21st May 2015

The Royal Commission into Family Violence
Chair
The Honourable Marcia Neave AO
PO Box 535,
Flinders Lane VIC 8009

By email: ONLINE SUBMISSION : http://www.rcfv.com.au/Submission-Form

(enquiries@rcfv.com.au)

Dear Commissioner Neave

The Victorian Medical Women's Society (VMWS) and the Australian Federation of Medical Women (AFMW) provide this submission to inform the Royal Commission into Family Violence.

We need to address our failure as a civil society to both prevent the experience of family violence, and respond to the longterm healthcare needs of victims of family violence, in order to alleviate the impact of abuse when it has already occurred. Our Government and medical responses need to be holistic, just and supportive of survivors over their lifetime because the impact on health and wellbeing is longterm.

Government initiatives to date, whilst welcome, have largely addressed the crisis needs of the minority who report the crime. However, the overwhelming majority of victims – both institutional and non-institutional - haven't reported early, if at all. Early reporting is essential, and General Practitioners (GPs) and primary care health providers need to be trained to support women who present, and 'ask the question' to support disclosure. Because the health effects of family violence and sexual violence become manifest over time, and result in complex physical and psychological health issues, the response needs to be properly-funded, holistic and longterm.

To date there has been no specific funding in health budgets to address longterm health problems and no uniform teaching of a sensitive, trauma-informed approach to medical and allied health students or to medical practitioners. A minority of medical practitioners ask their patients about a history of family violence and sexual violence even when they present with complex health issues.

There are related problems of avoidance of preventative healthcare and the inadvertent retraumatisation by medical practitioners when they don't understand the issues involved. As medical women, we are concerned that each person with a history of family violence and sexual violence receives the healthcare he or she needs from practitioners who understand the nexus between this trauma and subsequent ill-health. Medical curriculae to date don't include this as core teaching. Good treatment is also important in order to minimise the possibility of retraumatisation either as a repeat victim of sexual crime or as a result of inadvertent iatrogenic retraumatisation.

Australian women have identified intimate partner violence and sexual violence as two areas that have a critical and negative impact on their health. Sexual violence was identified as an important area that was often ignored by health professionals and the community as a whole.

The Australian Federation of Medical Women and the Australian Women's Coalition (AWC) ran a national summit, "Happy Healthy Women: Not just survivors", with community and professional stakeholders on improving responses to sexual violence. From the summit a number of recommendations were taken forward to the Hon. Kate Ellis.

These included the following:

Recommendation 16 *Incorporate long-term health sequelae of sexual violence (including assessment, treatment, management, and referral pathways) in undergraduate medical curricula, postgraduate training, and continuing medical education to equip doctors to recognise and respond effectively to the needs of survivors.(Australian Women's Coalition, Australian Federation of Medical Women et al. 2010 p.10)*

We believe that it is critical to train health professionals to respond effectively to family violence and sexual assault throughout their career, as undergraduates, postgraduates, in primary care and as specialists.

We are happy to support this recommendation with our endorsement, as a member of the reference group and aid with the dissemination through our website and newsletter and to support future upscaling (Hinton, Gannaway et al. 2011) of the project beyond undergraduate students while it is in keeping with the goals of our organisation.

In 2010, the AFMW received support for our findings when the Medical Women's International Association (MWIA) Congress adopted the following resolutions put forward by the AFMW based on our 2010 Happy, Healthy Women, Not Just Survivors (HHWNJS) project:

"In recognition that sexual violence to adults and children has far-reaching medical, psychological and community consequences for survivors and their communities, the MWIA:

- *Supports the elimination of all forms of sexual violence.*
- *Supports the education of communities to raise awareness and change attitudes towards sexual violence.*
- *Supports the education of health professionals to recognize, respond to and effectively support survivors of sexual violence; and*
- *Calls for the provision of long-term integrated counseling and health services to better support the survivors of sexual violence across a lifetime."*

In 2011 we attended the "Ending Gender-based Violence in the Asia-Pacific Region" Roundtable at Government House Canberra. The Roundtable endorsed the following AFMW recommendation:

"To ensure that health professionals are trained and supported to recognize and respond sensitively to gender-based violence and the serious physical and psychological sequelae over a lifetime. They should know pathways to care for survivors and support services and be equipped to provide longterm care."

Building on item number 10 in the Royal Commission into Family Violence, Terms of Reference:

"the expertise of professionals and academics working in the field of family violence, including any relevant international and Australian family violence research, past inquiries, reports and evaluations that may inform your inquiry and avoid unnecessary duplication."

The VMWS & AFMW submit the following recommendations:

1. That all doctors, both male and female, are facilitated to be better educated on what sexism means for our community. Incorporate long-term health sequelae of family and sexual violence (including assessment, treatment, management, and referral pathways) in undergraduate health care curriculae, postgraduate training and continuing education to equip health professionals to recognise and respond effectively to the needs of survivors across the lifetime.

2. That the importance of a healing medical response to victims of family violence and all other forms of sexual crime as an essential component of a just and supportive response be widely endorsed. To do this we need adequate funding, and a healthcare sector that has been taught how to provide sensitive, trauma-informed treatment as an essential component of their training.

3. As doctors, we would like to request that the Royal Commission ensure that people who have been affected by family violence, who take the opportunity to share their experiences with the Royal Commission, should be offered support and/or advised to seek help from a trusted professional should they feel distressed by the process.

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We are available for interview should the Commission wish to discuss any points further. We look forward to the continued discussion on this crucial issue. We can be contacted via email to vic@afmw.org.au or by phone to (03) 9421 1070.

Yours sincerely

By email

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Appendices:

1. Australian Women's Coalition, Australian Federation of Medical Women, Victorian Medical Women's Society. Happy Healthy Women: Not Just survivors. Advocating for a long-term model of care for sexual assault survivors. Sydney: AWC, 2010.
2. Vos T, Astbury J, Piers S, Magnus A, Heenan M, Walker L, et al. Measuring the health impact of intimate partner violence on the health of women in Victoria, Australia. *Bulletin of the World Health Organization* 2006;84:739-44.

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Measuring the impact of intimate partner violence on the health of women in Victoria, Australia

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Objective Using burden of disease methodology, estimate the health risks of intimate partner violence (IPV) among women in Victoria, Australia.

Methods We calculated population attributable fractions (from survey data on the prevalence of IPV and the relative risks of associated health problems in Australia) and determined health outcomes by applying them to disability-adjusted life year estimates for the relevant disease and injury categories for Victoria, Australia for 2001.

Findings For women of all ages IPV accounted for 2.9% (95% uncertainty interval 2.4–3.4%) of the total disease and injury burden. Among women 18–44 years of age, IPV was associated with 7.9% (95% uncertainty interval 6.4–9.5%) of the overall disease burden and was a larger risk to health than risk factors traditionally included in burden of disease studies, such as raised blood pressure, tobacco use and increased body weight. Poor mental health contributed 73% and substance abuse 22% to the disease burden attributed to IPV.

Conclusion Our findings suggest that IPV constitutes a significant risk to women's health. Mental health policy-makers and health workers treating common mental health problems need to be aware that IPV is an important risk factor. Future research should concentrate on evaluating effective interventions to prevent women being exposed to violence, and identifying the most appropriate mental health care for victims to reduce short- and long-term disability.

Bulletin of the World Health Organization 2006;84:739-744.

Voir page 743 le résumé en français. En la página 743 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 744.

Introduction

Reliable and comparable analysis of risks to health is essential for informing efforts to prevent disease and injury.[1] The burden of disease methodology provides a tool for estimating the impact of health problems and risky behaviours across a population, taking into account both illness and premature death.[2]

Previous burden of disease studies have been criticized for failing to provide an accurate and comprehensive picture of the burden of disease and injury among women by excluding some reproductive health conditions associated with significant rates of morbidity, and by omitting to measure the contribution of important risk factors, such as intimate partner violence (IPV), to burden of disease.[3,4]

Increasing evidence indicates that IPV is highly prevalent globally and has serious and long-lasting health consequences.[3,5] These include many disorders for which significant gender disparities in prevalence exist, such as depression, anxiety, eating disorders and reproductive and physical health problems.[6–9] To decrease gender disparities in health outcomes it is essential that the associated risk factors be clearly identified, measured and recognized as a priority for intervention.

Globally, evidence on the prevalence and the health consequences of IPV is growing steadily but, to date, the contribution of IPV to the burden of disease has not been estimated. The overall aim of our study was to estimate the contribution of IPV to the total burden of disease for women living in Victoria, Australia, in 2001. We were able to carry out this study due to the availability of good prevalence data on exposure to IPV and survey data on the health consequences of IPV in Australia, combined with a keen interest among government and nongovernmental organizations in Victoria. The first estimates of burden of disease for Victoria were developed for 1996 and updated to 2001 including IPV as a risk factor for the first time.[10,11]

Methods

Using the comparative risk assessment methods, we estimated the disease burden attributable to a particular risk factor by comparing current health status with a theoretical minimum counterfactual status.[1,12] For IPV, the theoretical minimum was defined by the counterfactual status of no past or current exposure to IPV in a population. The attributable fraction of disease burden in the population was determined by the prevalence of exposure to the risk factor and the relative risk of disease occurrence attributed to exposure. We then applied the

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attributable fractions to overall population estimates of mortality or disability burden for each of the health outcomes causally linked with the risk factor.

Prevalence

The national Women's Safety Survey (WSS) constitutes the most recent, comprehensive measurement of the prevalence of IPV in Australia.[13] We used two categories of exposure to IPV — physical or sexual violence by a partner in the past 12 months and physical or sexual violence by a partner more than 12 months ago (Table 1). We opted to use the Australian prevalence as the Victorian age-specific estimates had wide confidence intervals.

Table 1. **Prevalence of intimate partner violence by age from Women's Safety Survey 1996, Australia**

Age group (years)	Physical or sexual violence	
	In past 12 months % (95% CI[a])	More than 12 months ago % (95% CI)
18–24	5.2 (3.5–6.9)	9.0 (6.7–11.3)
25–34	4.6 (3.3–6.0)	19.1 (16.7–21.5)
35–44	3.2 (2.1–4.4)	22.7 (20.2–25.3)
45–54	2.0 (1.0–3.0)	23.0 (20.2–25.9)
>55+	0.8 (0.3–1.2)	11.7 (10.0–13.4)
Total	**2.9 (2.4–3.3)**	**17.0 (16.3–17.7)**

[a] CI = confidence interval.

Health outcomes

We based most of our estimates of the risk of adverse health outcomes on the Australian Longitudinal Study on Women's Health (ALSWH).[14] Three representative cohorts of Australian women aged 18–23, 45–50 and 70–75 years when first surveyed in 1996, have been re-surveyed at three-year intervals.[15] We obtained data from the first two surveys from the study custodians (1996 and 2000 for the youngest cohort; 1996 and 1998 for the middle-aged cohort). The sample sizes for each cohort at first interview were 14 739 and 14 011 for the youngest and middle-aged cohorts, respectively. For the youngest cohort we defined exposure to IPV by combining separate questions on "being pushed, grabbed, shoved, kicked, or hit", "being forced to take part in unwanted sexual activity" and "ever having been in a violent relationship with a partner/spouse". The first two questions were reported for the past 12 months and more than 12 months ago similar to our estimates of prevalence from the WSS. The questionnaires for the middle-age cohort did not include the third of the above questions and hence we could not distinguish IPV from violence perpetrated by others. The surveys of the older cohort in 1996, 1999 and 2002 did not include these specific questions on violence.

The self-reported health outcomes in the ALSWH included psychological disorders such as depression, anxiety disorders and deliberate self-harm; reproductive health conditions; sexually transmitted infections; and harmful health behaviours including smoking, drinking and illicit drug use. We chose the combined response to the questions on "vaginal discharge" or "herpes" as a proxy for all sexually transmitted infections; the question on "abnormal Pap smear" as a proxy for cancer of the cervix; the question on deliberate self-harm as a proxy for suicide; and the combined response to questions "eating unusual amounts in last month" and "lost control over eating" as a proxy for eating disorders.

We used multinomial logistic regression to compute the relative risk of reporting such health outcomes comparing women exposed to previous or current IPV with those reporting no such exposure to violence following a method developed by others in a previous analysis.[16] All statistical analyses were performed using Stata 8.0 and systematically controlled for socioeconomic variables (level of education, employment status, occupation, marital status, language spoken, indigenous status, place of residence) as well as smoking and drinking status.

Relative risks

The magnitude of the relative risks between IPV and all health outcome categories were comparable between the first and second survey and between the youngest and middle-age cohorts. As we could not evaluate outcome data in the middle-age cohort specifically for partner violence and the second survey had greater detail on the health outcomes of interest we decided to use the relative risks from the second survey of younger women and assumed these apply to women of all ages (Table 2). The only exception was tobacco smoking for which we assumed an exponential decrease between the higher relative risk in the youngest age cohort and the lower estimate in the middle-age cohort. As we found no significant association between violence and premature birth we decided not to include low birth weight in our list of health outcomes affected by violence.

On examining the coronial database, the Australian Institute of Criminology found that 57.6% of femicides were perpetrated by a partner and we applied this proportion to the total number of femicides recorded in Victoria in 2001.[17] For physical injuries, we took the average of the relative risks reported for having sustained bruises (2.86; 95% confidence interval (CI): 1.20–6.97), lacerations (2.03; 95% CI: 0.92–4.55) and fractures (2.62; 95% CI: 0.98–7.25) in the past five years reported from a Brisbane (Queensland, Australia) Emergency Department.[18]

Population attributable fractions

Population attributable fractions by age and cause were calculated in Excel using the formula:

$$PAF = \frac{\sum_{i=1}^{k} p_i (RR_i - 1)}{\sum_{i=1}^{k} p_i (RR_i - 1) + 1}$$

where p_i is the prevalence of exposure level i, RR_i is the relative risk of disease in exposure level i and k is the total number of exposure levels.[19,20] The population attributable fractions (Table 3) were then applied to the 2001 burden of disease estimates in disability-adjusted life years (DALYs) for the relevant disease and injury categories.[11]

We used simulation-modelling techniques and present uncertainty ranges around point estimates that reflect all the main sources of uncertainty in the calculations. For this purpose, the @RISK

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software (Palisade Corporation, New York) allowed multiple recalculations of a spreadsheet, each time choosing a value from distributions defined for input variables. The probability distributions around the input variables were based on standard errors of the prevalence and relative risk estimates. We calculated 95% uncertainty ranges for our output variables (bounded by the 2.5th and 97.5th percentiles of the 2000 values generated).

Findings

Our findings suggest that IPV has a significant impact on the health of Victorian women (Table 4). The largest contribution to the burden of disease associated with IPV was poor mental health. We found that depression, anxiety and suicide together contributed to 73% of the total disease burden associated with IPV, while harmful health-related behaviours (tobacco, alcohol and illicit drug use) accounted for another 22%.

Our results indicate that the impact was most marked among women below 45 years of age, where physical and sexual violence occurring within the context of an intimate relationship accounted for 7.9% (95% uncertainty interval 6.4–9.5%) of the total burden of disease. The impact decreased substantially among women above 45 years to 1.5% (95% uncertainty interval 1.3–1.8%) in accordance with the decrease in prevalence of IPV among older women. For the total population of women (i.e. all ages combined), IPV accounted for 2.9% (95% uncertainty interval 2.4–3.4%) of the total burden of disease.

Table 2. **Relative risk estimates for the association between intimate partner violence (IPV) and health outcomes from survey round two of youngest age cohort of the Australian Longitudinal Study on Women's Health, 2000**

Condition	IPV in past 12 months % (95% CI[a])	IPV more than 12 months ago % (95% CI)
Smoking	2.98 (2.09–4.25)	2.79 (2.33–3.34)
Alcohol abuse	1.82 (1.04–3.18)	1.47 (1.03–2.10)
Illicit drug use	2.27 (1.63–3.17)	1.23 (1.02–1.48)
Depression	3.05 (2.18–4.28)	1.96 (1.59–2.42)
Anxiety	2.59 (1.59–4.20)	1.83 (1.36–2.47)
Eating disorders	1.87 (1.39–2.51)	1.22 (1.04–1.43)
Sexually transmitted infections	2.24 (1.40–3.58)	1.54 (1.15–2.08)
Abnormal Pap-smear	1.43 (1.03–2.00)	1.46 (1.22–1.75)
Deliberate self-harm	7.05 (4.55–10.93)	2.53 (1.81–3.56)

[a] CI = confidence interval.

We found that IPV was a greater risk for ill-health among women 15–44 years of age than seven other major risk factors that traditionally have been included in burden of disease studies (Fig. 1). It was more than twice the risk of the next most important factor, illicit drug use, which contributed to less than 4%. For all ages combined, IPV caused more disease among women than alcohol and illicit drugs.

Discussion

The disease burden attributable to violence against women by intimate partners has not been estimated before. Our findings indicate that in Victoria IPV is an important risk to the health of women, particularly younger women. While the impact of IPV on the occurrence of particular health problems is being increasingly reported, the major advantage of the burden of disease methodology is that it allows a comprehensive measurement of all health risks including mortality and disability. Our estimates were facilitated by the availability of a well-conducted population survey on the exposure to IPV and survey data from a longitudinal women's health study, thus allowing an analysis of the association between exposure and health outcomes. However, our estimates required a large number of assumptions and extrapolations.

