

Happy, Healthy Women, Not Just Survivors

Briefing Paper

Professor S. Caroline Taylor and Dr Judith Pugh

25 June 2010



Happy, Healthy Women, Not Just Survivors. Briefing Paper
Human Research Ethics Committee, Edith Cowan University, Declaration No. 5033
Office of Research and Innovation No. 36898 SUB/16120

Acknowledgements

This project is funded by the Australian Women's Coalition Inc, from funding received from the Australian Government Office for Women. It was commissioned by the Australian Federation of Medical Women (AFMW) in conjunction with the Victorian Medical Women's Society (VMWS).

We would also like to thank Dr Raie Goodwach, President VMWS, and Associate Professor Dr Jan Coles, Vice President AFMW, for their feedback on this document.

Citation for this report

Taylor, S.C., & Pugh, J. (2010). *Happy, healthy women, not just survivors. Briefing paper*. Joondalup, WA: Social Justice Research Centre, Edith Cowan University.

Researcher Contact Details

Professor S. Caroline Taylor
Foundation Chair in Social Justice
Head, Social Justice Research Centre
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027

Phone: 61 8 6304 5866

Fax: 61 8 6304 5866

Email: c.taylor@ecu.edu.au

CRICOS IPC 00279B

FOREWORD

The briefing paper 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). The paper provides the background information and evidence that informs and enables the AWC to more effectively advocate for improving the health and well being of women survivors of sexual trauma.

Sexual violence is a common experience for women in Australia, with one in three reporting sexual violence over their lifetimes and one in ten¹ reporting penetrative or attempted penetrative sexual abuse. Significant health consequences result over a lifetime, and with domestic violence, sexual violence is responsible for the greatest burden of disease for women aged between 18 and 45 years. In spite of this, women who experience sexual violence are reluctant to access healthcare services. There is a critical dissonance between survivors' needs and service provision.

With this work the AWC, AFMW and VMWS address this dissonance. National advocacy for survivors of sexual violence to become "happy healthy women" will assist communities and professionals to respond more effectively to survivors. It is an essential aspect of developing healthy Australian communities.

The briefing paper is a critical step required to adequately inform national policy development in this area. This paper succinctly reviews the recent medical literature on the long term physical and mental health sequelae, health risk behaviours and costs to the Australian community of sexual trauma.

Key stakeholders' contributions from the national 'Happy Healthy Women, Not Just Survivors Summit' follow the literature review highlighting the issues that need to be addressed in order to safely and effectively meet the needs of survivors over a lifetime.

¹ Dunne, M. P., Purdie, D. M., Cook, M. D., Boyle, F. M., & Najman, J. M. (2003). Is child sexual abuse declining? Evidence from a population-based survey of men and women in Australia. *Child Abuse & Neglect*, 27(2), 141-152. doi: 10.1016/s0145-2134(02)00539-2

The lack of education and training for health professionals was identified as a barrier to good healthcare. Current Australian undergraduate training practices are summarised and educational resources described to assist in addressing this deficit.

Our congratulations and thanks to Professor Caroline Taylor and Dr Judith Pugh of the Social Justice Research Centre, Edith Cowen University, for producing this timely work.

A handwritten signature in black ink that reads "J. Coles". The signature is written in a cursive style with a long horizontal stroke at the end.

Associate Professor Jan Coles

Vice President Australian Federation of Medical Women

On behalf of the Dr G. Caspar (AWC), AFMW and Dr R. Goodwach (VMWS)

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EXECUTIVE SUMMARY

This paper, which was commissioned by the Victorian Medical Women's Society (VMWS) in conjunction with the Australian Federation of Medical Women (AFMW), reviews the literature on the long-term physical and psychological health impacts of sexual trauma in women and overviews how this knowledge translates into medical education and best practice in medical treatment in Australia. It incorporates the views of stakeholders at the recent national, multidisciplinary 'Happy Healthy Women, Not Just Survivors Summit' who, like the VMWS and the AFMW, regard sexual violence against women as a human rights and social justice issue as well as a major public health problem. Current policy directions indicate that the long-term support and therapeutic health services needs of women survivors of historical sexual trauma have not been adequately recognised by Federal and State/Territory Governments.

