


delivery to victim/survivors. The guidelines make specific reference to the incidence of sexual assault in intimate relationships and refer to alternative protections available under Queensland law (*Queensland Interagency Guidelines for Responding to Adult Victims of Sexual Assault*: 27 para 4.4.15).

A comprehensive list of support agencies is attached to the guidelines and includes domestic violence support services. The experience of the SARRG is testament to the benefits of collaboration of agencies at a local level. The authors report that the police treatment of victim/survivors has improved due to their involvement in SARRG and subsequent exposure to feedback about “inappropriate, judgmental and insensitive responses towards survivors of sexual violence” (Brazier et al. 2001: 2). The SARRG also provided an opportunity for Townsville agencies to share protocols and to review what worked best to support the needs of victim/survivors (Brazier et al. 2001: Conference paper abstract).



The experience of the SARRG is testament to the benefits of collaboration of agencies at a local level.

The Queensland Sexual Offences Medical Protocol includes detailed documentation of the procedure to be followed in the event of a forensic examination and includes consent forms for the release of information to Queensland Police. A form to request that the results of tests be forwarded to a nominated health practitioner or other person is also included in the Protocol. The Protocol is provided along with specimen collection materials and instructions for the handling and handover of specimens and information to Police and forensic science agencies.

The Queensland example is important because it illustrates the contemporaneous nature of the struggle to implement and maintain consistent and appropriate service provision in response to sexual assault.

DISCUSSION

In sections one and two of this paper, we explored the historical development of protocols in Australia and outlined the details of inter-agency protocols as they currently exist. This final section is in two major parts.

First, we examine some of the common themes that have arisen out of this snapshot view of health sector protocols and ask how the protocols remain relevant to the work of health, support, and legal agencies, and what might be done to improve their effectiveness?

In the second part we analyse recent Australian and international research that examines the profound impact of sexual assault on the individual lives of (mostly) women, on families, and on communities and the significance of these studies in considering any future re-design of inter-agency protocols that respond to victims' long-term health care needs.

Effectiveness of protocols

The agency perspective

While some of the protocols, at least in principle, begin to address the concerns of victim advocates as well as take into account the issues raised by research over the past three decades, there are a number of limitations, at an agency level, that

effect their implementation. A significant finding of this paper is the variation in understanding, within any particular sector, of the applicability of protocols. Three major city-based services suggested that their protocols tended to direct the service-response provided by agencies outside of major city areas and were not in fact, for varying reasons, applied directly within their own services.

The extent to which the inter-agency protocols were known about and/or adequately applied across health, sexual assault service-providers and legal agencies was certainly uneven according to staff at several sexual assault support services. In general, senior staff across most of the key organisations appeared to have some knowledge and understanding of the protocols they operated under (and were signatories to), although there were occasions when individuals were clearly unsure of the status or existence of claimed to have no knowledge at all. On other occasions, sexual assault workers suggested that agencies that were unclear about the status of interagency protocols, sometimes gave deference to the manuals and procedures that more broadly governed the service response of the organisation. For example, hospital emergency department workers might refer to “in-house” hospital procedures, while police might direct attention to their operating procedures manuals as over-riding the status of any other type of document.

Another factor impacting on the effectiveness of protocols is the extent to which collaboration between agencies has genuinely been achieved. Integrated health service delivery models, like those found in Sydney, Perth, Hobart and Adelaide, have been most effective in streamlining the extent to which victim/survivors will be obliged to repeat the details of their abuse. These integrated health models offer forensic and counselling services on the same premises, either attached to, or close by hospitals where emergency departments can provide medical treatment for serious injury. Pregnancy and STI testing and the provision of prevention and amelioration measures such as emergency contraception counselling services, follow-up medical care, and short-term counselling for acute or recent sexual assault, are all provided in an environment of relative security and comfort.

Another advantage of such an integrated model is the opportunity for increasing specialisation and professional development in sexual assault service provision afforded to medical personnel. The Melbourne metropolitan CASA model meets this concern to a certain extent. Hospital services are located close-by where all medical and follow-up medical health care can be accommodated. Counselling is provided in a discrete non-medicalised environment, similar to the Sydney, Perth, Hobart and Adelaide services. Brisbane, Townsville and Gold Coast services in Queensland also provide similar services.