Study limitations

The prevalence data date from 1995, while our estimates of health outcomes relate to 2001. While there is some more recent information available on prevalence,[21] we chose the 1995 WSS because it is representative for the Australian population and contained more detailed and sensitive questions than other surveys. The implicit assumption was that the prevalence of IPV had not changed between 1995 and 2001. A limitation of WSS was that indigenous women and women from non-English-speaking backgrounds were under-represented. Also, because the survey only addressed women it was not possible to estimate the disease burden among men. Moreover, there were no comparable data on the health risks of IPV among men.

The ALSWH was the best source to estimate the magnitude of the association of IPV and major health outcomes, as it was representative of the whole of Australia and had a large enough sample size to examine the health consequences of reported violence. However, the ALSWH also had important limitations.

Table 3. **Population attributable fractions for health outcomes associated with intimate partner violence, Australia**

Health outcome	Age group (years)	
	18–44	45
Femicide	0.58	0.58
Suicide	0.35	0.27
Physical injuries	0.06	0.01
Depression	0.21	0.16
Anxiety	0.17	0.15
Eating disorders	0.06	0.03
Tobacco	0.23	0.06
Alcohol	0.10	0.07
Drug use	0.08	0.06
Sexually transmitted infections	0.13	0.10
Cervical cancer	0.10	0.07

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First, the response to the initial invitation to participate in the study was low (41%) and the retention rate was 71% between the first and second survey among the youngest cohort, which we chose for our analyses. Women reporting IPV in the first survey were more likely to be non-responders in the second survey, raising the question of whether non-response was related to severity of exposure to violence and subsequent health outcomes. To explore this possibility, we conducted an independent analysis, comparing the association between exposure to IPV and health outcomes in the first survey between those who did and did not respond to the second survey. There was no difference in the magnitude and direction of these associations. Moreover, for the health outcomes assessed during both the surveys, we found that the association with IPV had similar similar magnitude and direction. We concluded that there was no evidence of selection bias caused by the lower retention rate in the second survey and thus based our estimates on analyses of the second survey because of its more detailed health status information.

Second, exposure to violence in the ALSWH was not defined as in the WSS. Therefore, we could only use a set of proxy questions from the survey to approximate the exposure categories as defined in the WSS replicating previous analyses based on the same data.[16] The only way to distinguish IPV from violence perpetrated by others in ALSWH was to assume that anyone reporting "ever having been in a violent relationship with a partner" was abused by their partner if also reporting current or past, physical and/or sexual violence even though these were separate, unlinked questions. We explored whether we could include estimates of the health impact of emotional violence perpetrated without physical or sexual abuse. As the WSS recorded emotional violence in the past year only and the ALSWH asked about emotional violence that had ever been experienced, we decided not to include this aspect of IPV. This has led to some underestimation in our estimates. However, emotional violence only is much less common than physical or sexual violence which often occur together with emotional violence.[22]

Table 4. **Burden of disease in disability-adjusted life years (DALYs) by cause and age attributable to intimate partner violence, Victoria, Australia, 2001**

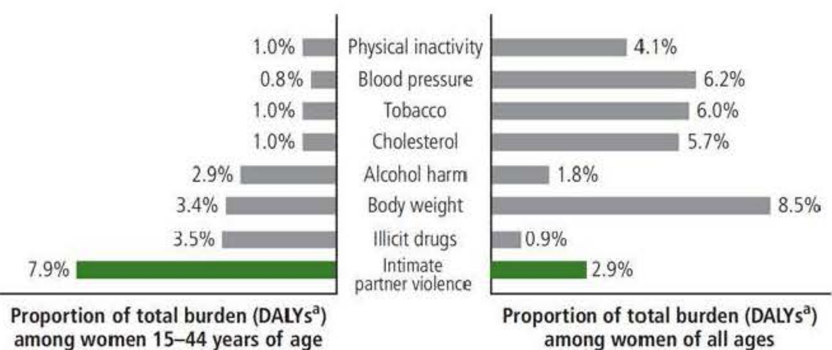
Health outcome	Age group (years)		Total	Total IPV burden, %
	18–44	⩾45		
Femicide	134	91	225	2.4
Suicide	763	243	1006	10.7
Physical injuries	39	14	53	0.6
Depression	2169	1086	3255	34.7
Anxiety	2027	532	2559	27.3
Eating disorders	48	0	48	0.5
Tobacco	177	1159	1336	14.2
Alcohol	215	254	468	5.0
Drug use	210	19	228	2.4
Sexually transmitted infections	100	9	109	1.2
Cervical cancer	29	61	90	1.0
Total	**5911**	**3468**	**9380**	**100**

Third, data on violence against women were available for the youngest and middle-age cohorts only, at the time of the second survey. Only the youngest cohort was asked about ever having been in a violent relationship with a partner. Hence, the analyses of the middle-age cohort could not distinguish IPV from violence perpetrated by others. Nevertheless, the relative risk estimates were similar in the youngest and middle-age cohorts for all health outcomes apart from smoking. We therefore decided to use the relative risk estimates derived from the youngest cohort and applied these across all ages. Only for smoking we applied a gradient by age between the relative risk estimates of the young and middle-age cohorts.

Fourth, measurements of outcomes are based on limited self-reported health status questions. While we acknowledge that these measurements are inadequate proxies for the prevalence of formally diagnosed disorders we nevertheless assumed that the difference in frequency of these proxy measures between women exposed and women not exposed to violence reflects differentials in the occurrence of more objectively defined health states. Finding a similar magnitude of relative risk estimates for different proxies for the same health state gave us more confidence in the validity of this approach.

Fifth, a cross-sectional analysis is a weak design to examine the relationship between a risk factor and disease outcomes because it cannot indicate whether exposure to the risk factor preceded the health outcome, a necessary condition to prove causality. A longitudinal study design would be better suited to study this issue. Despite the large overall study size of ALSWH the number of women who newly reported IPV between the first and second survey was too small and

Fig. 1. **The proportion of burden of disease attributable to eight major risk factors among women aged 15–44 years and women of all ages, Victoria, Australia, 2001**



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the health status information too limited to examine temporality. However, we decided that a causal relationship between IPV and health outcomes was much more plausible than a health outcome being the cause of IPV.

In burden of disease studies researchers often face the problem of imperfect data. As burden of disease results are intended to contribute to policy decision-making, abandoning the analyses due to imperfect data would convey the message that health problems for which this imperfect information exists are not important. The general approach to address this problem is to make estimates if they have at least some degree of plausibility. We argue that our data sources had enough strength to warrant completing the analyses. The similarity in the direction and magnitude of the relative risk estimates in the two age groups, for recent and previous exposure, and for different proxy questions on the same health problem in the ALSWH, as well as the similarity of our relative risk estimates with those in the international literature, swayed the argument towards completing and presenting the attributable burden of IPV.[7,8] It does mean, however, that some caution is warranted in interpreting the magnitude of the estimates.

Conclusion

The implications of our findings are manifold. First, IPV is documented as a priority health problem as well as a human rights issue and social problem, particularly among younger women. Second, health staff treating mental health and substance abuse problems in women should become more aware of how often IPV is associated with common disorders. Third, the awareness of IPV as a significant risk to health needs to be extended to the media and the general public in support of population-wide and community-based interventions aiming to decrease violence. Fourth, a concerted effort is required to establish a knowledge base of the effectiveness and cost-effectiveness of the different ways of intervening because in addition to social and economic adverse consequences IPV also significantly impacts health. ■

Acknowledgments

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Competing interests: none declared.

Résumé

Mesure des effets de la violence du partenaire sexuel sur la santé de la femme dans l'Etat de Victoria (Australie)

Objectif Estimer les risques pour la santé de la violence du partenaire sexuel chez les femmes de l'Etat de Victoria en utilisant la méthodologie de la charge de morbidité.

Méthodes L'étude a consisté à calculer les fractions attribuables dans la population (à partir de données d'enquête sur la prévalence de cette forme de violence et les risques relatifs de problèmes de santé qui lui sont associés en Australie) et à déterminer les issues sanitaires en les appliquant aux estimations des années de vie perdues ajustées sur l'incapacité pour les catégories pertinentes de maladies et de traumatismes, dans l'Etat de Victoria (Australie), en 2001.

Résultats Chez les femmes de tous âges, la violence du partenaire sexuel est à l'origine de 2,9 % (intervalle d'incertitude à 95 % : 2,4-3,4 %) de la charge totale de morbidité et de traumatismes. Chez les femmes âgées de 18 à 44 ans, la violence du partenaire sexuel est associée à 7,9 % (intervalle d'incertitude à 95 % : 6,4-9,5 %) de la charge de morbidité globale et constitue un risque plus important pour la santé que les facteurs de risque traditionnellement observés dans les études sur la charge de morbidité tels que l'hypertension, le tabagisme et l'excès pondéral. La charge de morbidité attribuée à la violence du partenaire sexuel est due pour 73 % à des problèmes de santé mentale et à 22 % à l'abus de tabac, d'alcool ou de substances illicites.

Conclusion Les résultats montrent que la violence du partenaire sexuel constitue un risque important pour la santé de la femme. Les responsables de la politique de santé mentale et les agents de santé appelés à soigner les problèmes de santé mentale courants doivent être conscients de l'importance que constitue cette forme de violence en tant que facteur de risque. De nouveaux travaux de recherche devraient porter sur l'évaluation d'interventions efficaces pour éviter que les femmes soient exposées à la violence et sur la détermination des soins de santé mentale les plus appropriés pour les victimes afin de réduire l'incapacité à court et à long terme.

Resumen

Medición del impacto de la violencia de la pareja en la salud de la mujer en Victoria (Australia)

Objetivo Estimar los riesgos que supone para la salud de las mujeres del estado de Victoria (Australia) la violencia de la pareja (VP), utilizando para ello la metodología de la carga de morbilidad.

Métodos A partir de los datos de encuestas realizadas en Australia sobre la prevalencia de la VP y los riesgos relativos de los problemas de salud conexos, calculamos las fracciones poblacionales atribuibles y determinamos los resultados sanitarios, aplicándolos a las estimaciones de los años de vida ajustados en función de la discapacidad que se perdieron en Victoria, en el año 2001, por las enfermedades y lesiones pertinentes.

Resultados En las mujeres de todos los grupos de edad, la VP fue responsable de un 2,9% (intervalo de incertidumbre del 95%: 2,4 a 3,4%) de la carga total de enfermedad y lesiones. En las mujeres de 18 a 44 años, la VP se asoció al 7,9% (intervalo de incertidumbre del 95%: 6,4 a 9,5%) de la carga general de morbilidad, y representó para la salud un riesgo más importante que los factores de riesgo incluidos tradicionalmente en los estudios sobre la carga de morbilidad, tales como la hipertensión arterial, el consumo de tabaco y el peso corporal excesivo. Los problemas de salud mental representaron un 73% de la carga de morbilidad atribuida a la VP, y el abuso de sustancias psicotrópicas el 22%.

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Conclusiones Los datos obtenidos indican que la VP supone un riesgo importante para la salud de la mujer. Los planificadores de las políticas de salud mental y los profesionales sanitarios que atienden los problemas de salud mental comunes deben tomar conciencia de que la VP es un factor de riesgo importante. Las investigaciones futuras deberían centrarse en la evaluación de intervenciones eficaces que eviten la exposición de las mujeres a la violencia y en la identificación de los cuidados de salud mental más apropiados para reducir la discapacidad de las víctimas a corto y a largo plazo.

ملخص

قياس أثر عنف القرين الحميم على صحة المرأة في فيكتوريا، أستراليا

الهدف: تقدير المخاطر الصحية لعنف القرين الحميم على المرأة في فيكتوريا، باستخدام منهجية تقدير عبء الأمراض.

الطريقة: حسبنا الأجزاء من المعطيات التي تعزى للسكان في مسح أجري حول معدل انتشار عنف القرين الحميم والمخاطر المتعلقة به للمشكلات الصحية المرافقة له في أستراليا، وتعرفنا على الحصائل الصحية بتطبيق هذه المعطيات على التقديرات الخاصة بسنوات العمر المصححة باحتساب مدد العجز الناجمة عن المرض المدروس وفئات الأذيات في فيكتوريا، أستراليا في عام 2001.

الموجودات: يُعد عنف القرين الحميم مسؤولاً عن 2.9% (بفترة عدم ثقة مقدارها 95% إذْ تراوحت القيم المقاسة بين 2.4% و3.4%) من مجمل عبء الأمراض والأذيات لدى المرأة في جميع الأعمار. أما لدى النساء بين 18 و44 عاماً، فقد ترافق عنف القرين الحميم مع 7.9% (بفترة عدم ثقة مقدارها 95% إذْ تراوحت القيم المقاسة بين 6.4% و9.5%) من مجمل عبء الأمراض، وكان الخطر على الصحة أكبر من عوامل الخطر التي تندرج في العادة ضمن دراسات عبء الأمراض، مثل ارتفاع ضغط الدم وتعاطي التبغ وزيادة وزن الجسم. بينما ساهم سوء الصحة النفسية في 37% من عبء المرض المعزو إلى عنف القرين الحميم، وساهم تعاطي مواد الإدمان في 22% منه.

الاستنتاج: تشير الموجودات التي وصلنا إليها إلى أن مكونات عنف القرين الحميم تمثِّل تهديداً خطيراً لصحة المرأة. ولابد أن يدرك أصحاب القرار السياسي في الصحة النفسية والعاملون الصحيون الذين يعالجون المشكلات الشائعة في الصحة النفسية أن عنف القرين الحميم من الأخطار الهامة؛ ولابد أن تركز البحوث في المستقبل على تقييم التدخلات الفعَّالة لوقاية النساء من التعرُّض للعنف وللتعرُّف على أكثر السُّبُل الملائمة لرعاية الضحايا في الصحة النفسية، للإقلال من العجز الطويل الأمد والقصير الأمد.

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Happy Healthy Women
Not Just Survivors

CONSULTATION REPORT

Advocating for a long-term model of care for survivors of sexual violence

AUSTRALIAN WOMEN'S COALITION

JUNE 2010

PRESENTED BY
AUSTRALIAN WOMEN'S COALITION (AWC)
AUSTRALIAN FEDERATION OF MEDICAL WOMEN (AFMW)
VICTORIAN MEDICAL WOMEN'S SOCIETY (VMWS)

Australian Women's Coalition

The Australian Women's Coalition (AWC) Inc is a national collective of 18 women's organisations working collaboratively to advance the status of women. More information about the AWC, including links to its member websites, is available at www.awcaus.org.au

THE MEMBERS OF THE AUSTRALIAN WOMEN'S COALITION INC

Aboriginal Legal Rights Movement

Australian Bosnian Women's Cultural Association Inc

Australian Church Women Inc

Australian Federation of Medical Women

Catholic Women's League Australia

Conflict Resolving Women's Network Australia Inc

Council on the Ageing Australia

Girl Guides Australia Inc

Hindu Women's Council of Australia

Mothers Union Australia

Muslim Women's National Network Australia Inc

National Council of Jewish Women of Australia Ltd

National Council of Women of Australia Inc

Pan Pacific and South East Asia Women's Association Australia Inc

Soroptimist International of Australia Inc

The Salvation Army

VIEW Clubs of Australia

Zonta International District 23 Inc and Zonta International District 24 Inc

Australian Federation of Medical Women

The Australian Federation of Medical Women (AFMW) is a not for profit, politically neutral, non sectarian, non government organisation representing Australian medical women advocating for, and supporting, the health and welfare of our local, national and international communities. More information is available at www.afmw.org.au

Victorian Medical Women's Society

The Victorian Medical Women's Society (VMWS) was founded in September 1896 with the aim to further the professional development of medical women by education, research and improvement of professional opportunities. It promotes the health and welfare of all Victorians particularly women and children, and is affiliated with the AFMW. More information is available at www.afmw.org.au/vic

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Project Executive Committee

DR RAIE GOODWACH

Dr Raie Goodwach, MBBS, MPS is a medically-trained psychotherapist who has trained and taught in psychosexual therapy, family therapy, hypnotherapy and the Feldenkrais method. She was a Consultant to the Sexual & Relationship Counseling Clinic, Monash Medical Centre for 18 years and an Honorary Lecturer in the Department of Obstetrics & Gynaecology. As an Advisor to Andrology Australia and as a member of the teaching staff of Family Planning Victoria she facilitates professional workshops on the treatment of sexual difficulties and is involved in the development of educational resources for general practitioners. She has a private psychotherapy practice and supervises, teaches and publishes in the areas of sexual difficulties and adoption.

As President of the Victorian Medical Women's Society she feels honoured to have the opportunity to go beyond treatment in the privacy of the consulting room to advocating publicly for optimal treatment of all women with a history of sexual violence in partnership with the Australian Federation of Medical Women and the Australian Women's Coalition. She believes this initiative is an essential aspect of developing a healthy Australian community.

