



**The development and evaluation of an education
program for service providers about culturally and
linguistically diverse (CALD) client
victims/survivors of child sexual abuse**

**TECHNICAL REPORT 1
(FULL REPORT)**

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Contact for follow up

This project has received funding from Griffith University (\$5K Research Encouragement Grant 2018) under the title, ‘Addressing child sexual abuse in ethnic minority communities in Australia’. It is being carried out by Dr Pooja Sawrikar at Griffith University (GU), School of Human Services and Social Work (HSV), Parklands Drive, Southport, 4222, Gold Coast, Queensland, Australia; p.sawrikar@griffith.edu.au.

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Disclaimer

The views and findings expressed in this Report are those of the author’s only, and do not reflect those of Griffith University. Three Technical Reports will be written across this project, corresponding to each of its methodological stages. Content in the Introduction will overlap, so that each Report can be read as a stand-alone document. However, the Method, Results and Discussion sections will vary, making them each overall different from one another.

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ABBREVIATIONS

AASW	Australian Association of Social Workers
AMA	Australian Medical Association
APS	Australian Psychological Society
BPD	Borderline personality disorder
CALD	Culturally and Linguistically Diverse ¹
CP	Child protection
CPD	Continuing Professional Development
CSA	Child sexual abuse ¹
CSAMS	Child Sexual Abuse Myths Scale (Collings, 1997)
DFV	Domestic and family violence
FAE	Fundamental attribution error
GP	General practitioner
GU	Griffith University
HREC	Human Research Ethics Committee
IPV	Intimate partner violence
MH	Mental health
NAATI	National Accreditation Authority for Translators and Interpreters
NGO	Non-government organisation
NSW	New South Wales
PTSD	Post traumatic stress disorder
QLD	Queensland
TIS	Translating and Interpreting Service
SA	South Australia
VIC	Victoria

¹ See [Project Methodology](#) for detailed explanation on the use of abbreviations for child sexual abuse and CALD throughout this project.

THE TARGET AUDIENCE

Stage 1 of this project is about educating service providers about the psychosocial experience of child sexual abuse in culturally and linguistically diverse (CALD) communities. It highlights two issues in particular as points of difference with the psychosocial experience of child sexual abuse in Anglo communities – cultural differences by virtue of originating from countries high on *collectivism* (familism), and *racism* by virtue of being a racial minority in Australia. These two factors lead to immense barriers in disclosing the abuse and seeking professional help. If and when these barriers are crossed, there may be a preference to seek medical help over ‘talk therapists’; seen as more culturally acceptable.

As such, the primary target audiences for this stage of the project were general practitioners (GPs), psychiatrists, counselors, social workers, and psychologists. All these ‘health and well-being’ service providers need to be aware of the psychosocial experience of child sexual abuse in CALD communities, so that they can understand their client better and not falsely assume that the experience is essentially the same for all victims/survivors, and to be able to make appropriate referrals among each other to address the diversity within this client group in ways that best meets the individual’s needs.

As the focus is on ‘culturally appropriate clinical treatment’, service organisations providing counselling or advocacy for the broader issue of domestic and family violence (DFV) – which can encompass sexual assault – were also considered relevant for this project. Organisations that provide professional training on child sexual abuse and researchers and policy developers responsible for disseminating information were also seen as relevant, as a critical component of their work would be to identify ‘what works’ in the clinical setting.

In comparison, service providers whose core business relates to legal aspects of child sexual abuse were not identified as key for the purposes of this project. This included child protection authorities responsible for assessing and substantiating allegations of child sexual abuse as the legal definition of child sexual abuse drives their work, and police, lawyers, and legal advisors for victims/survivors of child sexual abuse and their families seeking criminal redress. While they have not been targeted for Stage 1 to help ensure the education program was delivered to the intended audiences – those that provide mental health services in some way, either formally or otherwise – they were not excluded either and may still benefit from aspects of the program. Thus, this Report can be read widely by any type of service provider and community member, to be adapted to their main line of work.