However, a high degree of collaboration amongst colleagues from different disciplines (for example nurses, doctors and counsellors within services) is a prerequisite for the effective implementation of this integrated kind of model. Genuine efforts to work collaboratively is not always possible. For example, emergency department personnel at some of the hospitals considered do not share this type of close collegial relationship.

Furthermore, the advantages of the integrated model are not available outside major metropolitan centres, and protocols designed with this model in mind may not always be appropriate to regional and remote services. For example, the requirement in Victoria to provide medical and forensic services within two hours of a report being made, for instance, is no simple matter when the only means of access to services for the victim is via plane or boat.

As a worker from one sexual assault service noted:

“Access to forensic examinations is difficult. A victim might travel a couple of hours to a police station, from which they may be taken to another to be interviewed by CIB (again a couple of hours drive), and from there might have to be driven another couple of hours to be examined by a Doctor, back to the station for a second time, then back home.”¹⁶

Many island communities all around Australia have no specialised on-site services for responding to sexual assault. Even where there are a number of services that might separately be able to provide a health care response to sexual assault, in more isolated regions, they may not have established the mechanisms through which they can better co-ordinate their responses. This is of course also true in some major city areas, although not for the same reasons. Even where protocols are able to be applied, and can be adapted to localised situations, there is often an issue of accountability. Few of the inter-agency protocols had been subject to evaluation or included formal mechanisms for monitoring compliance.

It must also be acknowledged, however, that the existing inter-agency protocols may be fundamentally inconsistent with the kind of approach that might be more culturally appropriate to meet the needs of particular communities. At least two Indigenous communities, according to the workers in these regions, have begun to consolidate their own programs for dealing with violence against women. These programs bear philosophical similarities to the major city protocols but operate in distinctively community-based ways with specific reference to the skills of community elders rather than be accountable to the government departments.

Flexibility is also important in those regions where forensically-trained medical staff must substitute for doctors where none are available, or where doctoring is variable due to high turnover rates. While the allocation of sufficient resources to training and recruitment could conceivably address the shortfall of trained specialists, the need to more permanently place specialists outside of the major cities areas is well recognised. Interest in the training of nurses to provide forensic services is increasing in Australia. Recommendation 7(a) of the report by the Department of Health and Human Services (DHHS) in Tasmania, titled *Justice Matters*, is “considering adopting or adapting the American model of Sexual Assault Nurse Examiners (SANE) in sexual assault cases” (Davies 2002: 10).

A recent report from the United Kingdom, *Forensic Nursing: An Option for Improving Responses to Reported Rape and Sexual Assault*, concludes that “forensic nursing can provide a cost-effective option to: address delays in the provision of forensic examinations; increase the availability of female forensic examiners; and also has the potential to enhance professional standards” (Regan et al. 2004:1). Nurses have previously been able to access specialist forensic training in Australia. For example, the doctors employed by the rape and sexual assault service in South Australia, Yarrow Place, currently deliver training in forensics where some of the participants in the course have been nurses (some from remote areas). The difference with SANE training is that it is a program developed specifically for professional nurses.¹⁷ SANE nursing certainly provides one option for addressing some of the issues arising with the paucity of forensic expertise in regional areas.

In discussing the effectiveness of the inter-agency protocols, a majority of workers were nonetheless enthusiastic or hopeful about the protocols improving the working relationships across agency groups. This is perhaps best demonstrated by

the continued goodwill between parties to existing protocols, and their willingness to continue developing practices according to perceived needs of victim/survivors and of the system. Nonetheless, it is important for agencies to have access to “evidence-based” understandings of how the protocols are working in practice if the inter-agency protocols are to remain relevant to the needs of individual victims.

The victim/survivor perspective

How successful the individual protocols may have been for ameliorating the difficulties originally identified by victim survivors has not been comprehensively assessed. Some information can be gleaned from surveys (Heenan and Ross 1995; D’Arcy 1999), or through listening to the testimonies of victims about their contact with services following disclosure (see for instance, Keally and Killey 1996; Kripps 1996).

Nonetheless, it is important for agencies to have access to “evidence-based” understandings of how the protocols are working in practice if the inter-agency protocols are to remain relevant to the needs of individual victims.

