9%
	programs to teach medical staff to preserve evidence for criminal investigation		2	0.4%
	Others		9	2.0%
Gender	Men（years old）		383	87.4%
		~under 30	18	4.1%
		30〜39	135	30.8%
		40〜49	128	29.2%
		50~ over	95	21.7%
	Women（years old）		55	12.6%
		~under 30	19	4.3%
		30〜39	26	5.9%
		40〜49	9	2.1%
		50~ over	0	0.0%
		n.a.	8	1.8%

to preserve evidence for criminal investigation" were also considered important. Additionally, a number of participants thought that law reform was necessary to foster cooperation between the police and health care providers.

Discussion

In a multi-country study conducted by the World Health Organization, the prevalence rate of sexual violence by a partner ranged from 6% to 59%, and by a non-partner, from 0.3% to 11.5% in participants aged up to 49 years. In the same study, 3% to 24% of the participants reported that their first sexual experience was forced and occurred during adolescence. Among women, prevalence rates for sexual and/or physical violence involving an intimate partner across the lifespan range from 15% to 71%. Although limited in number, other studies support similar or higher prevalence rates for physical and sexual DV in same-sex relationships[10].

The results of the present study demonstrated a lack of cooperation between health care professionals, especially doctors, and the police in dealing with DV cases. In Japan, Ishii et al.[11] developed and assessed a Japanese version of a DV screening inventory, but only a small number of Japanese health care facilities screen their patients for DV. The number of DV victims receiving support is small compared with the number of violence instances reported to the police[12) 13)]. Only 0.4% to 0.6% of all cases in which victims of DV and sexual abuse are taken into protective custody in Japan are due to reporting by health providers[14) 16)]. Yamada, et al.[17] concluded that cooperation reinforcement is necessary to provide victim support. The causes of the present situation and measures that can be taken for its improvement are discussed below.

Presently, even if clinic doctors suspect DV when examining a patient, they rarely try to find out details or report it to the police. In doing so, they hope to protect the patient's privacy, and at the same time, avoid involvement in troublesome situations. They often say that they did not report because the patient asked them not to do so. However, to lessen the physical and emotional distress of the victim, it is important to provide necessary protection and begin investigation as soon as possible. For this purpose, it is necessary to simplify the reporting procedure, making it clear that reporting benefits the patients and causes no disadvantage to health care providers.

Inter-institutional cooperation issues and the role of one-stop centers

When a victim of DV is brought to hospital by ambulance, the fire department notifies the police immediately. However, in cases when a victim seeks medical treatment themselves, most hospitals do not report it to the police. To achieve efficient cooperation between health care providers and the police, both systems have to work together to address numerous issues, such as developing a framework for information sharing, professional staff management, and technological support. Moreover, both systems must share a common understanding of dealing with DV, which must be achieved not only at the top levels but also among professionals working directly with victims.

One-stop centers are facilities where victims of incidents or crimes who need support can receive police, legal, welfare, and health services in one centralized location. One-stop centers are established to reduce the psychological and financial stress of victims and to prevent further damage[12) 18) 20)]. Here victims can receive appropriate protection and efficient support without having to wait for hours in crowded hospitals. It is also important to increase the number of shelters and provide financial assistance to victims through local administrations.

As victims may have external injuries, impaired functions in urogenital organs, and trauma syndrome, including phobia, stigma, and self-accusation, when they visit medical facilities, these medical facilities should urgently improve their situations in terms of supporting DV victims, especially regarding preparedness of rooms with enough privacy and safety, and assignment of staff with specialties in forensic nursing.

Understanding and application of related law

A number of respondents indicated problems with victims' information disclosure. Owing to their narrow interpretation of the Personal Information Protection Act, health care providers are often reluctant to provide medical examination results and other confidential information on their patients to the police, thus delaying the procedures necessary for securing the victim's protection. In Japan, it is not mandatory to report cases of DV to the police, and such reporting is usually done with the consent of the patient, except in cases that include the mistreatment of a child and where reporting is legally obligatory. If patient consent is not obtained, nurses try to convince patients to allow evidence collection. The present study discovered a significant