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INTRODUCTION

Overview of the multi-year study

Readers are referred to the [Project Methodology](#)² for detailed information on the three-staged study, including:

- Theoretical background
- Conceptual framework
- Timeline and tasks
- Significance of project
- Definition of ‘culturally and linguistically diverse’

This document will be assumed as read for the remainder of this Report. This information has not been included here to avoid overlap in content across the three Technical Reports that will be prepared across this project (corresponding to each of its methodological stages).

Aims, research questions (RQs), hypotheses, and significance of Stage 1

What is the main aim of Stage 1, and its more specific research questions and hypotheses?

The main aim of Stage 1 was to develop a program that educates mental health service providers about CALD victims/survivors of child sexual abuse and their needs in the clinical setting, and then examine whether and how it improved their service delivery in the moderate term. It thus used a mixed-methods and longitudinal design; triangulating quantitative survey data with qualitative open-ended data over a six month period.

² www.nomoresilence.info/publications

The more specific research questions (RQs) of Stage 1 are in Table 1. Each of these eight RQs map to several hypotheses. In turn, these map to questions in the program evaluation surveys (T1 baseline and T2 follow-up; see Appendix C). For quick reference, a summary of the hypotheses that were supported are also identified.

Why is Stage 1 of the study important?

Addresses an apparent gap in knowledge

The content of the education program was primarily informed by a systematic literature review conducted in the area in 2016. One key finding of that review was that of the three types of service organisations for client victims/survivors of child sexual abuse available in Australia at the time, most were ‘mainstream’ ($n = 62^3$, compared to two ‘multicultural’⁴ and two ‘ethno-specific’⁵), and of these, only one delivered services informed by research on best practice regarding cultural competency.⁶ A multicultural organisation is defined as one that aims to provide services to CALD communities from any ethnic background, an ethno-specific organisation is one that aims to provide services to specific CALD communities, and a mainstream organisation caters to clients from any background. This finding revealed what appears to be a substantial gap in current service provision for CALD victims/survivors: it may be that services are culturally sensitive but publicly available information on such information is scant.

³ These have not been identified here due to the high number, but have been included in Appendix A which contains an updated list of relevant service organisations. Also, at the time the review was conducted in 2016, the list of organisations only included those providing direct support services. In this project, the list has been expanded to include indirect support service organisations (e.g. information provision, training, etc.).

⁴ These two multicultural organisations were: (a) *Immigrant Women’s Support Service* (<http://www.iwss.org.au/>) and (b) *Transcultural Mental Health Centre* (<http://www.dhi.health.nsw.gov.au/Transcultural-Mental-Health-Centre/Transcultural-Mental-Health-Centre-Home/default.aspx>).

⁵ These two ethno-specific organisations were: (a) *Tzedek* (A Jewish community free of child sexual abuse) (www.tzedek.org.au) and (b) *Australian Muslim Women’s Centre for Human Rights* (<http://ausmuslimwomenscentre.org.au/>).

⁶ This organisation was: *1800 Respect* (<https://www.1800respect.org.au/>).

Develops capacity within existing organisations with a CPD program

While more multicultural and ethno-specific organisations do need to be developed to increase choice for clients, this endeavour is outside the scope of this project. Instead, the focus here is on developing capacity within existing organisations (most especially mainstream, since they are the most common type) with training and certification in a cultural competency program endorsed for Continuing Professional Development (CPD) points by the Australian Association of Social Workers (AASW), eligible for CPD endorsement by the Australian Psychological Society (APS), and advertised with the Australian Medical Association (AMA).

These associations cover the primary target audiences for the program, which were counselors, social workers, psychologists, general practitioners (GPs), and psychiatrists. The program also aimed to be relevant to organisations that do not provide frontline support services but rather information that supports knowledge about child sexual abuse and/or CALD communities, thereby also developing their organisational capacity.