ASSOCIATE PROFESSOR JAN COLES

Associate Professor Jan Coles is a leading Academic General Practitioner working in sexual violence research. She has worked in clinical medicine and general practice for 25 years. Her main area of research is sexual violence and women's health and the impact of childhood sexual violence on early mothering. She has presented her sexual violence research internationally and has been invited by the Sexual Violence Research Initiative to run international sexual violence workshops for researchers. She is a leading medical educator at Monash University and is responsible for the clinical skills in Year 1 and 2 MBBS at Clayton Campus. The early clinical skills program she developed incorporates an early introduction to sexual and family violence and models vertical integration in training health professionals to respond to sexual violence across the undergraduate curriculum. She has successfully supervised honours and postgraduate students in the areas of family violence and sexual abuse, child abuse and women in medicine. Her professional leadership roles are with the Women's Working Party of Wonca (World Organisation of National Colleges and Academies of Family Medicine), President-elect and Vice-President of the Australian Federation of Medical Women and the immediate past president of the Victorian Medical Women's Society.

DR GABRIELLE CASPER

Australian Women's Coalition (AWC) President, Dr Gabrielle Casper, is a Sydney gynaecologist with a special interest in women's health and human rights. She is the immediate Past President of both the Australian Federation of Medical Women and the Medical Women's International Association (MWIA). She has represented MWIA at the World Health Organisation and United Nations Meetings. In 2003 she was part of the official Australian delegation to the United Nations Commission on the Status of Women in New York. Dr Casper received the 2004 Australian Medical Association (AMA) Women's Health Award and also the 2004 AMA Women in Medicine Award. In 2006 Dr Casper was awarded the Vocational Pride of Excellence Award for her contributions to medicine by Rotary International District 9680. Dr Casper enjoys working as a gynaecologist and cares for her patients with compassion and understanding while lobbying to improve women's health in Australia and overseas. Dr Casper was one of the original representative members of AWC from 2002. She held the position of Vice President until she was elected as President in 2008.

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AWC Project Consultant

DR FRANCES PANOPOULOS MPSYCH PHD

Dr Panopoulos is a Social Policy Consultant and the AWC's national coordinator. Her professional experience spans the private, public, academic and NGO sectors. Her public service has included policy and program roles with the Australian Government Departments of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA); Defence; and the Office of the Privacy Commissioner. In her work with the AWC she has been a key contributor to several projects and policy documents, including the AWC's invited submission on the Australian Government's New National Women's Health Policy. She is a committed advocate for women's issues, with a particular interest in: mental health reform; inter- and intra-cultural issues; and the translation of community and academic concerns into well-informed public policy.

AWC community advisors

MAJOR JENNY BEGENT SALVATION ARMY

Jenny is currently the State Director of The Salvation Army's social and community services in Western Australia. She has been a Salvation Army officer for 25 years, serving in social and community services. Her main area of expertise is Family Violence. She has held office on several state peak bodies, been appointed to a number of state Committees and Boards, and is active in community activities in her personal life. Her particular interests are social policy and reintegrating the marginalised into safe and secure communities and ensuring that women who experience violence are able to live full lives following the violence.

ROBYN GASPARI BA, JP, PHF

For over 30 years Robyn has been involved in diverse activities that have heightened her awareness of the issues for both women and men who have experienced unwanted sex incidents as children, as teenagers and/or as adults. In the past few years Robyn has provided supervision to Managers and their staff in a number of NSW Women's Refuges. Her other hands-on experience includes: 10 years as a cancer support worker; 2 years as a hospital chaplain; 24 years as a conflict resolution practitioner in Australia, New Zealand, Malaysia and India; and a number of years on the Boards of Christian Community Aid Eastwood and Lifeline Harbour to Hawkesbury. She is currently Chairman of Lifeline NSW and has been associated with the Australian Women's Coalition since 2002 - originally as District Governor of Zonta International from 2002-04 and subsequently as President of Conflict Resolving Women's Network Australia Inc from 2004-10. Robyn held the roles of AWC Financial Convenor from 2002-04, Treasurer from 2004-06, President 2006-08 and Immediate Past President from 2008-10.

Messages of support

LIBBY LLOYD AM

This report provides evidence of the adverse long-term health consequences for women victims of sexual violence and it highlights the issues that need to be addressed to promote their healing. It will also considerably assist professionals respond more effectively to survivors' needs over their lifetimes.

I am proud that the previous Rudd/Gillard Government demonstrated its strong commitment to the prevention of violence against women through its draft National Plan, developed from the report *Time for Action*, which was the result of the considerable work of the former National Council to Reduce Violence against Women. This commitment continues through the new Violence against Women Advisory Group (VAWAG).

I am delighted that the Victorian Medical Women's Society and the Australian Federation of Medical Women, with the support of the Australian Women's Coalition, are leading the way to addressing the real and long-term needs of those women who have been affected by sexual violence with this evidence-based response, which is strongly linked to both *Time for Action* and the draft National Plan.

Libby Lloyd AM
Chair Violence against Women Advisory Group (VAWAG)
Chair (former) National Council to Reduce Violence against Women

PROFESSOR AFUA HESSE (GHANA)

The issue of long-term care for survivors of sexual violence is an ongoing and pressing concern for medical women around the globe. As President of the Medical Women's International Association (MWIA) I am therefore very pleased to endorse this timely work undertaken by our Australian colleagues in preparing a new model of care for survivors.
The report is in line with a recent resolution on the long-term effect of sexual violence proposed by Australian medical women and passed unanimously at the MWIA's 28th International Congress held in Germany in September 2010.
The resolution states:

> *Whereas Sexual violence to adults and children has far-reaching medical, psychological and community consequences for survivors and their communities, the MWIA:*
> *1. supports the elimination of all forms of sexual violence*
> *2. supports the education of communities to raise awareness and change attitudes towards sexual violence*
> *3. supports the education of health professionals to recognise, respond and effectively support survivors of sexual violence*
> *4. and calls for the provision of long-term integrated counselling, health and legal services to better support the survivors of sexual violence across a lifetime.*

Women doctors around the globe look forward to hearing the Australian Government's response to the 'Happy, Healthy Women: Not Just Survivors' Consultation Report.

Professor Afua Hesse
President Elect
Medical Women's International Association (MWIA)

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DR MICHAEL STEINER

The Australian Medical Association (AMA) is committed to enhancing the health of our patients. Enhancing the health of patients means advocating for access to wide ranging, accessible health services. It also means addressing the many underlying factors which can impact on the health of our patients. The AMA Position statement on Women's Health notes the importance of women being able to access comprehensive health services which recognise the particular needs of women. The position statement identifies the care of victims of sexual assault as a particular need for women.

AMA NSW is proud to have been asked to support the work of the Australian Women's Coalition (AWC) in putting forward the 'Happy, Healthy Women: Not Just Survivors' Consultation Report.

The AMA NSW encourages the Government to take seriously the call to action contained in the 'Happy, Healthy Women: Not Just Survivors' Consultation Report and we look forward to working with the AWC to progress these critical issues.

Dr Michael Steiner
President
Australian Medical Association (NSW)

Foreword

The Happy Healthy Women, Not Just Survivors report advocates for a long-term model of care for survivors of sexual violence.

The Australian Government has shown a strong commitment to the prevention of violence against women.

The recommendations presented in this paper seek to address a gap in the national agenda relating to the long-term healthcare needs of the one in three Australian women who are survivors of sexual violence.

The establishment of a multidisciplinary foundation or Centre of Excellence (including referral pathways to strengthen access to care) is critical to drive the recommendations in this report forward.

The consultation report that follows arises from a joint advocacy initiative between the Australian Women's Coalition (AWC), the Australian Federation of Medical Women (AFMW) and the Victorian Medical Women's Society (VMWS).

While the Government's initiatives to date have focused on the immediate aftermath of disclosure, with dedicated rape crisis centres and phone counseling, insufficient attention has been paid to the long-term needs of sexual assault survivors. With most survivors not disclosing sexual violence for at least ten years the existing Government initiatives, while very important, do not address the health and well being issues which may be ongoing and exacerbated by life events years later. In short, there remains a critical dissonance between survivors' needs and service provision.

The 'Happy Healthy Women: Not Just Survivors' project was therefore driven by the need to improve the recognition of the sequelae of sexual violence in order to promote sensitive and competent healthcare which provides long-term healing opportunities for survivors of sexual violence. The long-term aim is to enable communities and professionals to more effectively respond to sexual abuse survivors as an essential aspect of developing healthy Australian communities. The approach is also expected to reduce the cost burden associated with inadequate treatment over the longer term.

The present consultation report is a critical step in informing national policy development in this area. It provides a blue-print for the issues that need to be addressed in order to safely and effectively meet the needs of survivors over a lifetime. The recommendations are informed by key stakeholders' contributions during a series of roundtable discussions and the 'Happy Healthy Women, Not Just Survivors' National Summit.

In addition to the consultation process, the recommendations are supported by a timely review of the recent medical literature prepared for this project by Professor Caroline Taylor and Dr Judith Pugh of the Social Justice Research Centre, Edith Cowan University. The review looks at the long-term physical and mental health sequelae, health risk behaviours and costs to the Australian community of sexual violence, and identifies the lack of education and training for health professionals as a barrier to good healthcare. Current Australian undergraduate training practices are summarised and educational resources described to assist in addressing the deficit.

We extend our sincere thanks to those who participated in the National Summit and roundtable discussions for their commitment to advocating for a long-term model of care for survivors of sexual violence.

Dr Raie Goodwach   Associate Professor Jan Coles   Dr Gabrielle Casper

Part 1 A new model of care

HAPPY HEALTHY WOMEN, NOT JUST SURVIVORS

Introduction

The vision for the 'Happy Healthy Women, Not Just Survivors' project is a national policy and practice landscape that supports long-term optimal treatment for survivors of sexual violence.

At the time of compiling this report, the Australian Government announced a further $12.5 million over four years to establish a new 'first door' counseling service for women who are at risk of or have experienced physical or sexual violence.[1]

While the additional counseling services are welcome, the assumptions under-pinning such Government programs are based on a short term vision that does not take into account the needs of women who do not disclose, or disclose at a much later date.

In contrast to the prevailing policy approach in Australia, the present project advocates for a comprehensive model for responding to the needs of survivors over the longer term.

The new model is based on clinical and research evidence that sexual violence manifests in physical, psychological and social harm that has implications well beyond the initial trauma stages at which services are presently targeted.

The community, professional, academic and survivor groups who were consulted for this project identified the following five themes as the key issues to be addressed when improving the health and healthcare of survivors across their lifespan:

- Effecting cultural change in Australia – changing community attitudes and behaviours
- Changing survivors' behaviour related to health care
- Changing health care services
- Investigating the impact of sexual violence over the lifespan
- Changing the legal environment in Australia.

Part 1 of this report addresses each of the key themes as an individual issue and presents recommendations developed from those key themes. The recommendations are drawn from creative solutions offered by the stakeholders who participated in the consultation phases of the project.

The project is under-pinned by a literature review identifying deficiencies in existing responses to sexual violence. The review forms Part 2 of the present report.

[1] Media release dated 16 July 2010, 'Government announces initiatives to address domestic and family violence', Tanya Plibersek MP, Minister for Housing, Minister for the Status of Women.

Recommendations for reform

EFFECTING CULTURAL CHANGE IN AUSTRALIA - CHANGING COMMUNITY ATTITUDES AND BEHAVIOURS

Sexual violence should be recognised as a social issue that requires socio-cultural change. Contextual factors associated with poor health and wellbeing in survivors must be changed in order to achieve social justice for survivors, empower survivors, reduce their alienation, and increase their connectedness to others in the community. Changing community attitudes and behaviours is critical and requires a national 'joined-up' approach to policy and responses across the lifespan.

Recommendation 1 Educate the Australian community as well as public policy makers, Governments, healthcare and legal professionals to raise awareness of sexual violence, its consequences, long-term sequelae and the needs of survivors.

Recommendation 2 Provide survivors with information to assist them to negotiate the healthcare, support and legal systems and empower them to make decisions.

Recommendation 3 Develop national 'joined-up' policy and coordinated responses.

Recommendation 4 Develop schools-based education programs that raise awareness of sexual violence, include respectful relationships and are gender-sensitive throughout the community, as well as appropriate and targeted programs for high risk groups (people with disability, Aboriginal and Torres Strait Islanders).

Recommendation 5 Develop national strategies to prevent the perpetration of sexual violence (community and prison based).

CHANGING SURVIVORS' BEHAVIOUR RELATED TO HEALTH CARE

There is a need to help survivors change their health-related behaviour so that they can lead healthier lives. The ability to recognise symptoms related to experiences of sexual violence will enable prompt self-referral and support, which will in turn aid recovery.

Recommendation 6 Educate patients to recognise the nexus between experiences of sexual violence and poor health and empower them to access and manage their health care (e.g. holding own medical records).

Recommendation 7 Create a national database for survivors (including information; self-help resources; referral pathways; profiles of agencies; recommended health, legal and support professionals) which includes the distribution of information in multiple (accessible) formats and languages.

Recommendation 8 Initiate an ongoing health promotion campaign to raise awareness of sexual violence.

Recommendation 9 Develop ongoing accessible and affordable community and healthcare services which extend far beyond the acute response.

CHANGING HEALTH CARE SERVICES

There is a need for enhancements to the health care system that provides formal support to survivors (medical and mental health systems). The current system is fragmented and in need of an overhaul to reorient it towards inter-disciplinary and cross-sectoral models of service provision (including the third sector that provides both services and advocacy). Current funding arrangements and the corporatisation of general practice, in particular, are regarded as problematic.

Survivors require equitable access to affordable specialised counseling services that fit the ongoing nature of the health impacts of sexual violence. Medical professionals, in general, lack the knowledge, skills, attitudes, and values to appropriately identify, treat, and manage the complex health sequelae of sexual violence and the full range of issues that survivors may present with in various settings. Building the capacity of healthcare professionals through education and training, therefore, features amongst proposed solutions especially for primary health care providers.

Recommendation 10 Provide holistic, integrated and affordable healthcare models of service which address both physical and psychological needs and include complementary models of wellbeing.

Recommendation 11 Provide long-term, dedicated government funding of, and policy priority for, specialised services for survivors of sexual violence.

Recommendation 12 Assist the Government to augment and improve service provision across all sectors to intervene and effectively respond to the health consequences of sexual violence thereby reducing the economic burden to the nation.

Recommendation 13 Provide family-oriented, relationships-based services (particularly to address the flow-on effect to children).

Recommendation 14 Improve coordination and communication within and across services (including intra-sectoral and cross-sectoral partnerships, and interdisciplinary teams) to improve linkages and understanding between agencies.

Recommendation 15 Provide Medicare reimbursement that appropriately remunerates all service providers for time-intensive services (including history-taking, multi-disciplinary health care planning, and long-term psychological therapy) and rebates patients (thus recognising the economic burden of long-term utilisation of services).

Recommendation 16 Incorporate long-term health sequelae of sexual violence (including assessment, treatment, management, and referral pathways) in undergraduate medical curricula, postgraduate training, and continuing medical education to equip doctors to recognise and respond effectively to the needs of survivors.

Recommendation 17 Establish a national clearinghouse for healthcare professionals (including research in the field, patient resources, professional support and referral resources).

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INVESTIGATING THE IMPACT OF SEXUAL VIOLENCE OVER THE LIFESPAN

There is a recognised need for a comprehensive evidence based strategy that firmly establishes the relationship between sexual violence and lifetime health sequelae. The establishment of such evidence would guide future practice and provision of care to survivors.

Recommendation 18 Establish a multi-disciplinary foundation or Centre of Excellence (including referral pathways to strengthen access to care) to drive initiatives.

Recommendation 19 Conduct Australian longitudinal research into all aspects of the health impacts of sexual violence (including the disaggregation of gender-based violence data by gender and type of violence) to provide evidence for policy, healthcare, and support programs and services and provide resources so existing Australian longitudinal data can be analysed.

Recommendation 20 Improve the evidence for models of care and community interventions to effect change.

CHANGING THE LEGAL ENVIRONMENT IN AUSTRALIA

More criminal convictions of perpetrators of sexual violence are necessary to change cultural and community attitudes. However, it is also recognised that the adversarial legal system often re-traumitises survivors (Taylor, 2004a; 2004b). At present, few survivors receive compensation for past and future losses sustained as a result of the violence.

Recommendation 21 Simplify the prosecution process; for crimes of this nature, replace the accusatorial system with an inquisitorial system (e.g. as in France).

Recommendation 22 Impose sanctions or outcomes to reflect the seriousness of the crime.

Recommendation 23 Publicly critique and change legal and medical discourses that perpetuate tolerance of sexual violence (e.g., definition of incest as less harmful form of abuse).

Recommendation 24 Implement Australia-wide education of police, legal professionals, and judges towards responsive and sensitive practice and services that protect survivors from re-traumatisation.

Recommendation 25 Establish Australia-wide third party insurance (or similar) to compensate survivors for special damages and general damages resulting from sexual violence, and facilitate claims by parents/ guardians on behalf of abused children.