The Victorian evaluation of the Police Code of Practice was certainly helpful for being able to identify problems of non-compliance early, and ensuring that the Code did not lose momentum in shaping more workable relationships across the key agencies involved (Heenan and Ross 1995). It also meant that the principles of prioritising the victims needs (medical, emotional and legal) were further endorsed. Other protocols, such as the Queensland Guidelines, have built in the requirement and the resources for ongoing monitoring. There is the potential in this context for greater attention to be given to how relevant and effective the guidelines continue to prove, and to monitor any changes in practice, service use, and victim satisfaction.

Sexual assault and health: International research and policy directions

The health effects of sexual violence have only recently emerged as an area of concern in public policy terms. It is now clear that violence against women is a primary indicator of women’s health outcomes across the life-span. Here we look briefly at international and Australian research into what is fast becoming a compelling evidence base that reliably links women’s ill-health with the incidence and prevalence of domestic violence and sexual assault. We consider at the implications of this overview for ongoing development and practice of agency responses to sexual assault in the health sector, and for specific sexual assault protocol development and implementation.

Public/community health and sexual violence

The effects of sexual assault and other forms of violence take a significant toll on the health of entire communities. In Australia this was reliably illustrated in the recently-published report by the Victorian Health Promotion Foundation (hereafter VicHealth) titled “The health costs of violence: Measuring the burden of disease caused by intimate partner violence” (VicHealth 2004). The report confirms what women survivors have been telling us for decades, that sexual and physical violence has an enduring impact on their health.

Indeed, the study found that: “Intimate partner violence is responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking” (VicHealth 2004: 8).

Internationally, the World Health Organisation (WHO) has held a series of conferences looking at public health over the past three decades and now recognises the impacts of violence against women as one of the most significant health issues facing world communities. Research considered by World Health Organisation and the Global Forum for Health Research have identified the health burden of sexual assault and violence against women as greater than the combined effects of malaria and traffic accidents (WHO 1997, vol. 4).

Moreover, there have been moves in recent decades to position health with the language of human rights. In 1978 the International Conference on Primary Health Care, meeting in Alma-Ata made the following Declaration (in part):

“The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right” (Declaration of Alma-Ata International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978).¹⁸

The Ottawa Charter for Health Promotion in 1986 also recognised that public health policy is central to providing the conditions in which communities can build flexible and sustainable partnerships aimed at addressing health concerns. The Charter further notes that this requires “full and continuous access to information, learning opportunities for health, as well as funding support” (*Ottawa Charter for Health Promotion* 1986: Strengthen Community Action).

The collective findings of this research confirm that sexual violence is preventable and generates serious and ongoing consequences for the health and wellbeing of individual victim/survivors, has a calculable cost to the whole community both in financial terms and in terms of the health of communities, and requires a proactive, determined focus on the part of government and community in order to reduce and ultimately eliminate it. The role that health sector protocols can play in this context cannot be underestimated in terms of ensuring the health needs of victim/survivors are met, throughout their lives.

We know that we have the capacity to respond as a community to serious and preventable health problems. An example is the enduring cultural change brought about by a concerted and sustained effort to address the alarming trauma and damage caused by traffic accidents. It is no longer culturally acceptable to drive under the influence of alcohol and many publicly funded campaigns aimed at reducing injury and death from speeding, driving while fatigued, and dangerous driving, have reduced the incidence of traffic accidents dramatically since campaigning commenced in earnest in the 1970s.

Given what research now shows us about the health burden of sexual and other forms of violence, it is not unrealistic to expect that we would respond with the same dedicated efforts to reducing the causes or contributors to the trauma and damage that results from violence. Campaigns aimed at primary prevention will require major policy commitments from all levels of government. On the other hand, health sector protocols may assist by providing earlier points of intervention through which victims may access support and more readily link their health status with their experiences of violence.

In 1997 the World Health Organisation declared violence against women and girls a major health and human rights issue (WHO 1997, vol. 4). International policy directions in addressing the health needs of those who have experienced sexual violence are reflected in Australian federal and state health policies as discussed in

section two. In theory at least, Australian policy responses to the health needs of victim/survivors of sexual violence align well with international policy directions. This is also true in the specific instance of health sector protocols as exemplified in the major sexual assault services around the country. It could be said that they represent models of good practice. There are, however, a range of factors that continue to influence the practical application of these umbrella policies and these are explored further below.