The program ended with a 30-minute open forum discussion for attendees to make comments and ask questions about the program scope and content. These were incorporated into the final online version of the education program; accessible to all service providers across Australia (and internationally), and offering CPD certification. The link to the online program is available from the [Project Website](#).⁷

Education has flow-on effects to the client group

Educating service providers means that CALD client victims/survivors will be more likely to receive a service that is aware of how racial, gendered, and professional power could be abused (even unintentionally) in the clinical setting. This is a critical risk to mitigate because it could further alienate people who have already suffered an abuse of power (child sexual abuse) and who incur many barriers to professional help-seeking in large part because of (but not limited to) the cultural value for family privacy. Thus, protecting the victim's mental well-being in the clinical setting with knowledge about cultural competency is essential to good practice.

⁷ www.nomoresilence.info/becoming-accredited

Generates new knowledge

In addressing the eight RQs, Stage 1 will be able to provide comprehensive and up-to-date research evidence and knowledge regarding how best to address the needs and experiences of CALD victims/survivors of child sexual abuse and their families and communities within the clinical setting. Specifically, it will:

- explore whether cultural competency really is low in current service provision in Australia, as the current national literature suggests
- identify barriers to and facilitators of service providers attending such an education program across various Australian cities
- identify aspects of the education program perceived as effective and ineffective and why, across various Australian cities, and
- examine whether service providers' gains in knowledge about child sexual abuse and CALD communities are sustained over a medium-term.

Table 1: Summary of research questions, hypotheses, and results

RESEARCH QUESTIONS	HYPOTHESES	SUPPORTED
Six months post program attendance, do service providers and their organisations:	Six months after attending the education program:	
Knowledge about child sexual abuse and CALD communities		
1. Improve on their cultural self-efficacy (knowledge, confidence, sensitivity/respect)?	1. Service providers will improve on their self-rated general knowledge about CALD groups (<i>B.1</i>).	✓
	2. Service providers will improve on their self-rated confidence to work with CALD victims/survivors of child sexual abuse (<i>B.2</i>).	✓
	3. Service providers will improve on their self-rated sensitivity to ethnic diversity in daily work practice (<i>B.4</i>).	✗
2. More appreciate the difficulty of making sense of cross-cultural prevalence data on child sexual abuse?	4. The proportion of service providers who believe that the prevalence of child sexual abuse in some cultural groups is negligible will decrease (<i>B.6</i>).	✗
	5. The proportion of service providers who believe that cross-cultural prevalence data is accurate or close to accurate will decrease (<i>B.7</i>).	✓
3. More appreciate that there may be cross-cultural differences in belief of the myth that most perpetrators of child sexual abuse are unknown to the victim?	6. The proportion of service providers who believe that belief of the myth that perpetrators of child sexual abuse are more likely to be unknown is cross-culturally equivalent will decrease (<i>B.8</i>).	✓
4. More appreciate that there may be cross-cultural differences in belief of myths about child sexual abuse that shift culpability to the victim?	7. The proportion of service providers who believe that belief of myths about child sexual abuse that shift culpability to the victim is cross-culturally equivalent will decrease (<i>B.9</i>).	✓

Knowledge about service provision for CALD victims/survivors of child sexual abuse		
5. More appreciate the need for cultural self-awareness to help take responsibility for racial power?	8. Service providers will improve on their self-rated cultural self-awareness (B.3).	x
	9. The proportion of service providers who have heard of 'white privilege' will increase (B.5).	x
6. More appreciate the need to be aware of the pros and cons of a medical versus sociological approach to treatment?	10. The proportion of service providers who believe that a sociological approach to the treatment of mental illness as a result of child sexual abuse is useful or effective will increase (B.10).	✓
7. More appreciate the need to avoid omnipotence to help take responsibility for professional power?	11. The proportion of service providers who encourage additional self-help strategies, family therapy, and group therapy will increase (B.11).	✓
8. More appreciate the need for organisational support to provide good practice to CALD victims/survivors of child sexual abuse?	12. The proportion of service organisations that use trained bilingual staff or interpreters on matters relating to sexual assault will increase (C.5).	✓
	13. The proportion of service organisations that train their interpreters on matters relating to sexual assault will increase (C.6).	x
	14. The proportion of service organisations that pre-brief their interpreters before meeting a client with a matter relating to sexual assault will increase (C.7).	x
	15. The proportion of service organisations that de-brief their interpreters after meeting a client with a matter relating to sexual assault will increase (C.8).	x
	16. The proportion of service provider staff from a CALD background employed by a service organisation will increase (C.11a).	x