Sexual trauma includes 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. One in three women in Australia are estimated to be victims/survivors of sexual trauma over their lifetimes (Mouzos & Makkai, 2004) while the prevalence rate for child sexual abuse is between 12 and 20% of Australian women (ABS, 2006; Fleming, 1997). As many survivors do not disclose their experiences of sexual trauma (de Visser, Smith, Rissel, Richters, & Grulich, 2003; Fleming, 1997; Golding, Wilsnack, & Learman, 1998; Lievore, 2003; Mouzos & Makkai, 2004) it is likely that doctors see women for health problems associated with sexual trauma without even realising it (Martin et al., 2008; Plichta, 2004). Not surprisingly, health care services and the medical encounter can retraumatise affected women (Hooper & Koprowska, 2004; Hooper & Warwick, 2006).

Most research in the area comes from cross-sectional samples of women in the United States (US) and there are few longitudinal studies. Nonetheless, the effect of childhood and adulthood sexual trauma on women's physical and psychological health is long lasting and presents as an array of symptoms and medical conditions in patients, which adversely affect their health-related quality of life. Sexual trauma is often associated with reproductive and sexual health problems including gynaecological and obstetric problems and sexually transmitted infections; lifetime mental health disorders; other chronic physical health problems; and substance abuse and dependence. The complex psychophysiological changes are confusing to

both survivors and health care professionals resulting in under-detection, misdiagnosis and ineffective treatment (Monahan & Forgash, 2000).

Despite the higher utilisation of health care services by women with a lifetime history of sexual trauma compared to nonvictimized women (Campbell et al., 2006; Koss, Koss, & Woodruff, 1991; Martin et al., 2008) only partial estimates of medical expenditures are available for recent sexual assault and selected composite estimates for lifetime health costs of domestic violence. The total cost of sexual assault to the Australian community in the previous 12 months to 2005 was estimated to be \$720million (Rollings, 2008). The total cost of lost output for sexual assault for the same period was \$259million, and intangible costs of pain, suffering and lost quality of life totalled \$424million.

To strengthen the services to women survivors of sexual trauma and enhance the Australian workforce capacity, the National Council to Reduce Violence against Women and the Children (NCRVWC) (2009) recommended the inclusion of content on sexual assault and domestic and family violence in compulsory course work for undergraduate medical students and in postgraduate professional development. There is little published research evaluating medical school curricula and postgraduate medical training in Australia. Information about the inclusion of sexual violence in the current coursework of undergraduate and graduate entry medical programs was available from eight Australian universities. Most focus on recent sexual assault and/or sexual abuse and not the long-term health sequelae of sexual trauma over the lifespan. Content is generally presented as stand-alone sessions in the latter years of the programs and is largely delivered as part of the women's and children's/infant's health component or the obstetrics/gynaecology component of programs. A small number of clinical practice guidelines are published by professional peak medical bodies and government departments in the areas of forensic examination and medical management of victims/survivors of sexual assault; working with patients in general practice who have survived abuse and violence; and identifying and managing patients and families experiencing intimate partner violence.

In terms of Australian best practice guidelines, State and Territory interagency protocols between health services, sexual assault services, police services, and public prosecutors have been developed (Olle, 2005). However, the 'Review of Queensland Health Responses to Adult Victims of Sexual Assault' (KPMG, 2009) highlighted the gaps between such interagency guidelines and practice. It found that access to forensic and medical services and counselling and support services is

inequitable and does not meet the needs of survivors (of recent or historical sexual assault). Existing interagency protocols in Australia address acute and crisis care responses (Olle, 2005). Similarly, the NCRVWC's Plan focuses on prevention, early intervention and crisis care and support services. By comparison, recent Government initiatives in the United Kingdom (UK) aim to increase access to support and health services for survivors of historical sexual violence and abuse towards managing the long-term physical, psychological and social consequences.