Evidence Based Approach

In addition to the consultation process, the AWC, AFMW and VMWS commissioned a literature review that identifies key deficiencies in the way that historical sexual violence and its health sequelae are dealt with in the Australian context. This section summarises some of the key points from the literature review, which is reproduced in Part 2 of this report.

PREVALENCE

- It is estimated that over their lifetimes one in three women in Australia are survivors of sexual violence.
- The prevalence rate for childhood sexual abuse lies between 12 and 20% of Australian women.

DISCLOSURE AND RE-TRAUMATISATION

- Despite the prevalence rates, many survivors do not disclose their experiences of sexual violence.
- Doctors are likely to see women for health problems associated with sexual violence without even realising it.
- Health services and the medical encounter can re-traumatise affected women.

PHYSICAL AND MENTAL HEALTH OUTCOMES

- Sexual violence is often associated with reproductive and sexual health problems, lifetime mental health disorders, other chronic physical health problems, and substance abuse and dependence.

HEALTH SERVICE DEFICIENCIES

- The complex and often confusing psycho-physiological presentations can lead to under-detection, misdiagnosis and ineffective treatment.

SOCIAL CONSEQUENCES AND HEALTH SERVICE COSTS

- Compared to non-victimised women, those with a lifetime history of sexual violence are higher users of health care services.
- The total cost of sexual assault to the Australian community in the previous 12 months to 2005 was estimated to be $720million.

REFORMING MEDICAL CURRICULA

- Most existing curricula focus on recent sexual assault and/or abuse and not on the long-term health sequelae of sexual violence over the lifespan.

EXISTING GUIDELINES AND POLICIES

- Existing interagency protocols in Australia are inadequate in that they only address acute and crisis care responses.
- The National Plan to Reduce Violence Against Women and Their Children does not adequately address the needs of survivors of historical sexual violence and abuse.

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Who was consulted

A key strength of this project has been its emphasis on consulting a broad group of stakeholders representing both professional groups and the advocacy community.

The approach was informed by several roundtable discussions with AWC member organisations, doctors including A/Professor Jan Coles (AFMW) and Dr Raie Goodwach (Psychotherapist and President VMWS), Libby Lloyd AM (Chair VAWAG) and Professor Caroline Taylor (Foundation Chair of Social Justice, Edith Cowan University).

Preliminary roundtable discussions culminated in a National Summit held in Melbourne on 7 May 2010 and hosted by the VMWS, AFMW and AWC.

Finally, a literature review was undertaken by Professor Caroline Taylor and Dr Judith Pugh, in consultation with A/Professor Jan Coles, Dr Raie Goodwach and AWC members.

AWC ROUNDTABLE DISCUSSIONS

In a series of roundtable discussions held in preparation for the National Summit, the members of the Australian Women's Coalition (AWC) raised several key issues of concern to them, including:

- the need for significant funding for longer term, integrated support given the multidisciplinary nature of the services and holistic context of healing (health, social, psychological and spiritual)
- the need for education and training at multiple levels – for health and justice professionals as well as within the broader community
- the need to benchmark competencies for a range of professionals, not just health professionals
- the need for uniform protocols to guide legal and health professional responses to victims of sexual violence
- the positive role of the AWC and its networks and affiliates as dissemination points, with multiple levels of access for affected women
- access issues for women living in rural and remote areas
- cost of counseling for women of low socio-economic means
- challenges particularly affecting trafficked women and girls
- specific challenges for women and girls who come into contact with the justice system, given that many of them have significant pre-existing life histories of abuse.

AWC MEMBER ORGANISATIONS

Aboriginal Legal Rights Movement

Australian Bosnian Women's Cultural Association Inc

Australian Church Women Inc

Australian Federation of Medical Women

Catholic Women's League Australia

Conflict Resolving Women's Network Australia Inc

Council on the Ageing Australia

Girl Guides Australia Inc

Hindu Women's Council of Australia

Mothers Union Australia

Muslim Women's National Network Australia Inc

National Council of Jewish Women of Australia Ltd

National Council of Women of Australia Inc

Pan Pacific and South East Asia Women's Association Australia Inc

Soroptimist International of Australia Inc

The Salvation Army

VIEW Clubs of Australia

Zonta International District 23 Inc and Zonta International District 24 Inc

THE NATIONAL SUMMIT

The National Summit brought together a diverse group of stakeholders including representatives from:

- peak medical women's bodies
- national women's organisations
- disability services and networks
- Centres Against Sexual Assault
- survivors of sexual violence
- not-for-profit social and community services
- community-based advocacy groups
- church groups
- university-based researchers
- medical professionals (including GPs, obstetricians, and psychiatrists)
- medical and nurse educators
- public health services and hospitals
- legal and police services

SUMMIT PARTICIPANTS

Ms Ruth Baker, Lawyer, Lewis Holdway Lawyers

Major Jenny Begent, State Director Social and Community Services, Salvation Army, Western Australia

Ms Robyn Berry, Edith Cowan University

Ms Nisha Bhatnagar, Hindu Women's Council of Australia

Mrs Dot Boxhall

Associate Professor Jan Coles, Australian Federation of Medical Women/Department of General Practice

Associate Professor Deb Colville, Ophthalmologist & Medical Educator, National Coordinator Australian Federation of Medical Women

Ms Leonie Christopherson AM, Australian Women's Coalition (AWC) / National Council of Women

Ms Janine Dillon, Office of the Public Advocate

Dr Kate Duncan, General Committee, Victorian Medical Women's Society (VMWS)

Ms Catherine Evans, National Representative, Soroptimist International Australia

Sgt Patrick Flemming, Branch Manager, Hervey Bay Police Citizens Youth Club, Qld

Ms Robyn Gaspari, President, Conflict Resolving Women's Network Australia Inc

Ms Pauline Gilbert, Manager, CASA House (Centre Against Sexual Assault)

Dr Raie Goodwach, President, Victorian Medical Women's Society (VMWS)

Ms Nikki Greenway

Associate Professor Kelsey Hegarty, Director Postgraduate Nursing Programs, University of Melbourne

Ms Karen Hogan, CASA Victorian Centres Against Sexual Assault

Ms Keran Howe, Executive Director, Victorian Women With Disabilities Network

Dr Kay Jones, Senior Research Fellow, Monash University

Mrs Anne (Patricia) Kennedy, Australian Church Women Inc

Ms Adeline Lee

Dr Gita Mammen, Consultant Psychiatrist

Dr Judy McHugh, Manager, Centre Against Sexual Assault (CASA)

Dr Francoise Muller-Robbie

Dr Debbie Owies, Southern Health (Victoria)

Dr Frances Panopoulos, Social Policy Consultant and Coordinator Australian Women's Coalition (AWC)

Dr Judith Pugh, Research Associate, Social Justice Research Centre, Edith Cowan University

Ms Rosney Snell, Board Member, Aboriginal Legal Rights Movement (ALRM)

Dr Angela Taft, Senior Research Fellow, Mother and Child Health Research, La Trobe University

Dr Meilen Tan, Royal Australian and New Zealand College of Psychiatrists (RANZCP)

Professor S. Caroline Taylor, Foundation Chair in Social Justice, Social Justice Research Centre, Edith Cowan University

Dr Rosalind Terry, The Alfred

Dr Joanne Wainer, Director, Gender and Medicine Research Unit, Monash University

Ms Carolyn Worth, Convenor / Public Officer, Victorian Centres Against Sexual Assault

Dr Desiree Yap, President, Australian Federation of Medical Women

SUMMIT OPENING ADDRESS

Opening address Happy Healthy Women, Not Just Survivors Summit, 7 May 2010, Melbourne, delivered by Dr Raie Goodwach, President, Victorian Medical Women's Society

It's my honour to welcome you here today as important stakeholders in the "Happy Healthy Women, not Just Survivors" national summit. This advocacy project was initiated by the VMWS in conjunction with the AFMW with funding from the AWC.

Our Government has shown a strong commitment to the prevention of violence against women. Libby Lloyd AM, Chair of the Commonwealth's Violence Against Women Advisory Group sent us the following message of support:

> *Dear Raie and Jan*
>
> *Re: Invitation to the 'Happy Healthy Women, not Just Survivors' summit.*
>
> *I am sorry that due to other commitments I can't join you today for the 'Happy Healthy Women, not Just Survivors' summit. Our Government is committed to the prevention of violence against women. I offer my support for this important pilot project funded by the AWC in which the medical women of Australia are taking a lead in raising awareness of the long-term health needs of survivors of sexual trauma and the importance of good treatment for those who have been affected.*

We initiated this project because we believe that a Government that is interested in prevention of violence against women should also be interested in the long-term health and welfare needs of the one in three women who have already suffered sexual trauma.

These criminal acts have few consequences for the perpetrators but long-term impacts on the victims.

That they have little recourse to justice is not our topic for today. That their lifetime health needs are not recognised by government and not understood by the helping professions is our focus today.

Government initiatives to date have focused on the immediate aftermath of disclosure with dedicated rape crisis centres and funding for phone counseling. The ordinary doctor has no training in the area. With most survivors not disclosing their trauma for at least ten years the Government initiatives, whilst very important, do not address the health and wellbeing issues which may be ongoing or exacerbated by life events years later, for example with childbirth or breastfeeding.

A related concern is that what is done as part of routine healthcare can inadvertently retraumatise these women and add to their pain and suffering. We want to redress the lack of understanding and lack of simple protocols that lead to this.

We believe that government policymakers need solid evidence to show them why funding is needed for long-term treatment to remedy the physical and psychological damage so we have happy, healthy women, not just survivors. For this reason we commissioned a literature review which has been carried out by Dr Judith Pugh from Edith Cowan University, supervised by Professor Caroline Taylor, Foundation Chair in Social Justice to give us a clearer idea about what is known about the long-term sequelae of sexual trauma and identify the gaps in knowledge. We wanted to know: How often do victims of sexual trauma receive holistic, integrated treatment that addresses their physical and psychological needs? Are there 'best practice' models so we're not trying to re-invent the wheel?

We convened this summit so we could get your valuable input – survivors, community bodies, representatives of government, the treating professionals, lawyers and police. The resolutions from this Summit will be taken forward to Government by the AWC.

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Today we are focusing on the medical response and effects on women. We have not forgotten that there are health consequences for men who have been sexually traumatised, and difficulties for female and male victims of sexual trauma in the legal arena – but because of time and funding restraints we had to limit our focus.

My work as a therapist has taught me that trauma that is buried is not gone – it gets written in the body as symptoms. Doctors by and large haven't understood the connection between sexual trauma and patients' symptoms – between the body, the spirit and the mind.

Our limited goal in this pilot project is to advocate for funding to begin a process that will help doctors understand and treat women who have suffered sexual trauma holistically. We would know we were successful if women who have been traumatised felt they could tell their treating doctors and feel listened to, understood and having their physical and psychological needs addressed respectfully.

Integrated treatment is now understood for illnesses like diabetes and heart disease. You look to the cause and try to address the cause as well as the symptoms. This type of model strikes me as one that could be helpful in the treatment of sexually-traumatised women.

And now to our speakers. I feel honoured that each of you accepted our invitation to speak, because each of you brings a different and important perspective.

Our first speaker is Dot Boxhall. We are honoured you are with us today.

Dot Boxhall is a survivor of childhood sexual abuse and rape. Dot has become a leading activist, advocate and media spokesperson for fellow survivors in her home state of Tasmania and was a founding member of Survivors Confronting Child Abuse and Rape. Amongst her many activities in this area, she has set up a network of support groups for survivors and provided evidence to government about mental health issues.

Our second speaker is Jenny Begent the State Director of the Salvation Army's Social and Community Services in Western Australia. Her main interests and passions are in issues relating to social and women's policy. She has served in the community sector for 25 years in areas such as domestic violence, drug and alcohol services, prisons and homelessness.

Our third speaker Robyn Gaspari is immediate past president of AWC. She brings the experience of 19 women's groups representing 3 million women with her today. She was a member of the delegation to the 2004 United Nations' Commission on the status of Women.

Our final speaker is Angela Taft a Senior Research Fellow at the Mother and Child Health Research unit at Latrobe University and an honorary fellow in the Department of General Practice, University of Melbourne. She has a strong interest in the rigorous combination of qualitative and quantitative methods to answer complex questions about women's health.

Closing remarks:

I want to thank all of you for giving your time and energy to join us here today. This is an important first step toward developing a more effective national response to the health needs of women who have a history of sexual trauma.

In particular, I want to thank our speakers – Dot, Jenny, Robyn and Angela. They set the scene for your hard work so ably led by Jan. Caroline, thank you both for organising the research and summarising the findings so eloquently.

Our combined input will now be digested by Judith Pugh, Caroline, Jan and myself and we will put forward a number of motions to the AWC to advance to government to help them understand why there should be specific funding and specific focus. Prevention is always better than cure, but when people are already traumatised they need good treatment both for their own health and wellbeing and the wellbeing of future generations. Trauma is transmitted when it is not treated.

Part 2 Review of evidence

HAPPY HEALTHY WOMEN, NOT JUST SURVIVORS

Scope of the review

Academic researchers of the Social Justice Research Centre (SJRC), Edith Cowan University, were invited to review the literature on the long-term health sequelae, health risk behaviours and costs to the community of sexual violence and to examine whether this knowledge translates into medical education and best practice in medical treatment in Australia. The literature review, reproduced below, was submitted to the AWC in June 2010.

About the reviewers

Professor S. Caroline Taylor

Professor S. Caroline Taylor is the Foundation Chair in Social Justice and Head of the Social Justice Research Centre at Edith Cowan University. She was appointed to this role in November 2008. She is an Honorary Research Associate at the Indigenous Law Centre, University of New South Wales. Professor Taylor is recognised as one of Australia's leading experts in the field of child and adult sexual violence and domestic violence and the criminal justice response to victim/survivors and social models of trauma and recovery. Her work has been cited to support law reform in a number of Australian jurisdictions and is frequently cited in various state parliamentary Hansard documents when ministers and other politicians have referred to her work, advocacy and influence in the area of sexual violence, child abuse and domestic violence. She is the author of several monographs, journal articles, reports and media opinion pieces.

Professor Taylor was appointed to the Advisory Committee for the Victorian Law Reform Commission's Inquiry into Sexual Offences Law and Procedure (2002-2004). The commission drew heavily on Professor Taylor's research to inform their Interim and Final Reports with the latter report detailing 201 recommendations for law reform. Professor Taylor's PhD thesis received the prestigious 'Jean Martin Award' from The Australian Sociological Association for the most outstanding PhD in social sciences from an Australian university for 2000-2001. By invitation she conducts training seminars and workshops for police, judges, lawyers, medical practitioners, psychologists and teachers on the topic of sexual violence, children's rights, trauma impact, and healing and recovery. She also conducts closed workshops for survivors. Professor Taylor founded a charity organisation in 2004 (Children of Phoenix Org) that provides education and training scholarships and mentors for children, adolescents and adults affected by childhood sexual abuse. In recognition of her contribution to law and policy reform, public education and awareness and her ongoing advocacy for the rights of children and women, Professor Taylor was awarded a Human Rights award from HREOC in 2006. Professor Taylor provides expert opinion evidence in sexual offence proceedings. She currently leads a Large ARC Linkage Grant 5 year project with Victoria Police ($1.3 million) to improve their response, investigation and management of adult sexual offences. Her most current work on social exclusion and identity wounding for rape survivors will be released as a book in 2010.

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Dr Judith Pugh, PhD, MEd, Postgrad Dip Curriculum & Educational Technology, BA, Dip Ed

Dr Judith Pugh works as a researcher associate in the Social Justice Research Centre and the School of Nursing, Midwifery and Postgraduate Medicine and at Edith Cowan University, Western Australia. She has a clinical nursing background.

Dr Pugh has been the research associate on a number of social research projects including a recent Australian Research Council Linkage Project examining the costs of meeting and not meeting the need for support services for people with intellectual disability in Western Australia; and another Lotterywest-funded project examining the relationship between the local government and the non-government sectors for community development and community servicing in WA.

Dr Pugh is currently involved with studies related to the transition experience of adolescents with type 1 diabetes moving from juvenile to adult diabetes clinics with the School of Nursing and Midwifery, Curtin University of Technology, in conjunction with the Centre for Nursing Research, Sir Charles Gairdner Hospital.

She also has considerable experience in the non-government sector researching, writing and producing community education and health promotion resources about hepatitis C. She has published in the area of news reporting on hepatitis C in Australia and is a reviewer on the area for scholarly journals.

The need for this project

Violence against women is a human rights and social justice issue. It is a serious and unremitting issue of global concern. In 1993, the United Nations' (UN) General Assembly adopted the Declaration on the Elimination of Violence Against Women in recognition of the prevalence worldwide of violence against women of all ages in the family and society, which is 'likely to result in physical, sexual or psychological harm or suffering to women' (General Assembly, 1993, Article 1). The UN appointed a Special Rapporteur with a 'mandate to collect and analyse comprehensive data' on violence against women and monitor the responses and actions of all governments to this issue including their efforts to remedy the consequences of violence to women over the lifespan (Dept Public Information, 1996, p. 1a). To fully enact the philosophy underpinning 'human rights' it is incumbent upon the Australian Government to develop and provide a sound, integrated model of health care that embraces a holistic understanding of what is needed to help women who have been affected by sexual violence heal. To do so is not only cost-effective in a fiscal sense but also in terms of reducing the life-long socioeconomic costs that burden survivors, their families and the community.