- | | |
|--|---|
| 17. The proportion of service provider staff from a CALD background employed in a management position by a service organisation will increase (C.11b). | x |
| 18. The frequency of choice offered to CALD client victims/survivors of child sexual abuse about having or not having an ethnically-matched service provider will increase (C.12). | x |
| 19. The proportion of service organisations that provide training on culturally appropriate service provision for CALD client victims/survivors of child sexual abuse will increase (C.9). | ✓ |
| 20. Service providers will increase their rating of their service organisation's value for a 'multicultural framework' within mission statements, philosophy, practice frameworks, etc. (C.3). | ✓ |
| 21. Service providers will increase their rating of their service organisation's implementation of a 'multicultural framework' within daily practice work (C.4). | ✓ |
| 22. The proportion of service organisations that collect data on ethnicity-related variables will increase (C.1). | x |
| 23. Service providers will increase their rating of their service organisations' links with local CALD community organisations and/or members (C.13). | ✓ |
| 24. The proportion of service organisations that contain images of a target client group that is ethnically diverse on its website will increase (not assessed on survey; independently assessed by researcher). | ✓ |
-

METHOD

Ethics

Approach

The first formal research activity was to obtain approval from Griffith University's (GU) Human Research Ethics Committee (HREC) to conduct the evaluation study for Stage 1. The application was submitted, and received approval, in November 2018. It included the development of the Ethics Information Statement and evaluation instruments. This in turn required the development of the education program. All these informal activities were conducted between April and October 2018.

Principles

This project strictly observes ethical principles identified in the 2018 Ethical Research Code of Conduct. In each Stage of the project, informed consent iterating that participation is voluntary will be obtained; recruitment of participants will use an arms-length approach to minimise perceived coercion to participate; if applicable, reimbursement amounts will be appropriate; materials will be in easy-read form for people with low English proficiency, intellectual disabilities, and/or young people; permission to record the open forum sessions at the end of each program delivery will be sought first; all research outputs will be deidentified; and all language used in project outputs will be non-racist, non-sexist, and non-defamatory of CALD, Anglo, and Indigenous communities in Australia and elsewhere, and of victims/survivors of child sexual abuse and their families and communities.

Program and evaluation instrument development

Approach

As stated previously, the results of the systematic literature review conducted in 2016 formed most of the content of the education program for service providers. Grey literature available from the websites of government departments and non-government organisations (NGOs)

were also reviewed, and included in the program where relevant. A Google search found no publicly available education/training programs on child sexual abuse and ethnic minorities that could be adapted to the Australian context, and as a way of checking that key content was present in the program developed in this study. The final program content was prepared for the ethics application and associated evaluation instruments, which all needed to accurately correspond to each other.