Limiting factors on health responses

Specialist sexual assault services, including women's health sector agencies, provide responses that address the core concerns of victim/survivor centred practice within a feminist framework. Individuals in other health services, as well as individual police members, are certainly striving to improve their practice in terms of responding appropriately to the needs of victim/survivors of sexual assault. Unfortunately, however, the overwhelming experience of women accessing health services for issues arising from sexual violence is that the health sector is generally ill-prepared and under-informed about the health issues victim/survivors face. Some services may in fact respond in ways that further compounds the effects of violence on victims by responses that are more informed by prejudice, than by understanding the social and situational contexts in which most sexual assault occurs.

Several Australian studies have documented some of the factors restricting or preventing appropriate responses by the health sector and other services, despite best practice policy and protocols. Surveys conducted as part of the Australian Longitudinal Study on Women's Health, known widely as Women's Health Australia, found that in response to questions about the effectiveness of help sought in instances of violence only "a relatively small proportion of the women were satisfied with the help they received when they asked for it" (Parker 2001:191). While the researchers are here referring to women's experiences of domestic violence broadly, they nonetheless surmise that "the ability of health and police services to respond appropriately to women who have experienced violence and abuse needs improvement". Parker goes on to note that there are possibilities for much improved outcomes for women experiencing violence with a "more proactive approach from health, social and police services" (2001: 191).

A major factor limiting the capacity of the health system to respond is 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. Research by Mazza, Dennerstein and Ryan (1996: 15) found that in a population of women¹⁹ attending their general practitioner, "importantly, about three-quarters of respondents [to the survey] had never been asked by their doctors about domestic violence or childhood physical abuse". In the case of both adult and child sexual assault, 53 per cent of survey respondents had not disclosed to their doctor because they "had never found it relevant to the consultation" and for 27 per cent their doctor had never asked (1996: 15). Overall, among the 15 general practices in Mazza's study sexual violence was grossly under-detected by doctors. As Mazza notes, not only are women not making the connection between their symptoms and sexual violence, neither are their doctors. She goes on to suggest that where the potential for abuse is overlooked in diagnosis, "treatment is likely to be inappropriate and potentially harmful" (Mazza et al. 1996: 17).

Others have commented on the paucity of medical professional recognition of the issue of sexual violence. Jenny Barry (1992: 48) observes that although "the community has been grappling with adult sexual assault for a long time . . . the

medical profession has been notably silent in this area". In recognition of the harmful impacts of under-detection or misdiagnosis of the health effects of sexual violence, the Australian Health Minister's Advisory Council (AHMAC) undertook to address the lack of awareness and skills among medical professionals and commissioned the interactive educational module, *Medical Responses to Adults Who Have Experienced Sexual Assault* (Olle 2004). This module will be available to doctors across Australia in 2004.

The potential to redress this failure to identify and respond to sexual violence is perhaps one of the most heartening aspects of work in this field. According to the World Health Organisation (WHO 1997, vol. 9: 2):

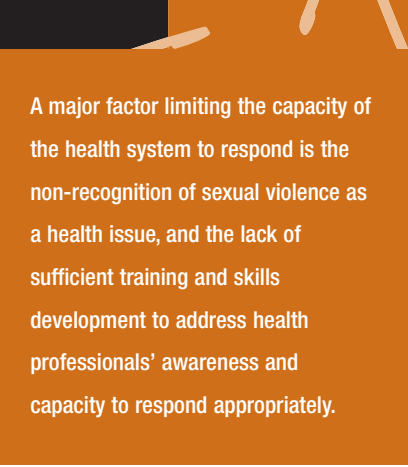
"Studies show that with proper training and protocols, health care workers can become more sensitive to issues of violence against women. One example is the emergency department of the Medical College of Pennsylvania, Philadelphia, PA, United States. After introducing training and protocols on violence, the proportion of female trauma patients found to be battered increased fivefold, from 6 per cent to 30 per cent."

The impact of the lack of specialised knowledge and insight outside of sexual assault services is to limit the capacity of the whole health system to respond appropriately. On the other hand, it is hard to overstate the potential for vastly improved health outcomes across the spectrum both in terms of responding to individual victims and for the whole community.

A range of other factors also influence the practical delivery of appropriate health responses. Most notably these include where services are limited by: size or resource levels; geographic proximity to other (partner or specialist) service providers; adequate skills and training in relevant and appropriate service responses; and where the requisite will to respond appropriately does not prevail or cannot be monitored and adequately supervised.