Summit participants identified five key issues and advocated solutions to improve the health and healthcare of survivors across their lifespan:

- Changing community attitudes and behaviours requiring a national 'joined-up' policy and responses across the lifespan, public awareness and community education campaigns, and schools-based education programs;
- Changing survivors' health-related behaviour to enable prompt self-referral and the development of coping skills requiring a national database of information and referral resources for survivors and an ongoing health promotion campaign;
- Changing health care services toward interdisciplinary and cross-sectoral models of service provision that provide equitable access to long-term, affordable, holistic, individualised health care and support and specialised counselling services requiring long-term, dedicated government funding and policy priority; integrated and streamlined services; and undergraduate education and postgraduate training to build the capacity of healthcare professionals especially GPs and support attitude changes;
- Investigating the impact of sexual trauma over the lifespan to provide comprehensive evidence of the relationship between sexual trauma and lifetime health impacts requiring the establishment of a multidisciplinary Centre of Excellence to drive initiatives (including longitudinal research) and host a national clearinghouse, and
- Changing the legal environment in Australia to achieve more criminal convictions of perpetrators of sexual violence and compensate survivors for past and future losses requiring an inquisitorial system for crimes of this nature in place of the accusatorial system; education of police, legal professionals and judges; and establishment of an Australia-wide third party insurance scheme.

INTRODUCTION

This paper was commissioned by the Victorian Medical Women's Society (VMWS) in conjunction with the Australian Federation of Medical Women (AFMW). Academic researchers of the Social Justice Research Centre (SJRC), Edith Cowan University, were invited to review the literature on the long-term physical and psychological health sequelae of sexual trauma in women and examine whether this understanding translates into medical education and best practice in medical treatment in Australia.

The project was part of a joint advocacy initiative of the Australian Women's Coalition Inc. (AWC), the VMWS, and the AFMW as the first step toward improving the long-term health and wellbeing of women who have suffered sexual trauma as children or as adults. It was undertaken on a part-time basis over an eight-week period. The project leaders were Dr Raie Goodwach (President VMWS), Dr Desiree Yap (President AFMW) and Associate Professor Jan Coles (Vice President AFMW). Professor S. Caroline Taylor, Foundation Chair of Social Justice and Head, SJRC, supervised the review of the literature by Dr Judith Pugh. The project was also informed by a national summit of key stakeholders, held in Melbourne on 7 May 2010, in which consensus recommendations were formulated for the AWC to advance to Government.

The vision of all involved is that medical doctors and other health professionals sensitised to the effects of childhood sexual abuse and adult sexual trauma will be able to help affected women with their long-term health problems and minimise inadvertent retraumatisation during the health encounter.

The broader vision, which could not be addressed within the scope of this pilot project, is that all survivors of sexual trauma—male and female—will benefit from encounters with health professionals who are sensitised to their needs. While this project focuses on medicos, the broader vision is that all professionals who come into contact with survivors, including police, lawyers, the judiciary, and educationalists, will also be sensitised.

THE NEED FOR THIS PROJECT

Violence against women is a human rights and social justice issue. It is a serious and unrelenting 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.

OVERVIEW

Sexual victimisation of women is a serious public health problem. It is estimated that one in three women in Australia² 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 Australia 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 disclose⁴ or report their experiences of sexual trauma to a third party, including health care providers (de Visser, Smith, Rissel, Richters, & Grulich, 2003; Fleming, 1997;

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).

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 briefing 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.

WHAT IS SEXUAL TRAUMA

In this briefing 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 interference 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 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 & Bittenheim, 1997). Robohm and Bittenheim (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).

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 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 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 led 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 nonvictimized 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 (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 search⁵ 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

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).

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 information⁶ 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 Eight⁷). 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 obstetrics/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, delivered by staff of

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.

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 '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’.

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 (see Appendix B). 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 (see Appendix C). 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.