Content and positionality

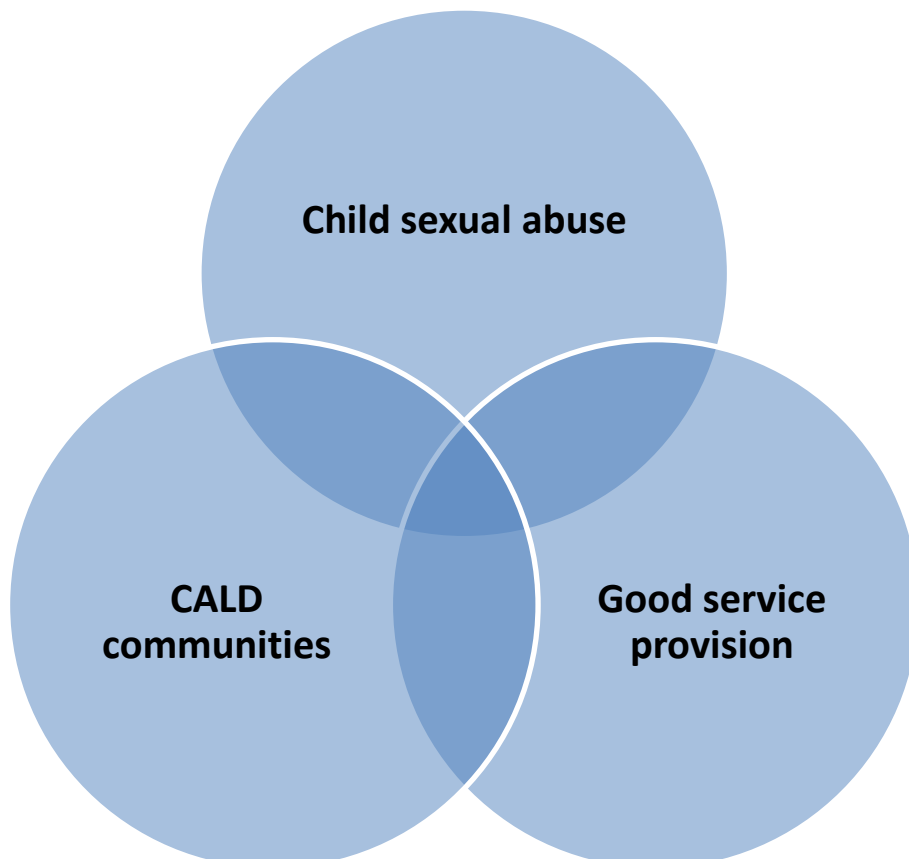
Stage 1 of the project takes the position that it is up to organisations to offer good services to the range of client groups they serve and this includes culturally competent service for CALD clients, rather than for organisations to try and change the cultures of their clientele. That is, it is the responsibility of organisations to deliver services in ways that best meet the needs of victims/survivors of child sexual abuse from CALD communities.⁸ To this end, the content included:

- Knowledge about child sexual abuse and CALD communities
 - That prevalence is high across all cultures
 - That likely perpetrators are those known to the victim, rather than unknown strangers
 - That myths about child sexual abuse reflect false beliefs that can shift culpability to the victim
 - That supportive responses to disclosure are critical for mediating mental ill-health
 - That family reputation is of utmost importance in CALD communities high on collectivism
 - That relying on extended family and community for child rearing and child safety is normative in collectivist cultures
 - That discussing any matters to do with sex including abuse is a social taboo
 - That racism is a unique barrier to disclosure of child sexual abuse among CALD communities
- Knowledge about service provision for CALD victims/survivors of child sexual abuse
 - Personal factors
 - Having a sense of efficacy (including cultural knowledge, confidence, and sensitivity/respect) in working with CALD client victims/survivors of child sexual abuse
 - Being aware of and sensitive to non-ethnic factors for CALD client victims/survivors of child sexual abuse

⁸ In comparison, it is the responsibility of CALD communities to challenge harmful cultural beliefs and behaviours, in line with the principles of self-determination. This is addressed in Stage 2 of the study.

- Being aware of the pros and cons of medicalising mental illness due to child sexual abuse over the use of a sociological framework in CALD communities
- Being aware of and constructively engaging with the concept of ‘white privilege’
- Encouraging additional self-help, family, and group therapy to avoid professional omnipotence in a one-on-one setting
- Organisational/institutional factors
 - Having an ethnically diverse workforce including in management positions
 - Using interpreters trained in matters to do with sexual assault and providing such training
 - Providing regular training in cultural competency to staff to respond to new and emerging communities and staff turnover
 - Using a ‘multicultural framework’ within the service organisation’s mission statement, philosophy, practice frameworks, etc.
 - Mandatorily collecting data on ethnicity-related variables (e.g. country of birth, languages spoken at home, etc.)