Of concern to the VMWS and the AFMW are the deficiencies in current health care models of treatment to aid both physiological and psychological healing as well as specialised training for medical and allied health practitioners. Of particular concern is the lack of an integrated and cohesive model of long-term health care that recognises the long-term health sequelae for women associated with sexual trauma and the much needed development of policies and provision of funding and infrastructure to support this model of health care.

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Overview

Sexual victimisation of women is a serious public health problem. It is estimated that one in three women in Australia[2] are victims of sexual trauma over their lifetimes often in conjunction with physical and/or psychological violence, and often by an intimate partner (Mouzos & Makkai, 2004), while the prevalence rate for child sexual abuse in Australian women has been estimated at between 12 and 20%[3] (ABS, 2006; Fleming, 1997). Sexual trauma can adversely affect women's long-term physical, psychological and relational health. However, many survivors do not disclose[4] or report their experiences of sexual trauma to a third party, including health care providers (de Visser, Smith, Rissel, Richters, & Grulich, 2003; Fleming, 1997; Golding, Wilsnack, & Learman, 1998; Lievore, 2003; Mouzos, & Makkai, 2004). So it is likely that doctors may assess women for health problems stemming from sexual trauma without even realising the underlying causes (Martin et al., 2008; Plichta, 2004). Health care services and what is done as part of routine health care can retraumatise affected women (Hooper & Koprowska, 2004; Hooper & Warwick, 2006). To-date, however, Government initiatives have been focused on the immediate aftermath of disclosure and have not addressed the ongoing health and wellbeing issues.

This paper argues for expanded education and training of medical practitioners in the long-term health outcomes of, and delivery of health care to, women with a lifetime history of sexual trauma. It outlines how investment in undergraduate medical curricular, postgraduate training and the development of clinical practice guidelines for medical practitioners in the area of health care for women with a lifetime history of sexual trauma is warranted in light of the

- current evidence on long-term health sequelae associated with lifetime history of sexual trauma;
- health costs of the long-term health sequelae associated with a lifetime history of sexual trauma and other economic costs; and
- social justice issues.

[2] In the national Personal Safety Survey 2005, the Australian Bureau of Statistics (2006, p. 7) found that 17% of women had experienced sexual assault since the age of 15.
[3] In her research on the prevalence of childhood sexual abuse in a community sample of Australian women, Fleming (1997) found a rate of 20% for sexual abuse by an adult involving at least genital contact; in 14 of the 144 women the abuse involved either vaginal or anal intercourse (representing 2% of the sample population of 710 women). In the national Personal Safety Survey 2005, the ABS (2006, p. 12) defined child sexual abuse as 'any act, by an adult, involving a child under the age of 15 years in sexual activity'. It found that 12% of women had been sexually abused before the age of 15 according to this definition.
[4] Barriers to disclosing childhood sexual assault by adult victim/survivors include fear of family breakdown, fear for own safety, and fear of not being believed (Fergus & Keel, 2005).

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WHAT IS SEXUAL TRAUMA

In this paper, the term 'sexual trauma' is used to incorporate references to all forms of sexual assault, rape, attempted rape, contact and non-contact sexual violence, and childhood sexual assault. It refers to unwanted and non-consenting sexual activity in childhood, adolescence, and adulthood.

Sexual trauma and women's health: review of the literature

The English-language published literature was searched for links between women's experiences of sexual trauma and the potential for later, ongoing physical and psychological ill health across the life cycle. The data was extracted from the literature for the years 1995-2010, with additional related published research cited in reference lists. A Boolean search was made of the following four health sciences databases: CINAHL Plus; Medline; PsychINFO; and SPORTDiscus using "women's health" AND "sexual trauma", "women's health" AND "sexual violence", and "women's health" AND "sexual assault" as the key phrases. An additional search was made of the same databases using the key phrases "women's health" AND "child sexual abuse". The search outcome included: literature and research reviews; original research comprising survey research including large population-based surveys (self-administered questionnaires, interviewer-administered questionnaires, and inventories); secondary analysis; and limited qualitative research. Many of the studies sample women in the US; most are cross-sectional rather than longitudinal and researchers tended to utilise single items (yes/no) rather than measures that reflect the violence severity. Nonetheless, the association of women's childhood and adult sexual trauma with a broad range of longer-term health problems is such as to warrant careful consideration by those involved in medical care in Australia. An overview of the long-term health outcomes most reported follows.

The international literature shows, different populations and cultures notwithstanding, that the effect of sexual trauma on women's physical and psychological health is long lasting and presents as an array of symptoms and medical conditions in patients seeking health care services. Recognising that cause and effect cannot be determined from cross-sectional data and that aggregated data is often reported for physical and/or sexual trauma, particularly in relation to intimate partner violence (IPV), rather than sexual trauma per se, sexual trauma is often associated with reproductive and sexual health problems in women including gynaecological problems and sexually transmitted infections; mental health problems; other physical health problems; and substance abuse and dependence. The adult health sequelae of childhood sexual abuse, alone, arise from complex psychophysiological changes, which may confound both survivors and health care professionals resulting in misdiagnosis and ineffective treatment (Monahan & Forgash, 2000). Beset by health problems, women with a lifetime history of sexual trauma may have impaired daily functioning (self-care, work and recreation) and relational health (e.g., parent-child).

PHYSICAL HEALTH OUTCOMES

A lifetime history of sexual trauma including child sexual abuse has been linked to poor physical health and persistent problems for women including: functional gastrointestinal disorders and symptoms (e.g., irritable bowel syndrome and abdominal pain); chronic headache; back pain; chronic fatigue; sleep disturbances; and cardiovascular disease (Bonomi, Anderson, Rivara, & Thompson, 2007; Frayne et al., 1999; Leserman, et al., 1996; Leserman & Drossman, 2007; Linton, 1997; Salam, Alim, & Noguchi, 2006).

Affected women are likely to present with multiple physical symptoms and medical conditions and have lower SF-36 physical health scores (Bonomi, et al., 2007). In their review of the evidence, Leserman and Drossman (2007) reported that women with a lifetime history of sexual and/or physical abuse or IPV have 1.5 to 2 times the risk of functional gastrointestinal disorders and symptoms, which adversely impact their health-related quality of life and increases their utilisation of healthcare services. Explaining the relationship, Leserman and Drossman suggested that functional gastrointestinal disorders most likely resulted from 'dysregulation of the brain and the gut neurological systems' (p. 335).

In women survivors of violence including sexual trauma, co-morbid disorders such as sleep disturbances, hostility, and depression are thought to be associated with immune dysfunction (cytokine levels), which in turn increases their risk of cardiovascular disease and metabolic syndrome and associated type 2 diabetes (Kendall-Tackett, 2007).

GYNAECOLOGICAL AND OBSTETRIC HEALTH OUTCOMES

The list of persistent gynaecological problems in women following sexual trauma includes: pelvic pain; dysmenorrhoea (menstrual pain); menorrhagia (heavy or prolonged menstrual bleeding); non-menstrual vaginal bleeding or discharge; painful sexual intercourse; rectal bleeding; bladder infection; and painful urination (Campbell, Lichty, Sturza, & Raja, 2006; Salam et al., 2006).

A lifetime history of sexual assault is often found in women of reproductive age who present with one or more of the three of the most common of these gynaecological problems, that is, menstrual pain, excessive menstrual bleeding, and sexual dysfunction (Golding et al., 1998). The number and type of forced penetrations is associated with increased frequency of such gynaecological symptoms; and the odds of sexual trauma history increase with each symptom particularly for women less than 45 years of age (ibid., 1998).

For women with chronic pelvic pain, more extensive childhood sexual abuse and adolescent/adult sexual abuse has been associated with more severe pain and more inference from pain (Randolph & Reddy, 2006). A secondary analysis of data from the 1990 Ontario Health Survey (a large community survey), however, found that child sexual abuse alone was not significantly associated with chronic pain with functional impairment reported by women aged 15 to 64 years (Walsh, Jamieson, McMillan, & Boyle, 2007). The pain measure in this latter study, however, comprised 'one dimension of global pain rather than pain related to a specific body part [and] confounds pain with limitations in function' (pp. 1548-9).

Childhood sexual abuse and adult sexual trauma is also associated with a substantial risk for sexually transmitted infections (STI) and recurrent STIs including human papilloma-virus (HPV) infections, human immunodeficiency virus (HIV), an increased risk of cervical dysplasia, and an increased prevalence of invasive cervical cancer (Coker, Hopenhayn, DeSimone, Bush, & Crofford, 2009; Plichta, 2004). Various studies have found differences in condom use and the sexual behaviour of women who have suffered sexual IPV compared to non-abused women (Gielen et al., 2007; Plichta, 2004), sexually risky behaviour and forced sex amongst adolescent females (Howard & Wang, 2005), and high-risk sexual behaviour from an early age amongst survivors of childhood sexual abuse (Batten, Follette, & Aban, 2001), which goes part way to explaining the increased risk for STIs. Violence against women may indirectly influence cervical cancer risk through stress and immune suppression (Campbell, et al., 2006) while cigarette smoking increases the cervical cancer rates, particularly for women who experience sexual trauma.

In a case-control study in Germany, women with a history of childhood sexual abuse were more likely to

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seek treatment for acute gynaecologic problems than women in the control group (Leeners et al., 2007). A greater proportion of the women in this study who had experienced childhood sexual abuse reported experiencing psychological strain when visiting a gynaecologist than did the non-abused women. The researchers also found a similar association between a history of childhood abuse and experiences of psychological strain during dental treatment, which may be related to disparity in power between the health care provider and their patient; the potential pain; having to remain motionless; and actions and/or words that trigger memories or dissociation.

The medical evaluation of common gynaecological problems potentially puts women with a lifetime exposure of sexual trauma, including childhood sexual abuse, at risk of retraumatisation (e.g., memories of the original abuse) during gynaecological examinations such as pelvic examination, rectovaginal examination, and in some cases breast examination (Golding et al., 1998; Leeners et al., 2007; Robohm & Buttenheim, 1997). Robohm and Buttenheim (1997) found that most gynaecological care providers do not assess for a history of sexual abuse. Most women with a history of child sexual abuse surveyed by Leeners et al. (2007) felt that disclosing their abuse history to their gynaecologist would not be helpful, however, they thought that gynaecologists would 'benefit from training focusing on potential sequelae of CSA [childhood sexual abuse] and specific needs of women with CSA experiences' (p. 391). Findings such as these have implications for affected women's health seeking behaviour (e.g., preventative care), gynaecological practice, and medical training (including interpersonal sensitivity).

Pregnancy complications and poor pregnancy-related outcomes associated with a history of sexual trauma are likely to be mediated by the sequelae of trauma, that is, psychopathology (such as posttraumatic stress disorder, depression, anxiety, panic attacks, and dissociative symptoms); health problems (including STIs, gastrointestinal and gynaecological problems); and negative health behaviours (including substance abuse, eating disorders and risky sexual behaviour) (Rodgers, Lang, Twamley & Stein, 2003).

Taft, Watson and Lee (2004) conducted a secondary analysis of the 1996 younger women (18-23 years) cohort data of the Australian Longitudinal Study of Women's Health to identify reproductive events associated with violence. Treating physical and sexual violence as a composite variable, they found that reported physical or sexual violence, of either partner or non-partner origins, was associated with pregnancy, pregnancy losses (miscarriage or termination), and births in this cohort—more so than for women without a history of violence—and particularly if victimised by partners. Re-examining the cohort data from 2000, the researchers found that 'partner violence is the strongest predictive factor of pregnancy termination among young Australian women' (Taft & Watson, 2007, p. 141). As well as reporting adverse pregnancy events, the women who experienced intimate partner violence (physical/sexual) also reported adverse sexual and reproductive health impacts (vaginal discharge, herpes infection, hepatitis C infection, and Human Papilloma Virus) and mental health impacts (depression) more than did those who experienced non-partner violence or no violence (Taft, Watson, & Lee, 2005).

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HEALTH PROMOTION BEHAVIOURS

As well as its association with poor health status in women, Farley, Minkoff and Barkan (2001) suggested that for women aged 50 to 75 years, a lifetime history of certain traumatic events including sexual trauma is negatively associated with mammography screening for breast cancer. Women with a history of childhood sexual abuse have been found less likely to have had a Pap smear test as recommended for cervical cancer screening (Farley, Golding, & Minkoff, 2002). Robohm and Buttenheim (1997, p. 65) found that during gynaecological examinations, adult survivors of childhood sexual abuse reported more 'embarrassment, shame, vulnerability, and fear than did the controls' as well as significantly more trauma-like responses. In a survey of women in New South Wales, Harsanyi, Mott, Kendal and Blight (2003, p. 762) also found that a history of childhood sexual assault was associated with 'decreased intent to undergo cervical screening' and that affected women were likely to have negative experiences of screening. Importantly, they found that appropriate counselling and clinical behaviours effectively helped survivors undertake screening.

MENTAL HEALTH

The persistent impact of sexual trauma on women's' mental health is well documented. Lifetime victimisation is associated with an increased risk for later onset and high rates of anxiety, depressive symptoms and major depressive episodes that cause distress or disability (Bonomi et al., 2007; Burnam et al., 1988; Campbell, Dworkin, & Cabral, 2009; Coker et al., 2002; Monahan & Forgash, 2000). In turn, psychiatric and medical comorbidities have been found to mediate the relationship between sexual trauma and persistent pain (Haskell, Papas, Heapy, Reid, & Kerns, 2008).

When sexual violence happens at the same time as physical/psychological IPV or psychological IPV, affected women are likely to suffer more severe depressive symptoms; whereas the incidence of suicide attempts has been found to increase when sexual violence occurs with physical/psychological IPV (Pico-Alfonso et al., 2006). A historical cohort linkage study in Australia found that child sexual abuse (CSA) victims had a significantly increased risk of suicide (18-fold) and accidental fatal drug overdose (49-fold) compared to members of the general population and most were diagnosed with an anxiety disorder (Cutajar et al., 2010). Although suicide and fatal overdose cannot be directly attributed to CSA and there are likely to be other contributing risk factors, the researchers conclude that CSA should be considered a risk factor 'that mediates suicide and fatal overdose' (p. 184). Importantly, they found that 'victims of CSA did not die from self-harm until many years after the abuse [which] offers hope that interventions to reduce the fatal risks of self-harm can be implemented within a considerable window of opportunity' (p. 187).

Sexual trauma is also associated with a high incidence of posttraumatic stress disorder (PTSD) symptoms (Campbell et al., 2009; Campbell et al., 2006; Coker et al., 2002; Dutton, 2009; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Lang et al., 2008; Masho & Ahmed, 2007). Childhood sexual abuse is most likely a predictor of PTSD hyperarousal symptoms in adult female survivors of domestic violence (Griffing et al., 2006). In a cross-sectional telephone survey of adult females (N=1,769) resident in Virginia, those sexually assaulted before the age of 18 had an increased risk for PTSD (Masho & Ahmed, 2007). A community survey of adult females (N=391) recruited from a larger probability sample of women resident in South Carolina found similarly that child sexual assault (rape or molestation) was a risk factor for certain major mental disorders in adult women including PTSD; major depressive episodes; agoraphobia; obsessive-compulsive disorder; sexual disorders; suicidal ideation; and suicide attempt (Saunders, Villeponteaux, Lipovsky, Kilpatrick, & Veronen, 1992). Moreover, in this study, one-sixth of those women who were raped as children 'met diagnostic criteria for PTSD an average of nearly 30 years after the initial assault' (p. 200).

Symptoms of depression, anxiety, stress, and PTSD have been found to increase affected women's risk for other problems such as binge drinking (Timko, Sutkowi, Pavao, & Kimerling, 2008). It is likely that PTSD is just one of the many variables mediating alcohol abuse behaviour in women with a history of childhood

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rape (Epstein, Saunders, Kilpatrick, & Resnick, 1998). While revictimisation has been found predictive of more severe PTSD symptoms and associated poor health outcomes, PTSD may itself be a risk factor for revictimisation in affected women (Dutton, 2009). Given the poor health outcomes associated with PTSD (e.g., depression, substance abuse), Dutton advocated interventions that go beyond symptomatology to address coping behaviour or coping self-efficacy. Krakow et al. (2001), however, identified a complex relationship between posttraumatic stress and sleep disorders (sleep disordered breathing and sleep movement disorders) in female survivors of sexual trauma. Their finding that comorbid sleep disturbances in PTSD patients worsen posttraumatic stress and that sleep disorders are not necessarily secondary to PTSD has implications for both medical assessment and treatment.