Table 2: Level of cooperation with the police in dealing with intimate Partner violence cases (Multiple choice)

n=438

		General hospitals				Clinic				*p*
		Number of responses	%			Number of responses	%			
Level of cooperation	Separate places/facilities for examining victims	241	55.1%			217	49.5%			
	Entrances specified for victims	78	17.8%			51	11.6%			
	A space with a relaxed atmosphere	120	27.4%			134	30.6%			
	Leaflets encouraging victims to file damage reports with the police	199	45.4%			223	50.9%			
	Leaflets encouraging victims to turn to administrative bodies for support	150	34.2%			165	37.7%			
	A professional staff trained to work with IPV victims	172	39.3%			67	15.3%			
	Others	5	1.1%			5	1.1%			
Day time		n=438				n=438				<0.001
Civil situations Significant differences in attitudes	Sufficient	28	6.4%	184	42.0%	14	3.2%	118	26.9%	
	Mostly sufficient	156	35.6%			104	24.0%			
	Not quite sufficient	101	23.1%	140	32.0%	87	20.0%	132	30.1%	
	Insufficient	39	8.9%			45	10.4%			
	No experience	114	26.0%			184	42.4%			
		n=146				n=137				
The reason why cooperation was found not quite sufficient/insufficient	Absence of isolated rooms	81	55.5%			101	73.7%			
	Absence of rooms where victims could relax and calm down	56	38.4%			29	21.2%			
	Others	9	6.2%			7	5.1%			
Night time		n=431				n=414				<0.005
Civil situations Significant differences in attitudes	Sufficient	31	7.2%	177	41.1%	8	1.9%	102	24.6%	
	Mostly sufficient	146	33.9%			94	22.7%			
	Not quite sufficient	97	22.5%	138	32.0%	67	16.2%	112	27.1%	
	Insufficient	41	9.5%			45	10.9%			
	No experience	116	26.9%			200	48.3%			
The reason why cooperation was found not quite sufficient/insufficient	Absence of isolated rooms	73	51.0%			83	73.5%			
	Absence of rooms where victims could relax and calm down	56	39.2%			24	21.2%			
	Others	14	9.8%			6	5.3%			

Unpaired t-test

difference in hospital staff members' responses to police officers depending on the officer's gender and age; the police should utilize female police officers over the age of 40 years in such cases. However, few people fitting this description are available. Medical facilities should provide nurses with knowledge of forensic nursing to interact with the authorities[21]. Health care professionals should improve their understanding of the law and respond to DV by giving the highest priority to the protection and safety of victims.

Limitation of the study and future research

This study covered data collected in an area approximately one-fourth the size of Japan. However, as it is not a complete census, it does cover the entire relationship between hospitals and the police. Additionally, the responses came from police officers who are aware of being involved in DV incidents. Thus, we cannot eliminate the possibility of overlooked DV cases. It is necessary to enhance police officers' knowledge of DV and to conduct research concerning hospital scale and regional characteristics, such as urban and local areas, to improve the support systems for DV victims.

We only heard opinions from police officers in this survey. We aim to gather the opinions of medical professionals in a future study.

Conclusion

There were significant differences between general hospitals and clinics without hospitalization facilities concerning their responses to DV victims in both daytime and nighttime. An efficient measure for improving inter-institutional cooperation against DV is the establishment of one-stop centers where victims can receive all the necessary police, legal, welfare, and health services in one location.

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日本における親密なパートナーの暴力の被害者に対する支援
～病院の種別と昼夜による対応の違い～

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抄録
家庭内の暴力は被害者の心身に深刻なトラウマをもたらし、家族の生活や幸福感を脅かす。本研究は、日本における親密な関係にある暴力（DV）に関する警察の介入と一般病院や診療所との協働の課題を明らかにし、改善策を検討することである。
研究方法は横断研究であり、過去３年間にDV事犯（DV、ストーキング、高齢者虐待、児童虐待、性的虐待等）に対処したX県の警察官等に質問紙調査を行った。質問内容は、DVの被害者に対し「被害を調査するための場所/施設の分離」、「被害者専用の入り口」、「リラックスできる場所」、「被害者支援に関する情報提供」、「DVの被害者支援について訓練された専門職員の配置」等、病院側の支援体制を尋ねた。分析は、医療施設の種類によって被害者対応に差があるとの仮説に基づき、一般病院と診療所に分けて集計した。
結果、503名の警察官等に配布し、438名の回答を得た（回答率87.1％、有効回答率100％）。総合病院および診療所から十分な協力を得たと報告した回答者の数は、それぞれ184人（42％）および118人（27％）であった。回答者は、医療従事者が警察に対して非協力的な態度をとっており、DV事件をほとんど重要視していないことに言及しながら、DV報告方針の欠如を指摘した。一般病院と比較すると、診療所では夜間に被害者のプライバシーを保護する設備が不足していた。また、警察官の性別や年齢によって医療スタッフの態度に有意な差が認められた。
結論：一般病院と入院施設のない診療所の対応は均一ではなく、日中および夜間のDV被害者に対する対応に配慮が必要である。
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