KEY ISSUES AND POSSIBLE SOLUTIONS TO IMPROVE SURVIVORS' HEALTH AND HEALTHCARE

The following five themes were prominent amongst the key issues and possible solutions to improve the health and healthcare of survivors across their lifespan identified by summit participants:

1. Effecting cultural change in Australia – changing community attitudes and behaviours;
2. Changing survivors' behaviour related to health care;
3. Changing health care services;
4. Investigating the impact of sexual trauma over the lifespan, and
5. Changing the legal environment in Australia.

Happy, Healthy Women, Not Just Survivors

EFFECTING CULTURAL CHANGE IN AUSTRALIA

Summit participants agreed that 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. The main contextual factors identified were: inadequate awareness of sexual violence and the correlation between sexual violence and health; failure to believe and/or acknowledge survivors (as reflected in policy and legal system outcomes); and community knowledge, attitudes, and practices (individual behaviours and social norms).

Possible solutions:

- Educate public policy makers, Governments, and curriculum planners;
- National 'joined-up' policy and responses;
- Provide survivors with information to assist them to negotiate the healthcare, support and legal systems and empower them to make decisions;
- Public awareness campaign on sexual trauma equivalent to the 'Violence Against Women – Australia Says No' campaign and the 'beyondblue' national advertising campaign;
- Community education campaign about gender-based violence (e.g., as for HIV/AIDS and domestic violence);
- Schools-based education programs that include respectful relationships and are gender-sensitive (from 10 years of age), and
- Targeted education programs for at-risk populations (e.g., persons with intellectual disabilities, Aboriginal and Torres Strait Islander peoples).

CHANGING SURVIVORS' BEHAVIOURS RELATED TO HEALTHCARE

Summit participants saw a need to change survivors' health-related behaviours. Survivors require help to recognise symptoms related to sexual trauma, which will enable prompt self-referral and support to help their recovery (physical, mental, emotional, and relationship health) and the development of coping skills.

Possible solutions:

- Widely distributed information and referral resources in multiple formats and languages (including resources for specific at-risk groups e.g., the elderly; persons with intellectual disabilities; Aboriginal and Torres Strait Islander peoples; and people from culturally and linguistically diverse (CALD) backgrounds);

- National database for survivors (including information, self-help resources; referral pathways; profiles of agencies; recommended health, legal and support professionals);
- Ongoing health promotion campaign, and
- Empowering patients to manage their health care (e.g., holding own medical records).

CHANGING HEALTH CARE SERVICES

Summit participants recommended enhancements to the health care system that provides formal support to survivors (medical and mental health systems). They described the current system as fragmented and in need of an overhaul to reorient it towards interdisciplinary 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, were regarded as problematic. Discussion was inclined towards health promotion, combining health education, improvement in services at different levels, and advocacy—all of which aimed at enabling survivors of sexual trauma increased control over their health and wellbeing.

It was agreed that survivors of sexual trauma require and deserve equitable access to holistic, individualised health care assessment, treatment, and support otherwise they are at risk for retraumatisation by service providers and services (system). Research by Hooper and Koprowska (2004, p. 176) provides just such a description of retraumatising experiences of service provision shared by women survivors of childhood sexual abuse:

Further sexual abuse from professionals, indifference, disbelief or dismissiveness when they tried to tell of their childhood abuse, experiences of rejection or abandonment when discontinuities in service provision were poorly handled, betrayal of trust when confidentiality was breached, a sense of being unheard, invalidated and objectified when professionals relied exclusively on a medical model of mental illness or a distancing therapeutic style, punitive responses to self-harm in hospital Accident and Emergency departments, neglectful or intrusive responses from nursing staff in hospital and more.

Summit participants believe that survivors require access to specialised counselling services that fit the ongoing nature of the health impacts of sexual trauma (that is, long-term or ongoing, affordable if not free, and accessible).

Medical professionals, in general, were considered as lacking the knowledge, skills, attitudes, and values to appropriately identify, treat, and manage the complex health sequelae of sexual trauma and the full range of issues that survivors may present

with in various settings. It was thought that, by-and-large, the long-term health problems associated with sexual trauma are not appreciated by medical educators. Building the capacity of healthcare professionals through education and training and supporting attitude changes, therefore, features amongst solutions especially for primary health care providers.