As well as adversely impacting girls' mental health, childhood sexual victimisation has been associated with depressive symptoms into early adulthood in a probability sample of high school seniors (N=1,093) in Boston, Massachusetts (Schilling, Aseltine, & Gore, 2007). Forced sex was associated with sad/hopeless feelings and suicidal thoughts and behaviours in another sample of high school adolescent females (N=13,601) surveyed in the US (Howard & Wang, 2005). Another study of female undergraduates (N=257) in the US found that survivors of childhood sexual abuse reported higher levels of experiential avoidance than others in the group (Batten, Follette, & Aban, 2001). Survivors might, for example, suppress negative thoughts, feelings, or memories of private events or abuse substances to achieve the same effect. Avoiding private experiences was associated with psychological distress in these survivors. It is suggested that the way in which survivors of sexual abuse respond in thoughts and feelings to the abuse as a means of coping may be a most important factor in their functioning in adulthood.

Childhood sexual abuse involving penetration has also been associated with self-reported mental health problems in adult Australian women (Fleming, Mullen, Sibthorpe, & Bammer, 1999). Researchers found that childhood sexual abuse is associated with an increased risk of subsequent sexual trauma and domestic violence in adulthood (Fleming et al., 1999; Mouzos & Makkai, 2004) as is repeated and severe childhood sexual abuse (Coid et al., 2001).

Despite some limitations in study designs, research suggests that childhood sexual abuse is associated with eating disorder behaviour (Wonderlich et al., 2001). In their cross-sectional study, Wonderlich et al. found that this is particularly the case for those who experienced both childhood sexual abuse and rape in adulthood. However, the psychopathology and psychobiological dysregulation associated with the reported behavioural syndromes is not clear.

Another of the psychological symptoms associated with a lifetime history of sexual trauma is the negative impacts on childbearing, the mother's postpartum health, and the maternal-infant relationship associated with childhood sexual abuse (Heritage, 1998; Monahan, & Forgash, 2000). A woman's reaction to her body during pregnancy, when preparing for labour and birth, and the postpartum period presents medical issues and the potential for retraumatisation.

SUBSTANCE ABUSE AND DEPENDENCE

Various studies examined the relationship between women's lifetime sexual trauma (amongst other criminal victimisation) and the victim's problem drinking behaviour and dependency, illicit substance use, misuse, abuse, and dependency, and the consequences thereof including long-term health outcomes (see Logan, Walker, Cole, and Leukefeld (2002) for a comprehensive review of the literature on the factors, interventions, and implications of victimisation and substance abuse among women). However, the evidence as to the long-term impact of women's lifetime sexual trauma in this regard is not clear-cut.

Women who are problem drinkers may be more likely to have experienced sexual trauma than other drinkers (Ullman, Starzynski, Long, Mason, & Long, 2008). A population-based survey of women (N=6,942) in California found that binge drinking was associated with childhood sexual abuse and adverse experiences in adulthood including sexual trauma (Timko et al., 2008). Adults are most likely to experience alcohol related physical harm or health problems from binge drinking (Kaukinen, 2002). Kaukinen also found that adolescent victims of violent crime (sexual assault, robbery, physical assault) have higher rates of later binge drinking than non-victims, and are more likely to engage in binge drinking than childhood or adulthood victims. However, an earlier longitudinal study (from 1987 to 1993) of Norwegian girls (N=597 at time 1) found that early adolescent female victims of sexual trauma 'gradually developed a normal alcohol consumption pattern', whereas child victims were at risk of developing alcohol problems (abuse and dependency) in late adolescence (Pedersen & Skrondal, 1996, p. 574).

A survey of adults (N=3,132) in Los Angeles found that lifetime prevalence of alcohol and drug abuse or dependence is higher among men and women who have been sexually assaulted at some time in their lives than the non-assaulted (Burnam et al., 1988). There is also evidence that substance abuse and/or heavy alcohol consumption increase the risk for sexual revictimisation amongst specific populations of women with a lifetime history of sexual trauma, including college students, adolescents, and women subjected to IPV (Brown, Testa, & Messman-Moore, 2009; Gidycz et al., 2007; Howard & Wang, 2005; Macy, 2008; Shannon, Logan, Cole, & Walker, 2008). Moreover, the use of both alcohol and illicit drugs may escalate the severity of sexual trauma (Shannon et al., 2008).

In a community sample of Canadian women (N=309) with a history of IPV who were in the early years after leaving an abusive partner, those women with a lifetime history of child abuse and adult sexual trauma were more likely to take psychotropic medications (anxiolytics and antidepressants) and prescription pain medications (Wuest et al., 2007). It was thought that the use of other types of medications by this sample of women did not differ from women in the general population because of their relatively low incomes, employment history, and inability to pay for the over-the-counter medications they needed. Hence, the researchers recommended a holistic, social determinants approach to health care for women survivors of IPV.

An Australian study that compared drug and alcohol treatment (D&A) female clients with/without a history of child sexual abuse and survivors of child sexual abuse with/without current substance abuse but not in treatment (N=180), found that women survivors of childhood sexual abuse were vulnerable to substance abuse during their adolescence (Jarvis, Copeland, & Walton, 1998). Comparing patterns of recent use and current dependence levels, the researchers found that survivors of childhood sexual abuse in drug and alcohol treatment were three times as likely to have a problem with stimulants (cocaine and amphetamines) and reported more frequent use of alcohol than those in treatment without a history of abuse. This same group of survivors of childhood sexual abuse began using inhalants earlier and reported an earlier age of first intoxication than those in the D&A group only. Early age of intoxication was also associated with an early age of consensual sex, a greater number of traumas, paternal substance abuse, maternal substance abuse, and child physical abuse. Amongst survivors of childhood sexual abuse receiving counselling but not in drug and alcohol treatment, those with drug and alcohol problems reported high-impact sexual abuse later in their childhood and of shorter duration than those without drug and alcohol abuse. Qualitative data in this study showed that childhood sexual abuse was associated with self-medication—it 'could predispose women to substance abuse as a way of alleviating pain or building self-confidence' (particularly if ongoing abuse or

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neglect) and increased their risk of victimisation (p. 871). The survivors reported self-esteem problems and using substances 'in overcoming feelings of stigmatisation or powerlessness' (p. 873).

Children who live with someone who abuses substances are themselves likely to be prone to binge drinking as adults (Timko et al., 2008). Considering models of health care, Timko et al. suggested that family-oriented medical and mental health care may alleviate intergenerational substance abuse, and recommended screening for adverse childhood experiences in binge drinkers. A mother's sexual trauma history has also been linked to impaired parent-child relationships, particularly in the context of sexual assaults during adulthood (Reid-Cunningham, 2009). However, reparative relationships in adult life with 'partners, friends, relatives and/or service providers in a variety of different roles, can offer the opportunity to rework internal working models of the relationship between self and others, which in turn affects both access to social support and relationships with children' (Hooper & Koprowska, 2004, p. 168).

Sexual trauma also puts women at higher risk of smoking. A large scale study of US nurses (N=54,200), similar to a population-based cohort, found that the risk of smoking in women increased with the co-occurrence of physical, sexual, and psychological IPV but no history of childhood abuse—almost 2.5 times more than for women reporting no IPV (Jun, Rich-Edwards, Boynton-Jarrett, & Wright, 2008). In this same study, those women with a lifetime history of childhood abuse (psychological, physical and sexual abuse) tended to start smoking earlier than non-abused women. Howard and Wang (2005), too, found an association between heavy cigarette use and a history of forced sexual intercourse amongst adolescent females. In a representative sample of Australian adults (N=19,307), women with a lifetime history of sexual coercion were found to be more likely to be former or current smokers than other women (de Visser et al., 2003).

COSTLY LONG-TERM HEALTH OUTCOMES

Primary prevention activities and crisis care and support feature prominently in the outline of immediate actions proposed in the Australian Government's forthcoming National Plan to Reduce Violence against Women (National Plan), which addresses sexual assault and domestic violence in combination (Aus Govt, 2009). The National Council to Reduce Violence against Women and their Children (NCRVAWC), which advised the Government on the development of the National Plan, acknowledged the complexity of problems experienced by victim/survivors of sexual assault and domestic and family violence (NCRVAWC, 2009). It specifically noted that under-resourcing has lead to the prioritisation of services with 'insufficient services available for medium to long-term support such as counselling and [psychological] trauma recovery' (p. 76) as is the case for adult survivors disclosing past experiences of child sexual assault (p. 87). However, the NCRVAWC's Plan of Action (short, medium, and long-term) does *not* detail the many other long-term health sequelae for which services are also needed.

Long after the assault, women who have experienced sexual trauma are likely to present with poor daily functioning and a greater number of symptoms and medical conditions than is seen among women without a history of sexual trauma (Sadler, Booth, Nielson, & Doebbeling, 2000). The cumulative effects of these complex and often chronic health problems constitute a substantial proportion of total disease burden in women. The SF-36 Mental Component summary scores of women with lifetime history of sexual IPV or sexual and physical IPV, for example, is comparable to that for chronic diseases such as back pain, diabetes and heart disease to name just a few (Bonomi et al., 2007). Sadler et al. (2000, p. 477) found that the health-related quality of life scores of US female veterans more than a decade after surviving dual physical and sexual victimisation were lower than those of recent survivors of 'acute myocardial infarction or diabetes mellitus type II and were similar to those of patients with advanced Parkinson disease'. In Australia, IPV accounted for nine per cent of the total disease burden in Victorian women aged 15-44, and was the leading cause of death, disability and illness in this demographic (Victorian Health Promotion Foundation, 2004).

A number of US studies have found that women with a lifetime history of sexual trauma have more frequent health problems than women who have not been assaulted and, consequently, a higher frequency of use of health care services (Campbell et al., 2006; Martin et al., 2008). One such study of criminal victimisation on women's health service utilisation found that women with a lifetime history of sexual trauma and multiple assaults visited physicians twice as often as nonvictimised women, had 2.5 times greater outpatient costs in the index year (1986), and the victims' visits to physicians remained higher during the three years following the crime than pre-crime (Koss, Koss, & Woodruff, 1991).

Access Economics (2004) estimated the total annual cost of domestic violence (which includes physical and sexual violence, threats and intimidation, emotional and social abuse, and financial deprivation) in Australia in 2002-03 to be $8.1 billion (including the burden of disease). The total health costs for female victims of domestic violence comprised $314 million, nearly half of which were hospital costs ($145 million), followed by costs of pharmaceutical treatments ($61 million), and 35% of overall health costs (totalling $111 million) related to depression. This estimate of total health costs reflects composite health costs associated with some of the major long-term health problems discussed (depression, alcohol abuse, smoking, anxiety, drug use, STIs, and cervical cancer) but omitted other of the major long-term health problems (e.g., gynaecological problems). Access Economics provided the following indication of the average lifetime health costs per victim of domestic violence: '$3,827 for the health costs associated with premature death; $15,503 for the health costs associated with disability; and $19,330 altogether in health costs over a lifetime' (p. 67).

Following Mayhew's (2003) methodology for estimating the cost of sexual assault in Australia, which adjusts for the nature of the victimisation and likely levels of underreporting, Rollings (2008) estimated the total cost of sexual assault to the Australian community for the previous 12 months to 2005 to be $720million (approximately $7,500 per incident on average). She found the 'average medical costs for those who were injured (both hospitalised and non-hospitalised) were $1,330 per injury [and] overall, the medical costs for sexual assault with injury were an estimated $36m' (p. 19).

Lifetime income loss and reduced productivity can be attributed to the negative consequences of violent victimisation, including sexual trauma (see, for example, Kaukinen, (2002) for a discussion of the economic costs of alcohol harm amongst adolescent victims). Using representative cross-sectional household data from the 2004-05 National Health Survey, the Australian Institute of Health and Welfare (2010) found that the odds ratio of not being in the labour force among females who reported at least one risk factor (e.g., smoking; risky alcohol consumption) and at least one chronic disease (e.g., depression) was 1.4 times as high as for females reporting neither risk factor nor chronic disease. Rollings (2008) calculated the 2005 lost output (loss of paid and unpaid work that victim/survivors cannot do) for sexual assault without injury at $130 per incident and $9,300 per incident with injury; with the total cost of lost output estimated to be $259million. Intangible costs (pain, suffering and lost quality of life) were estimated at $11,000 per sexual assault incident with injury and $1,700 without injury (totalling $424million overall in 2005).

Studies to-date provide only partial estimates of medical expenditures attributable to sexual trauma to women due to data and methodological limitations including the: approach for estimating costs (e.g., bottom-up approach reliant on self-reports, top-down approach, or econometric approach with limited data on longer-term consequences); sampling frame; aggregation of data on sexual trauma with other types of criminal victimisation; selected service settings; selected health outcomes and diseases; time frames for cost measurement; currency of surveillance data; and underreporting of health care utilisation (see Brown, Finkelstein, & Mercy, 2008).

A number of researchers have recommended targeted screening of women for sexual trauma, for example, women with symptoms of depression (Bonomi et al., 2007); women with one or more of the common gynaecological problems of menstrual pain, excessive menstrual bleeding, and sexual dysfunction (Golding et al., 1998); and women who binge drink (Timko et al., 2008). The Taskforce on the Health Aspects of Violence Against Women and Children (2010) in England reported that routine assessment by National Health Service (NHS) staff for violence and abuse in women has been initiated in some settings

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(mental health and obstetrics). However, the Taskforce recommended targeted screening rather than routine assessment in all clinical settings on the proviso that:

> *clinicians should have a low threshold for asking about violence and abuse, triggered by a range of presentations, including physical injuries, psychological symptoms including somatising disorders, substance abuse, chronic pain, and recurrent gynaecological disorders. Patient behaviour such as repeat attendance in a general practice or emergency department, missed appointments, self-discharge, and repeated 'non-specific' admissions should also lead NHS staff to ask about abuse. (p. 30)*

Others put the case for universal screening for current and historical physical and sexual IPV, adolescent and adulthood sexual trauma, and childhood sexual abuse, particularly in women with chronic health conditions, to identify the many women who do not disclose their history of sexual trauma to healthcare professionals (Campbell et al., 2006; Coker et al., 2002; Coker et al., 2009; Dutton, 2009; Golding et al., 1998; Jordan, 2007; Koss et al., 1991). (Phelan (2007) provides a useful review of the debate about and case for routine or universal screening for intimate partner violence in medical settings, which is relevant to sexual trauma generally).

Research suggests that the health impact and cost of sexual trauma in women will be reduced by early identification and timely and appropriate intervention to treat and/or prevent health problems (Coker, Reeder, Fadden, & Smith, 2004). However, more studies need to be done in this regard to demonstrate cost savings from universal screening of women for lifetime exposure to sexual trauma; the provision of targeted health care services for women identified as having a lifetime history of sexual trauma; and alternative models of care for women with emerging longer-term health problems (for example, relational models of care, relationship-based interventions, interdisciplinary and interagency models).

Preparing medical professionals in Australia

A prevalence survey of women in a Melbourne general practice population, conducted November 1993 to February 1994, found that most of those with a lifetime history of sexual trauma had not disclosed their abuse because their general practitioner (GP) never asked (Mazza, Dennerstein, & Ryan, 1996). Such a deficit in the health care response (under-detection, misdiagnosis, and inappropriate services) has been attributed to 'the non-recognition of sexual violence as a health issue, and the lack of sufficient training and skills development to address health professionals' awareness and capacity to respond appropriately' (Olle, 2005, p. 34).

To strengthen services to women victim/survivors and enhance the workforce capacity, the National Council to Reduce Violence against Women and the Children (NCRVWC) (2009) recommended that the study of sexual assault and domestic and family violence be incorporated in compulsory course work for undergraduate medical students in the near future, and in postgraduate professional development in the longer term. The Taskforce on the Health Aspects of Violence Against Women and Children (2010, p. 28) in England similarly recommended the inclusion of violence against women and children in 'undergraduate training of all healthcare professionals, and at a basic postgraduate level, with advanced training for those specialties and professions most likely to have direct contact with women and children experiencing violence or abuse'.

Overseas, Leeners et al. (2007) reported that German medical school curricula and resident training do *not* include content on sexual violence. A 1993 survey of faculty and students' perceptions of US paediatric residency training in child sexual abuse evaluation found that the allotted time and quality of training did not adequately prepare residents with the skills they needed following residency (Giardino, Brayden, & Sugarman, 1998). The researchers noted the absence of a structured, standardised curriculum at that time. Hamberger (2007) reported that since 1989 most US and Canadian medical schools and postgraduate residency programs have included IPV in their curricula. He found that departments of psychiatry and behavioural science usually delivered undergraduate medical training in this area, suggesting that 'IPV is primarily a psychiatric problem and not a health problem generally' (p. 217). Postgraduate residency

programs tended to be delivered as part of family medicine or obstetrics/gynaecology. The overall curricular time allocated to IPV was no more than 2 hours, usually as stand-alone sessions although IPV training has been integrated into mainstream medical curricula in some instances (immersion programs, longitudinal models, problem-based curricula, delegated models, and fully integrated curricula). Hamberger identified personal, structural, and educational barriers to the implementation of IPV training in medical curricula. A review of four US studies that surveyed clinicians who assess and/or care for sexual assault survivors in emergency departments, found that 'few emergency department staff had specialised training concerning sexual assault (although many desired such training)' (Martin, Young, Billings, & Bross, 2007, p. 7).