Protocols are clearly one mechanism for reducing the extent to which individual factors can have a disproportionate influence on inter-agency responses. However, one significant and recurring theme to emerge in discussions with various workers was the extent to which the community profile of issues like sexual assault and intimate partner violence can sometimes be dependent on the attitudes and personalities of people living and working in the community itself (OSW 1998; Western Australian Ombudsman 2003; Neame and Heenan 2004). This factor may have the potential to drive efficient, appropriate and transformative service provision and greater recognition of the extent and effects of sexual violence on the community, or it may work to undermine effective responses. The particular values, insights and skills of workers can certainly influence the nature and approach to delivering services to victims of sexual assault and domestic violence in the local community.

Workers in some of the remote and very remote regions were careful to impress their awareness of the influence they themselves could have on a small and isolated community. One worker spoke of recently having left a position and speculated that it was time to move on because she felt it was possible that her personality and her style of response and interaction may, after some years in the area, have constricted community growth in directions she may not have recog-



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nised. The case study of the development of guidelines in Townsville, in Queensland, is further testament to the idea of progress being firmly linked to the commitment and energy of a small number of very determined people.

Finally, long-term health care is not specifically addressed in many of the protocols reviewed here. This is hardly surprising given that so much of the early policy focus was on fundamentally improving the response that victims of recent assaults encountered at the point of crisis care. However, the contemporary climate also inhibits a longer term focus. Sexual assault services are typically funded to provide short-to-medium term counselling. Hospitals, in this context, are therefore responding to mostly acute and shorter-term medical issues. Non-government services such as Women's Health Centres do provide a greater degree of longer-term support to women survivors through group programs and individual counselling, community development and public advocacy. However, this generally falls far short of assessing the kinds of life-span health outcomes that are increasingly being linked to women's long term experiences of intimate partner and family violence. This will require vastly new ways of responding to the issues.

The cost of sexual violence and health responses

In terms of cost to the community, research conducted by the World Health Organisation (WHO 1997, vol. 8) around sexual assault indicates that:

"The costs to society of violence against women are tremendous, in terms of health care alone. A proportion of these costs are for treating serious physical injury. A substantial amount is also spent on psychological problems including managing anxieties and symptoms which happier, more confident, women may be able to tolerate, ignore or shrug off."

They also cite costs in terms of systemic responses such as investigation and legal costs across the spectrum, rehabilitative programs for perpetrators, medical and social service costs (including child protection services), and costs associated with reduced productivity and employment.

The research that informs the reports written by Lesley Laing and Natasha Bobic (2002), Christina Lee (2001), and Vichealth (2004), also points to the false economy

in under-funding specialist services to victim/survivors of sexual violence especially given that these services are also the prime motivators in community education, and in driving discourse about appropriate support responses and prevention. In their literature review of studies into the costs of FDV, Laing and Bobic (2002: 26) note:

"Several of the studies addressed the question of the proportion of costs of domestic violence borne by different parties. The Tasmanian and Northern Territory studies found that governments bear the largest proportion of direct costs and that women bear the largest proportion of indirect costs. This, however, may be a consequence of the similar methodologies applied in these two studies. The approach of the Brisbane City Council study (Henderson 2000a) is interesting in this respect, in that the point is made that the direct costs of services provided by government are in fact indirect costs to the business sector, incurred through taxation. The Tasmanian and Northern Territory studies make a similar point – that is, that the whole community incurs high costs due to domestic violence – by denoting the share of costs paid by governments as 'community/government'."

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In any event it is clear that there are significant costs to all sectors of the community as a result of sexual and other forms of violence. Whoever bears the ultimate cost, the imposition of the costs is largely preventable. However prevention relies on the dedication of adequate resources and a commitment in policy terms to ensuring the stability and permanence of services working on prevention, without undermining the capacity of organisations to provide direct service to women, children and men who have already experienced sexual violence.

Against the Odds (OSW 1998), reports that in the instance of family and domestic violence, “it needs to be acknowledged that existing domestic violence services are typically stretched to their limits, and that demand for assistance far exceeds the present service-capacity of most agencies and organisations” (1998: 94). Kate Baxter further addresses the issue of resourcing in her paper on rural services, titled *Starting from Scratch* (in Breckenridge and Carmody 1992: 177-179). To this extent, studies confirm that a growing awareness of the prevalence, seriousness and persistence of violence against women, along with the health and economic costs to both individuals and the community, is almost directly correlating with an ever-*diminishing* pool of resources. A consistent response from across the sector of sexual assault services is that resourcing is inadequate to the task of meeting the growing demand for direct service – that is, one to one counselling and advocacy, and the demands of community education.²⁰

Concluding remarks

Health sector and interagency protocols aimed at providing consistent, professional and appropriate responses to sexual assault are relatively new features of the Australian health policy and practice landscape. In the afterglow of highly successful feminist lobbying throughout the 1980s, aimed at improving systems responses to women who were victims of sexual offences, services were keenly committed to establishing working agreements across agencies that would allow for victim’s emotional, medical and legal support needs to be consistently met.