Possible solutions:

- Help Government to understand the economic impact of the lack of treatment for the long-term health consequences of sexual trauma over the lifespan;
- Lobby Government to augment and improve service provision across all sectors (including coordinated women-centred services and confidential mental health services);
- Doctors to take on health advocacy role;
- Ongoing public awareness campaign re health impacts of sexual trauma;
- Long-term, dedicated government funding of specialised services for survivors of sexual trauma and policy priority;
- Holistic, integrated healthcare models of services provision (with long-term funding);
- Family-oriented, relationships-based services (particularly to address the flow-on effect to children);
- Empowering school staff to support children experiencing child sexual abuse and their families;
- Improved coordination and communication within and across services (including improving linkages and understandings between aged care assessment teams and family violence agencies and those between disability and sexual assault services);
- Intra-sectoral and cross-sectoral partnerships and/or networking and collaboration (interdisciplinary and multi-institutional) leading to cross-fertilisation of information and services;
- Streamlined services to reduce the number of times that survivors have to relate their experience and risk retraumatisation;
- One-stop shop (integrated services) with a primary healthcare professional for each client ensuring continuity of care (planning and coordinating care in consultation with client);
- 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);

- Incorporate long-term health sequelae of sexual trauma (including assessment, treatment, management, and referral pathways) in undergraduate medical curricula (examinable), postgraduate training, and continuing medical education (experiential and reflective learning models recommended);
- Incorporate long-term health sequelae of sexual trauma (including assessment, treatment, and management, and referral pathways) in undergraduate curricula and postgraduate training of all healthcare professionals;
- National clearinghouse for healthcare professionals (including research in the field, patient resources, and referral resources);
- Mandatory GP training for registration, accreditation, and reaccreditation, and
- Support services for healthcare professionals.

INVESTIGATING THE HEALTH IMPACTS OF SEXUAL TRAUMA OVER THE LIFESPAN

Summit participants recognised the need for comprehensive evidence of the relationship between sexual trauma and lifetime health sequelae, which can guide the provision of care to survivors of sexual trauma. Disaggregated, longitudinal data of the health impacts of sexual trauma over the lifespan (including revictimisation) is specifically required.

Possible solutions:

- Establish a multi-disciplinary foundation or Centre of Excellence (including referral pathways to strengthen access to care) to drive initiatives;
- Longitudinal research into all aspects of the health impacts of sexual trauma (including the economic costs of sexual trauma; at-risk populations) to provide evidence for policy, healthcare, and support programs and services;
- Collect evidence of advocacy and community interventions effecting change; and
- Establish a national clearinghouse.

CHANGING THE LEGAL ENVIRONMENT IN AUSTRALIA

Although the adversarial legal system in Australia is retraumatising for survivors of sexual violence (Taylor, 2004a; 2004b), summit participants were in agreement that more criminal convictions of perpetrators of sexual violence are necessary to influence community beliefs and attitudes. It was noted, however, that few survivors receive compensation from perpetrators for the past and future losses and expenses that they sustain as a result of the trauma including: loss of earnings; medical expenses; pain and suffering; loss of quality of life; trauma; and stress.

Possible solutions:

- Believe survivors and acknowledgement that it is not their fault;
- Assist survivors in self-determination;
- Simplify the prosecution process;
- For crimes of this nature, replace the accusatorial system with an inquisitorial system (e.g., as in France);
- Sanctions or outcomes to reflect the seriousness of the crime;
- 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);
- Australia-wide education of police, legal professionals, and judges towards responsive and sensitive practice and services that protect survivors from retraumatisation; and
- Establish Australia-wide third party insurance (or similar) to compensate survivors for special damages and general damages resulting from sexual trauma, and facilitate claims by parents/guardians on behalf of abused children.

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 lifespan⁸ ;
- 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

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.