A supplementary literature search[5] was undertaken for evaluations of medical curricula in Australia for content on the health sequelae and health care needs of women with a lifetime history of sexual trauma. Research evaluating medical school curricula and postgraduate medical training in Australia in regard to the long-term health outcomes of sexual trauma in women is itself lacking. According to Warshaw, Taft and McCosker-Howard (2006), traditional models of educating health professionals are not up to the task of addressing complex social issues such as intimate partner abuse and its impact on health and wellbeing.

In Australia, the professional body of The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) published *Medical Responses to Adults who have Experienced Sexual Assault: An Interactive Educational Module for Doctors* (Olle, 2004). The module targets obstetrics and gynaecology medical residents and registrars; trainees in emergency medicine, general practice, surgery, paediatrics, psychiatry, adult medicine; and paediatric practitioners. The content covers medical assessment, examination, and management of the acute sexual assault victim (including medico-legal aspects) and includes one case study about adult survivors of childhood sexual assault.

In the Australian Capital Territory (ACT) the Forensic and Medical Sexual Assault Care (FAMSAC) service, located within the Canberra Sexual Health Centre at the Canberra Hospital, developed and evaluated a sexual assault medical education program to train doctors in providing immediate forensic and medical care to men and women who have experienced recent sexual assault (Parekh, Currie and Beaumont-Brown, 2005). Course participants undertook a 16-session in-house program (Certificate in Forensic Medicine) for which they received continuing medical education (CME) points and were also enrolled externally in Monash University's Diploma of Forensic Medicine course. The researchers expect that the combined program will produce a high retention rate of trained doctors working in the area.

Some degree of information[6] about the inclusion of sexual violence in the current coursework of undergraduate and graduate entry medical programs (Bachelor of Medicine and Bachelor of Surgery) was available from eight Australian universities (including four of the Group of Eight[7]). Most of these programs focus on recent sexual assault and/or sexual abuse and not the long-term health sequelae of sexual trauma across the lifespan. Content is generally presented in the latter years of programs as stand-alone sessions and is most often delivered as part of the women's and infants'/children's health component or the ostetrics/gynaecology component of programs. A summary of content in the area follows in alphabetical order by university (see Appendix A for additional details).

Deakin University is currently delivering the third year of its inaugural four-year graduate entry MBBS program. Sexism, racism and gender issues are covered broadly in lectures or tutorials in Years 1 and 2, within the theme of 'Doctors, Peoples, Cultures, and Institutions'. Under the theme of 'Ethics, Law, and Professional Development', first year students also receive a lecture on sexual violence and other forms of violence, including the regulatory and ethical requirements for reporting abuse and mistreatment of children,

[5] A metasearch was conducted across health sciences databases (CINAHL Plus; Medline; PsychINFO, and SPORTDiscuss) and education databases (Academic OneFile; ProQuest 5000 International; Education Full Text; Eric (EBSCO); Eric (ProQuest); Eric + ED Documents, and A+Education) for published research on medical curricula (or medical school curriculum or medical training) and sexual trauma (or sexual assault, sexual abuse, or sexual violence).
[6] Online university handbooks and unit outlines were searched and clarification was sought from heads of schools of medicine about course work in the area of sexual violence in the undergraduate and/or postgraduate medical curricula. The approved institutional ethics declaration did not allow for surveying faculty and students about the perceived sufficiency of education/training, and curricula were not evaluated.
[7] The Group of Eight (Go8) is a coalition of the following Australian universities: The University of Adelaide; The Australian National University; The University of Melbourne; Monash University; The University of New South Wales; The University of Queensland; The University of Sydney, and The University of Western Australia.

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delivered by staff of the Victorian Child Protection Placement and Family Services. Under the same theme, another lecture delivered by staff of the Victorian Institute of Forensic Medicine introduces first year students to forensic assessment.

The University of Adelaide incorporates the topic of violence, including sexual violence, in the fifth and sixth years of its six-year undergraduate Bachelor of Medicine and Bachelor of Surgery (MBBS) program. An introductory lecture in Year 5 is delivered under the discipline of Obstetrics and Gynaecology. In Year 6, students have sessions (lecture and workshop) on the medical management of abuse and sexual violence, including management, potential medical and psychological presentations, and consequences of abuse and violence. The workshop component is conducted by Yarrow Place Rape and Sexual Assault Service, a community service under the auspices of the Women and Children's Hospital.

At The University of Melbourne sexual violence is covered in part as a mental health problem in the fifth year of its current undergraduate medical course delivered by the Department of Psychiatry. In problem based learning tutorials (to develop the learner's knowledge, skills and attitudes), the 'Woman Who Isn't Coping' and the 'Young Woman Who Is Dieting Excessively' aim to provide an understanding of how childhood experiences influence personality and development of mental illness in adulthood (including depressive disorders) and the psychosocial causes of eating disorders (anorexia nervosa and bulimia nervosa). 'Child Protection' is covered in a lecture during the fifth year unit 'Child and Adolescent Health'.

The University of Newcastle includes two large group teaching sessions on sexual assault (adult) and child sexual assault in the fourth year of its five-year undergraduate Bachelor of Medicine program. These are conducted within the core course of Women and Children's Health.

The University of New South Wales incorporates content on sexual abuse, domestic violence and child abuse across the three phases of its undergraduate medical curriculum. Students are assessed on their knowledge of their clinical and legal responsibilities in regards to non-accidental injury of children, and may be assessed on their knowledge of the clinical and legal issues in the assessment and management of sexual assault.

The University of Notre Dame Australia, Fremantle, addresses domestic violence issues in the learning objectives of the second year of its problem based learning program and in the third and fourth years during clinical rotations in obstetric, paediatric, psychiatry, and emergency department settings.

The University of Western Australia incorporates content on sexual violence in the obstetrics and gynaecology units in the fifth year of its undergraduate medical curriculum (identical to year three of its four-year graduate entry medical program). A case-based tutorial, which utilises the scenario of a 16-year old female visiting a GP for emergency contraception, precedes a two-hour workshop conducted by medical staff of the Sexual Assault Referral Centre (SARC) during the Women and Children's Health clinical attachment. The workshop provides an overview of recent sexual violence (sexual assault and/or sexual abuse), medical assessment, management, and forensic examination, medico-legal aspects, and support/counselling services.

The University of Western Sydney, which will graduate its first cohort of medical students in 2011, currently covers the topics of domestic violence and sexual assault in the fourth year of its undergraduate program in the Women's Health component of its curriculum. Content includes: health consequences; patient assessment and management (acute); public health considerations; and personal and professional development (skills, attitudes and responsibilities). Further lectures on domestic violence are planned for the fifth year of the program.

Guidelines for health care

CLINICAL PRACTICE GUIDELINES FOR MEDICAL SERVICES

Clinical guidelines offer medical practitioners the 'current best evidence of clinical efficacy and cost-effectiveness', incorporating patient preferences, upon which to base their care (Hewitt-Taylor, 2006, p. 15). As such, clinical guidelines are 'a secondary source of information, as they are a collated summary of the best available evidence, as interpreted by guideline developers' (p. 38). Guidelines provide practical guidance to aid clinical decision making and cover the spectrum of care for a particular condition and specific patient groups. Evidence-based care protocols, on the other hand, are 'detailed descriptions of the steps which should be taken to deliver treatment or care' (p. 49).

Overseas, the American Medical Association (AMA) released diagnostic and treatment guidelines on domestic violence in 1992 and child sexual abuse in 1993. The AMA Diagnostic and Treatment Guidelines on Domestic Violence (Flitcraft, Hadley, Hendricks-Matthews, McLeer, & Warshaw, 1992) provided medical practitioners with an overview of the statistics on domestic violence at the time; the forms of abuse (including sexual abuse); the interviewing process; diagnosis and clinical findings; interventions; barriers to identification; documentation; legal developments; risk management and duty to the victim; and trends in treatment and prevention. The AMA Diagnostic and Treatment Guidelines on Child Sexual Abuse (Berkowitz, Bross, Chadwick, & Whitworth, 1993) recommended a multidisciplinary approach to the diagnosis and management of child sexual abuse victims. The guidelines provided medical practitioners with an overview of facts about child sexual abuse; ethical considerations; presentation of patients; behavioural signs; the interviewing process; physical examination; documentation; reporting requirements; obtaining an order of temporary custody; testimony; risk management, and trends in treatment and prevention. Nonetheless, Martin et al. (2007, pp. 6-7) found that US studies 'focused on emergency department care for sexual assault survivors found that not all departments had written protocols concerning required care' despite having sexual assault and child abuse standard operating procedures.

As part of its 2007 Sexual Violence and Abuse Action Plan (SVAAP), the Home Office in the UK funded the King's College Hospital NHS Trust and the Metropolitan Police (2007) to develop The Care and Evidence Training Package. This free-access online multimedia resource (which is also available in DVD format) is intended to help front-line staff in accident and emergency departments, sexual health services, contraception services, and general practice understand the needs of victims and collect forensic evidence. The package comprises two training videos (care and evidence respectively); multiple choice tests; printable flow charts; printable forms; references and web links; downloadable training materials; and updates.

In Australia, the following professional peak medical bodies and government departments have published clinical guidelines addressing the care of women with a lifetime history of sexual trauma: The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), The Royal Australian College of General Practitioners (RACGP), and the Victorian Government Department of Justice. The RACGP clinical practice guidelines are also accessible from the Clinical Practice Guidelines portal of the National Health and Medical Research Council's National Institute of Clinical Studies.

The educational module, *Medical Responses to Adults who have Experienced Sexual Assault: An Interactive Educational Module for Doctors*, published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (Olle, 2004), provides clinical guidelines and standards of practice for the forensic examination and emergency medical management of victim/survivors of sexual assault. As previously noted, its target audience is obstetrics and gynaecology medical residents and registers; trainees in emergency medicine, general practice, surgery, paediatrics, psychiatry, and adult medicine; and paediatric practitioners. In a College Statement, the RANZCOG (2007, p. 1) also specifies that

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'RANZCOG Trainees should not be expected to perform sexual assault forensic examinations'.

The Royal Australian College of General Practitioners (2008) guidelines, *Abuse and Violence: Working with Our Patients in General Practice*, target GPs working with patients in general practice who have survived abuse and violence including intimate partner violence, adult survivors of child abuse, sexual assault, and elder abuse (including sexual abuse). The guidelines include information on: myths; prevalence; types of presentations in general practice (health effects and clinical indicators); identification of victim/survivors and/or patients and families at risk; medical management; mandatory reporting; case studies; tips; and resources. Importantly, these guidelines cover immediate and long-term health outcomes of lifetime history of sexual trauma in women. The guidelines list some of the trigger factors for flashbacks of traumatic events in victim/survivors of childhood abuse, introduce the concept of 'continual consent' (p. 40), and alert GPs to potential triggers in the GP-patient encounter that may inadvertently cause retraumatisation such as a Pap test (p. 41). Overall, the RACGP guidelines meet most of the criteria specified by the Australian Centre for the Study of Sexual Assault's (ACSSA) (2005) for good practice in service provision, namely, they: take into account contemporary research; take into account diverse groups including Aboriginal and Torres Strait Islanders, same sex couples, those with a disability, and cultural and linguistically diverse people; aim at improving the systems' responses to sexual assault; demonstrate sensitivity towards the barriers faced by victim/survivors in disclosing and reporting sexual assault; and have a clearly defined model (in this case, cycle of violence).

The Royal Australian College of General Practitioners (2009) *Guidelines for Preventive Activities in General Practice*, address GPs whose patients present for preventive care or are opportunistically identified when presenting with other problems. New to this 7th edition is the recommendation that as part of psychosocial care 'clinicians ask all pregnant adult and adolescent women about intimate partner violence, but that a case finding approach be taken in situations where patients have symptoms of intimate partner violence or abusive behaviour' (p. 60). The guidelines briefly outline who is at higher risk of intimate partner violence (including women with symptoms of mental ill health and chronic unexplained physical symptoms) and techniques for asking about intimate partner violence. These RACGP guidelines cite the consensus guidelines for primary care physicians, *Management of the Whole Family When Intimate Partner Violence is Present: Guidelines for Primary Care Physicians*, published by the Victorian Government Department of Justice's (2006), for identifying and managing patients and families experiencing intimate partner violence in their current relationship. While neither set of guidelines refer specifically to sexual trauma and do not address the long-term health sequelae associated with sexual trauma, many of the guiding principles for GP practice are relevant (e.g., recommendations regarding acknowledging and validating disclosure; ensuring confidentiality; monitoring personal and professional attitudes and beliefs; offering education and long-term support; impacts on children and parenting; social support; and patient referral) as are those for group practice or clinic management (e.g., staff training, ensuring patient confidentiality, and clinic protocols).

AUSTRALIAN BEST PRACTICE GUIDELINES FOR MEDICAL SERVICES

The aim of achieving equity of healthcare provision and consistency of care across geographical regions is at the heart of national clinical guidelines and standards of practice (Hewitt-Taylor, 2006, pp. 44-45). This fits with the Australian Women's Coalition's recommendation in its submission on the development of a New National Women's Health Policy for 'coordinate[d] policies addressing violence against women across all relevant strategies, including the new National Women's Health Policy' (Rutherford, Hirst, Casper, & Panopoulos, 2009, p. 5).

In England, the recent report of the Taskforce on the Health Aspects of Violence Against Women and Children (2010, p. 22), stated that NHS staff have a role to play in all three levels of prevention: 'primary (preventing violence and abuse before it happens), secondary (preventing further violence and abuse in those at risk of it) and tertiary (managing the long-term physical, psychological and social consequences of violence and abuse)'.

Prior to the aforementioned taskforce report, the UK Home Office (2007) published its Cross-Government Action Plan on Sexual Violence and Abuse (SVAAP), one aim of which was to increase access to support and health services for victims of sexual violence and abuse, both recent and historical. Immediate and long-term support and therapeutic health services are provided to survivors in the UK by the Voluntary and Community Sector, Sexual Assault Referral Centres (SARCs) and Statutory Health Services (e.g., accident and emergency departments, GPs). The SVAAP recognised the life-course impact of sexual violence and childhood sexual abuse on survivors, associated health inequalities, and economic costs. In terms of the UK Government's policy context, the SVAAP situated sexual violence and abuse as a public health issue and articulated the links with other strategies including those concerned with sexual health, mental health, safeguarding vulnerable adults, safeguarding children, and education. The SVAAP noted that recognised standards and quality assurance still needed to be developed for the voluntary sector services and SARCs. At the time of publication of the SVAAP, the Department of Health was developing 'evidence-based national service guidelines [to] inform policy, improve practice and promote access to appropriate services' for victims of violence and abuse (p. 26). These national service guidelines are to include 'service models, practice guidance and training materials' (DoH & Home Office, 2005, p. 18). Flowing from the SVAAP, the Department of Health and Home Office (2005) published National Guidelines for Developing Sexual Assault Referral Centres (SARCs) in the UK. The Guidelines provide best practice guidance and recognise the SARC model as the cross-sectoral partnership model of good practice for the immediate aftercare of victims of serious sexual violence. However, the Guidelines note that SARCs are 'not designed to offer long-term support and do not usually provide services for victims of historical sexual abuse' (p. 6).

Olle (2005) reviewed the historical development and range of formal health sector protocols in Australia to guide the provision of the best possible health care and support to victim/survivors of sexual assault many of whom suffer chronic health problems. Following on from the first Australian national standards of practice published in 1998, she found State and Territory interagency protocols between health services, sexual assault services, police services, and public prosecutors (e.g., guidelines, policies and procedures, codes of practice, and Memoranda of Understanding) addressed acute and crisis care responses (e.g., acute medical care and forensic medical examination) but did not specifically address the management of the longer-term health needs of victim/survivors across the lifespan.

The NCRVAWC (2009) recommended the development and implementation of model codes of practice to guide the cross-sectoral delivery of services to victim/survivors of sexual assault and domestic and family violence throughout Australia. It further recommended that the Council of Australian Governments (COAG) oversee the implementation of its Plan of Action via relevant Ministerial Councils (e.g., the

Australian Health Ministers' Conference) and linkages to other reform agendas (e.g., the National Action Plan for Mental Health). In contrast to the UK, the focus of the NCRVAWC's Plan is on prevention, early intervention, and crisis care and support services and does not encompass the tertiary management of the long-term physical, psychological, and social impacts of sexual trauma.

The 'Review of Queensland Health Responses to Adult Victims of Sexual Assault' (KPMG, 2009) on behalf of Queensland Health highlighted that gaps exist between interagency guidelines (best practice frameworks) for responding to adult victims of sexual assault and practice (actual services or responses). In the case of Queensland Health's 2001 Interagency Guidelines, the Review concluded that the Guidelines 'had not been comprehensively implemented' throughout Queensland (p. 6). As a consequence, access to forensic and medical services and counselling and support services was inequitable, and services did not meet the needs of victim/survivors of recent sexual assault nor victim/survivors of historical sexual assault. Considering the deficits in the system, the reviewers highlighted the need for:

- Clear pathways for victim/survivors of recent and historical sexual assault to access non-crisis counselling and health services and link into other services;
- Single service locations for providing comprehensive, holistic, victim-centred services to victim/survivors of both recent and historical sexual assault (short, medium, and long-term interventions);
- Implementation of hub model (sexual assault response hubs of expertise);
- Protocols (interagency guidelines) to clarify role responsibilities and processes;
- Trauma theory to underpin services for recent victim/survivors;
- Evidence-based standardised common assessment and planning tools and interventions and associated practice standards (for short, medium and long-term work);
- A professional development framework to guide training;
- Provision of services by appropriately qualified professionals both within the public sector and the community and voluntary sector; and
- Centralised monitoring, evaluations, and support for the implementation of policy and practice guidelines.