Lessons from overseas studies helped to shape the direction in which services in Australia would develop. In the late 1970s Ann Burgess and Lynda Holmstrom (1974a, 1974b) exposed the science of “rape trauma” that identified how immediate crisis intervention was more effective at dealing with the damaging effects of sexual violence. “Good practice” was seen to lie in agencies being committed to prioritising the emotional support and health care needs of victims regardless of whether s/he opted for police or legal intervention. National standards were formulated for workers in both specialist sexual assault services and other more generic health services that would consolidate a consistent service response to victims that was grounded first and foremost in practice, and where the rights of victims to determine any “next steps” were both supported and respected.

The mechanisms developed over the past two decades to guide inter-agency responses to sexual assault have attempted to coordinate service responses that manage what have historically been competing interests among, on the one hand, police and forensic doctors eager to maximise the potential for successful prosecutions and, on the other, counsellors advocating on behalf of victims to ensure their counselling and support needs are properly met. The influence of state and federal health policy in providing a backdrop against which protocols could be shaped was undeniably significant during the mid 1980s, alongside successful lobbying for improvements to police practices and calls for standardising good practice, nationally, across service agencies.

This ACSSA Issues paper has provided a snap-shot view for services to look across state and territory borders to assess the kinds of protocols that currently exist to guide inter-agency responses to the health care needs of victims. The table was designed to illustrate graphically the particular mechanisms that operate in each jurisdiction, and included: the parties to the protocol, the point at which the protocol was first introduced, the circumstances under which each protocol is activated, requirements for training by services and individuals who are signatories to the protocol, and the nature of forensic or medical care provided.

In the relatively short life of the existing protocols in Australia, the emphasis has remained squarely on the need for early intervention to mitigate the potentially long-term harm caused to victims of sexual assault who are left unsupported or disbelieved. This is now reflected in the vast majority of protocols with forensic and emergency medical responses clearly positioned as central within each document.

However, maintaining acute or crisis care responses as the optimum focus for responding to the health care needs of victims has resulted in less attention being given to the potential for longer-term or life-span health effects of sexual violence for individuals. Where specialist sexual assault services generally maintain services for victim/survivors regardless of the time elapsed since the assault, protocols within the mainstream health sector do not explicitly acknowledge the need for responses over time or over life-spans. For victim/survivors for whom no initial acute response was possible or desirable, or for those for whom no response was historically available, the health sector is only now beginning to recognise the possibility of providing responses in the longer term.

The approach taken by Yarrow Place, the rape and sexual assault service in South Australia, is a case in point. The service is designed to ensure that women's forensic and longer-term health care needs can adequately be met on site, regardless of when the assault occurred. Hence, women victims, who may months or even years after the assault endeavour to seek medical support, especially in terms of gynecological care, can continue to access the service at Yarrow Place and be assured of seeing a doctor who is both sensitive and aware of the effects of sexual violence.

Overall, this paper has demonstrated the importance of states and territories finding ways of evaluating their existing protocols that can allow for information-sharing across borders about how to progress or re-develop approaches to service-delivery in the light of new developments in the field. Moreover, following the emergence of research that reveals the compelling association between the health impacts of sexual assault and other forms of intimate and familial violence, greater attention must now be given to developing training for general practitioners and other workers within the health care system to raise their awareness and capacities in being able to identify and respond to health issues that can emerge as a result of being exposed to experiences of violence. It is here that the greatest scope lies for further developing health sector protocols that can better guide responses to both recent and past disclosures of sexual assault, in a bid to improve on the health outcomes for the vast majority of victim/survivors.

The way is open to build on the important lessons learned in the development of systemic acute responses and to more fully integrate the whole of life experience of individuals who experience sexual and physical violence. The health and well-being of victims, and the community at large, depends on it.