- 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.

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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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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)

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<p>The University of Melbourne Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery</p>	<p>Year 5 Specialty Health Rotations – Psychiatry</p>	<p>Problem based learning tutorials Women’s health – ‘Woman Who Isn’t Coping’</p>	<p>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.</p>
	<p>Year 5 Specialty Health Rotations – Psychiatry</p>	<p>Problem based learning tutorials Psychosocial – ‘Young Woman Who Is Dieting Excessively’</p>	<p>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</p>

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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) Phase 2 (Year 3/4) Society and Health3 Phase 3 (Year 5/6) Obstetrics and Gynaecology clerkship Phase 3 (Year 5/6) Children's Health (Paediatrics) clerkship	Lecture Lecture and tutorial Student attachment community centres providing care for 'victims' of domestic violence Lecture	Early parenting and postnatal depression with introduction to topic of child abuse Domestic violence recognition and prevention Clinical and legal issues in the assessment and management of sexual assault (may be assessed in final examinations) Non-accidental injury to children (Knowledge of medical clinical and legal responsibilities is assessed.)

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The University of Notre Dame Australia, Fremantle	Year 2 Foundations of Clinical Practice	Problem based learning	Domestic violence issues
Four-year graduate entry Bachelor of Medicine, Bachelor of Surgery	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 Year 5 Women's and Infant's Health attachment	Case-based tutorial (precedes SARC workshop) 2-hour workshop	Scenario of 16 year old female visiting GP for emergency contraception: <ul style="list-style-type: none"> • Consent • Contraception • Under age Workshop conducted by doctor from the Sexual Assault Referral Centre (SARC) covering: <ul style="list-style-type: none"> • 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

<p>The University of Western Sydney Six-year undergraduate Bachelor of Medicine, Bachelor of Surgery</p>	<p>Year 4 Women's Health – Domestic violence and sexual assault</p>	<p>Learning approach not specified</p>	<p><i>Scientific Basis of Medicine</i> Develops and applies a sound understanding of the scientific foundations of medical practice</p> <ul style="list-style-type: none"> ● Recognise that violence is a common problem with significant health consequences for women <p><i>Patient Care</i> Provides patient centred care as a member of an interdisciplinary team</p> <ul style="list-style-type: none"> ● 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 <p><i>Health In The Community</i> Promotes the health of individuals and populations, particularly Greater Western Sydney</p> <ul style="list-style-type: none"> ● Identify violence against women as a public health problem ● Cite prevalence and incidence of violence against women in local community and nationally <p><i>Personal and Professional Development</i> Demonstrates and develops professional skills, attitudes and responsibilities</p> <ul style="list-style-type: none"> ● 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
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^a Curricula details from online handbooks and/or heads of schools of medicine or directors of medical education.

APPENDIX B – 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 Cowen 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?

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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.

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.

Before I turn to the honour of introducing our panel who will set the scene for our work this morning, I would like to thank the AMA for providing this wonderful setting for our meeting. They have been a pleasure to work with.

I would also like to tell you about the open-hearted generosity of Coffee Darling, a little coffee shop in Darling St South Yarra, who insisted on providing morning tea and lunch when they heard about our Summit, and Toscano's fruit shop, who insisted I take lots of delicious fruit for us all to enjoy. The simple generosity of both because they believe this is a good cause is humbling. They wanted to help us in the way they could because they thought that we're doing a good job and need to be well fed to do it well.

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.

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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.

APPENDIX C – PARTICIPANTS HAPPY HEALTHY WOMEN, NOT JUST SURVIVORS SUMMIT, 7 MAY 2010, MELBOURNE

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 (VWMS)
Ms Catherine Evans, National Representative, Soroptimist International Australia
Sgt Patrick Flemming, Branch Manager, Hervey Bay Police Citizens Youth Club, Qld
Ms Roby 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 (VWMS)
Ms Nikki Greenway
Associate Professor Kelsey Hegarty, Director, Postgraduate Nursing Programs, The 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, Consultant 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