It should be noted that not everyone advocates the professionalisation of voluntary support services for women with a lifetime history of sexual trauma. A qualitative study of a volunteer group of health professionals (four doctors, a community psychiatric nurse, and six counsellors) who cared for adult survivors of childhood sexual abuse in the volunteer sector in Scotland found that their practices challenged some traditional medical approaches (Munro & Randall, 2007). Munro and Randall subsequently questioned the effectiveness of expert professional knowledge and notions of best practice in this field and whether the medicalisation of social problems is appropriate. They also found that the imperative for patient disclosure was problematic and was not always in the best interests of the patient. Similarly, Leeners et al. (2007, p. 391) suggested that gynaecologists allow women with a history of childhood sexual abuse to 'voice known problems without having to disclose past abuse'.

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Happy Healthy Women, Not Just Survivors Summit

The purpose of the national, multidisciplinary 'Happy Healthy Women, Not Just Survivors Summit' (held in Melbourne, May 2010) was to advocate 'for survivors of sexual abuse by gathering information from key stakeholders [regarding] the needs of survivors over a lifetime and the health resources and education requirements needed in order to develop a coordinated national response' (Goodwach & Coles, 2010, p. 1).

Victorian Medical Women's Society President, Dr Raie Goodwach, set the scene in regards to the multiple issues facing survivors of sexual violence. Thereafter, summit participants worked in groups to identify key issues and possible solutions to improve the health and healthcare of survivors of sexual trauma across their lifespan. The groups included representatives of peak medical women's bodies; national women's organisations; disability services and networks; Centres Against Sexual Assault; survivors of sexual trauma; not-for-profit social and community services; community-based advocacy groups; church groups; university-based researchers; medical professionals (including GPs, obstetricians, and psychiatrists); medical and nurse educators; public health services and hospitals; and legal and police services. Members of each group brought their different knowledge and perspectives to bear on the shared goal of the summit in an atmosphere of mutual respect and trust.

The issues identified reflect the participants' concern for both biomedical and nonmedical factors that impact on the health and wellbeing of survivors of sexual trauma (for example, the individual's responses and social, environmental, economic, and cultural factors), as well as participants' preference for interdisciplinary approaches to the provision of healthcare services for survivors (including, amongst others, biomedical sciences; public health; behavioural sciences including psychology; social sciences; education; and law). Similarly, they proposed possible solutions for social and behaviour change at an individual level (both survivor and service providers) and at a community level (including the healthcare sector and government) thereby offering ideas as to the 'who' and 'how' of action. The framing of key issues and possible solutions was in keeping with ecological, multi-level models that propose a multi-level approach to the phenomenon of sexual trauma in women, that is, psychological, social, economic, political, and cultural contexts (Dutton, 2009). From this perspective, the healthcare system (medical and mental health systems) represents a formalised support factor at the meso/exosystem level that contributes to the post-assault sequelae of sexual assault on women's physical and mental health, which has the potential to be beneficial or detrimental (e.g., secondary traumatisation) (Campbell et al., 2009). In this model, macrosystem factors affecting physical and mental health outcomes include healthcare professionals' beliefs and expectations – personal and interpersonal (e.g., supportive face-to-face interactions, victim-blaming treatment, and secondary victimisation).

Additionally, some summit participants emphasised the importance of relational models of care and relationship-based interventions in the medical response to and care of survivors of sexual trauma and their families (a point made by Reid-Cunningham (2009) when considering the parent-child relationship in relation to the mother's sexual assault history). Like Campbell et al. (2009), others were critical of models or approaches that pathologise women who have experienced sexual trauma by attaching a diagnosis such as posttraumatic stress disorder. However, as in the literature (see Campbell et al., 2006; Coker et al., 2002; Martin et al., 2008), other participants thought that trauma-informed interdisciplinary and interagency models of care could be adapted and expanded to help women after the emergent threat has passed and longer-term health problems are emerging.

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Conclusion

A history of sexual trauma is associated with poor long-term social wellbeing and physical health and mental health outcomes in women although the causes and mediating factors have not been elucidated in quality, sustained research; the history is often not disclosed and the diagnosis is not made by health professionals. Survivors are likely to use health services more than nonvictimised women but it is unlikely that many receive the treatment or management and ongoing health services and support (social and psychosocial) that they need and deserve. While much of the research literature reports about psychological trauma and impact on child and adult survivors, there is a dearth of research detailing an integrated holistic understanding of the psychosocial, physiological and socioeconomic impacts experienced by survivors of sexual trauma over the lifespan. Historical sexual trauma undoubtedly impacts women's lives and livelihoods; it is associated with human suffering in terms of morbidity, social functioning, participation in economically productive activities, and health quality of life. Yet the social and economic costs of sexual trauma over the lifespan borne by survivors, their families and the Australian community and the costs of *not* providing the health care and support services survivors need have not been determined.

Government policy and the health sector in Australia do not have a coordinated and integrated response to survivors of historical sexual trauma. At the individual level, health care providers and survivors of sexual trauma themselves generally lack the knowledge and skills to make the most of opportunities that arise to circumvent the long-term health sequelae particularly in general practice.

An extensive community of representatives of peak medical women's groups, national women's organisations, disability services, survivors of sexual trauma, not-for-profit social and community services, community-based advocacy groups, universities and research centres, healthcare practitioners and educators, public health services, and legal and police services is determined to change Government policies and establish programs and services in Australia for survivors of sexual trauma over the lifespan. Those at the recent national, multidisciplinary 'Happy Healthy Women, Not Just Survivors Summit' recognised the need to articulate national health sector policies and develop professional guidelines on health care related to a lifetime history of sexual trauma and incorporate relevant content throughout the undergraduate programs and postgraduate training of all health care professionals. They advocate integrated programs and services and multidisciplinary, cross-sectoral models of care to appropriately identify, assess, treat, refer, and support survivors. They also considered the social institutions and the norms, beliefs and practices in Australia that tolerate and perpetuate sexual violence against women and recommend awareness and education campaigns and programs to change the socio-cultural conditions within which women live. At the heart of the Summit, too, were discussions about acknowledging, respecting and empowering survivors to take control of decisions regarding their health and healthcare.

Research investigating the relationship between sexual trauma and long-term health sequelae is a priority to inform health care services and reduce the long-term burden of sexual trauma (individual and societal). This imperative is further underpinned by national and international recognition through bodies such as the UN that violence against women and its effects remain unremitting urgent human rights issues of global importance. In light of the literature and informed discussions at the Summit, further research is required in the following areas:

- Longitudinal research to provide comprehensive information about the health (biopsychosocial) consequences of a lifetime history of sexual trauma over the lifespan[8];
- Disaggregation of data on violence against women as there needs to be a clear differentiation between physical IPV, sexual IPV, IPV involving both physical and sexual violence, and sexual violence of non-partner origins;
- Evaluative studies of the interactions of survivors of sexual trauma with health care providers and the health care system (and related long-term outcomes) to provide best practice models;
- The social and economic costs of meeting and not meeting the need for health care and support services for women survivors of sexual trauma over their lifespan;
- The impact (benefits/adverse effects) and cost-benefits of implementing routine screening of women for history of sexual trauma within the health sector;
- Australia-wide survey of faculty and students' perceptions of undergraduate medical education and postgraduate training in the long-term physical and psychological health sequelae of sexual trauma in women; and
- Development and evaluation of undergraduate medical curricula and postgraduate medical training programs in long-term physical and psychological health sequelae of sexual trauma in women.

In closing, the long-term physical and psychological health sequelae of sexual trauma in women warrants the establishment of a national Centre of Excellence in Sexual Trauma Research—a multi-institutional, multidisciplinary and cross-sectoral collaboration. The Centre's priorities would be to pursue: academic and applied research to improve health outcomes; the development of pertinent health care models and building the capacity of health professionals to better manage the care of survivors; the development, monitoring, evaluation, and implementation of pertinent health sector policies and professional practice guidelines; the development and implementation of a clearinghouse to provide information about the long-term health impacts of sexual trauma to survivors, health professionals, educators, the media, and the community; and to provide a national focus and leadership to increase the capacity of the Australian community to prevent sexual violence and respond effectively to sexual trauma over the lifespan.

[8] The Raine Study, a prospective cohort study of pregnancy, childhood and adolescence in progress for 18 years (Raine Study, 2008), provides one such model of a multi-institutional, ongoing health research project.

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Appendix A

'SEXUAL VIOLENCE' IN BACHELOR OF MEDICINE, BACHELOR OF SURGERY CURRICULA OF AUSTRALIAN UNIVERSITIES [a]

UNIVERSITY	COURSE AND UNITS	LEARNING APPROACH	CONTENT
Deakin University **Four-year graduate entry Bachelor of Medicine, Bachelor of Surgery**	Year 1 Theme – Ethics, Law and Professional Development	Lecture	Lecture conducted by education officer of Victorian Child Protection Placement and Family Services covering: • Sexual and other forms of violence • Regulatory and ethical requirements for reporting abuse and mistreatment of children
	Year 1 Theme – Doctors, Peoples, Cultures, and Institutions	Lecture / tutorial x 1	Sexism, racism and gender issues
	Year 2 Theme – Doctors, Peoples, Cultures, and Institutions	Lectures x 2	
	Year 1 Theme – Ethics, Law and Professional Development	Lecture	Lecture conducted by staff of Victorian Institute of Forensic Medicine: • Forensic assessment
The University of Adelaide **Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery**	Year 5 Obstetrics and Gynaecology	Lecture	Introduction to violence (including sexual violence)
	Year 6 Obstetrics and Gynaecology	Lecture Workshop	Medical management of abuse and sexual violence including potential medical and psychological presentations; consequences of abuse and violence. Workshop conducted by staff of Yarrow Place Rape and Sexual Assault Service
	Year 6 Emergency Medicine Internship	4-week supervised placement Emergency Medicine Department	Cases of domestic / sexual violence (as arise)

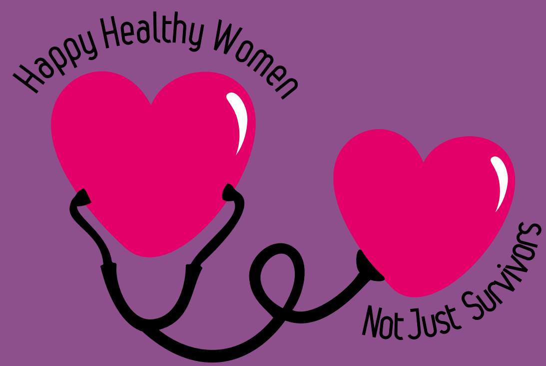
UNIVERSITY	COURSE AND UNITS	LEARNING APPROACH	CONTENT
The University of Melbourne **Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery**	Year 5 Specialty Health Rotations – Psychiatry	Problem based learning tutorials Women's health – 'Woman Who Isn't Coping'	**Knowledge** 1. Childhood experiences influencing personality and development of mental illness in adulthood. 2. Personality factors in aetiology and management of psychiatric disorders. 3. Minor and major depressive disorders. 4. Basic management in the community of depression, including pharmacological management. 5. Complexities of psychosocial issues in etiology and management of depression. **Skills** 1. Conducting psychiatric interview and MSE in people with a depressive disorder. 2. Conducting risk assessment in a person who has made a suicide attempt or threat. 3. Formulating cases of depression with comorbidity using a psychosocial model. **Attitudes** 1. Understanding and respect for people and the diverse manner their psychiatric disorder might present. 2. Understanding and respect for how personality and psychiatric illness might interact and affect how medical treatment is sought. 3. Understanding doctor's primary role in aiding patients with psychiatric illness is to access treatment in a way that is of benefit to them and will minimize conflict or difficulties for all involved. 4. Understanding how use of derogatory terms in "difficult" patients has stigma associated and can affect access to, and appropriateness of treatment.
	Year 5 Specialty Health Rotations – Psychiatry	Problem based learning tutorials Psychosocial – 'Young Woman Who Is Dieting Excessively'	**Knowledge** 1. Features of anorexia nervosa and bulimia nervosa 2. Biological, psychological and social causes of eating disorders 3. Major impairments, disabilities, handicaps and comorbidity besetting the patient and families suffering with eating disorders 4. Principles of treatment of eating disorders, including anorexia nervosa and bulimia nervosa in a range of community and inpatient settings with an emphasis on working with carers, family and other services 5. Importance of culture, developmental stage and gender when assessing and managing people suffering with eating disorders 6. Importance of stigma and cultural attitudes in the recognition and management of eating disorders, including accessibility and responsiveness of mental health services

			Skills 1. Conducting psychiatric interview, taking comprehensive history, performing comprehensive mental state examination in people with eating disorders 2. Diagnosing anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified 3. Formulating eating disorder cases using a biopsychosocial model 4. Managing patients with eating disorders presenting to a hospital resident or general practitioner 5. Conducting risk assessment in a person with an eating disorder 6. Managing psychiatric emergencies in patients with eating disorder 7. Diagnosing and managing the major general psychiatric sequelae and comorbidity of eating disorders **Attitudes** 1. Understanding and respect for the dignity and humanity of patients with eating disorders and their families 2. Not placing own values or beliefs about weight, shape, eating and community expectations on the patient and/or their family 3. Expecting and advocating that patients with eating disorders receive same levels of care as patients without psychiatric disorders, for both their eating disorder and any physical complaints 4. Respecting confidentiality of information of patients with psychiatric disorders, although there may be times when confidentiality cannot be absolute, including times of significant or grave psychiatric or general medical risk.
	Year 5 Child and Adolescent Health – Paediatrics	Lecture 'Child Protection'	
The University of Newcastle **Five-year undergraduate Bachelor of Medicine**	Year 4 Women's and Children's Health	Lectures x 2	Sexual assault (adult) Child sexual assault
The University of New South Wales **Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery**	Phase 1 (Year 1/2)	Lecture	Early parenting and postnatal depression with introduction to topic of child abuse
	Phase 2 (Year 3/4)	Lecture and tutorial	Domestic violence recognition and prevention
	Society and Health3	Student attachment community centres providing care for 'victims' of domestic violence	
	Phase 3 (Year 5/6) Obstetrics and Gynaecology clerkship		Clinical and legal issues in the assessment and management of sexual assault (may be assessed in final examinations)
	Phase 3 (Year 5/6) Children's Health (Paediatrics) clerkship	Lecture	Non-accidental injury to children (Knowledge of medical clinical and legal responsibilities is assessed.)

UNIVERSITY	COURSE AND UNITS	LEARNING APPROACH	CONTENT
The University of Notre Dame Australia, Fremantle **Four-year graduate entry Bachelor of Medicine, Bachelor of Surgery**	Year 2 Foundations of Clinical Practice	Problem based learning	Domestic violence issues
	Years 3 and 4 Clinical Apprenticeships	Clinical placements in obstetrics, paediatrics, psychiatry, and emergency departments	Domestic violence issues
The University of Western Australia **Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery** **Or four-year graduate entry medical program**	Year 5 Obstetrics and Gynaecology units	Case-based tutorial (precedes SARC workshop)	**Scenario of 16 year old female visiting GP for emergency contraception:** • Consent • Contraception • Under age
	Year 5 Women's and Infant's Health attachment	2-hour workshop	**Workshop conducted by doctor from the Sexual Assault Referral Centre (SARC) covering:** • What is sexual assault? • What is consent? • What is sexual abuse? • Incidence • SARC Services • Counselling services • Responding to disclosure • Taking a sexual assault history • Medical management and follow up • Clinical forensic examination and collection of evidence • Doctor's legal obligation • Impact of sexual violence • Several cases with discussion

The University of Western Sydney **Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery**	Year 4 Women's Health – Domestic violence and sexual assault	Learning approach not specified	**Scientific Basis of Medicine** Develops and applies a sound understanding of the scientific foundations of medical practice • Recognise that violence is a common problem with significant health consequences for women **Patient Care** Provides patient centred care as a member of an interdisciplinary team • Be alert to the "red flags" that may suggest domestic violence • Counsel patients for short-term safety • Explain the principles of management of a patient who has been raped **Health In The Community** Promotes the health of individuals and populations, particularly Greater Western Sydney • Identify violence against women as a public health problem • Cite prevalence and incidence of violence against women in local community and nationally **Personal and Professional Development** Demonstrates and develops professional skills, attitudes and responsibilities • Discuss the ethical and legal obligations in regard to maintaining confidentiality for victims of sexual and domestic assault • Explain the legal obligations of the practitioner attending a patient who has been raped

[a] Curricula details from online handbooks and/or heads of schools of medicine or directors of medical education.


Happy Healthy Women
Not Just Survivors