Figure 1: Three overlapping ‘circles’ of knowledge required for good service provision for CALD client victims/survivors of child sexual abuse



It thus reflects three overlapping ‘circles’ of knowledge: knowledge about child sexual abuse, knowledge about CALD communities, and knowledge about good service provision (see Figure 1). Service organisations may have strengths in one or more of these components, but the way they merge together for CALD victims/survivors of child sexual abuse is distinct. Thus, cultural competency in the services sector was seen to require appreciation that some experiences of being a victim/survivor of child sexual abuse are shared cross-culturally, while others are unique to CALD communities by virtue of originating from a culture high on collectivism and being a racial minority. That is, good service provision requires knowledge about similarities and differences between CALD and other victims/survivors, and how these impact on their needs in the clinical setting.

The final program that was developed and delivered is available (in online mode) at the [Project Website](#). Between October and November 2018, approval for CPD certification was sought and obtained from the AASW. The program is eligible for CPD certification from the APS, and the cost of obtaining CPD certification from the AMA was outside budget.

Program delivery and baseline sample description

Recruitment

Organisations that provide direct support to victims/survivors of child sexual abuse in the form of mental health services and advocacy (and therefore including counselors, social workers, psychologists, GPs, and psychiatrists) formed the primary target audience for the education program. Organisations that do not provide direct support services but rather conduct research or provide information or professional training about sexual assault, other forms of violence (e.g. domestic and family violence [DFV], intimate partner violence [IPV], etc.), or all forms of child maltreatment (e.g. physical abuse, sexual abuse, emotional abuse, and chronic neglect) formed another primary target audience group.

These organisations were invited to attend via email in January 2019, with two follow-up emails sent in February and March 2019 (see Appendix A). Recruitment of social workers was further boosted by an advertisement in the January AASW national bulletin, and four months listing on the AASW CPD Events website (December 2018–March 2019). To help further recruit psychologists, the program was listed for two months on the APS Events website (February–March 2019). Finally, a three-month listing on the AMA Events website was used to help recruit GPs and psychiatrists (January–March 2019). The length of advertising with each organisation was informed by budgetary constraints. Registrations were managed using the GU-compliant system ‘Cvent’.

While registering on Cvent, attendees could complete the non-mandatory question ‘How did you hear about this event?’ Of the 130 registrants, 73 (56.2%) responded. Five heard of the event from the AASW CPD Events listing, one heard from the AASW national bulletin advertisement, three heard from the APS Events listing, and one heard from their own internet search of “Brisbane and CSA”. The remaining 63 registrants heard from the emails sent from the researcher, indicating this as the most effective recruitment strategy.

Locations and length

Hotel meeting rooms in the four cities (Brisbane QLD, Sydney NSW, Adelaide SA, Melbourne VIC) were selected as the venues for three main reasons. The first is that they are a neutral location to the topic of child sexual abuse and culture; important for helping participants feel psychologically safe and comfortable. The second reason informing venue choice was CBD centrality; thereby enhancing accessibility for program attendees. Finally, the venues provided catering and audio-visual support; necessary for professionalism.⁹

Each venue was hired for half a day, and program deliveries lasted five and a half hours. This included time for registration, morning tea and lunch, explanation of the Ethics Information Statement (see Appendix B), completion and collection of the anonymous baseline surveys, delivery of the education program, the ‘Q&A forum’ after program delivery, and anonymous completion of the survey on satisfaction with the program (see Appendix E). All four program deliveries occurred in late March/early April 2019.

Sample

State, gender, and age

Tables 2 and 3 summarise descriptive and frequency data about the sample collected from the Baseline Survey. In total, 130 service providers registered, but 120 attended the program on the day, and eight either chose not to complete the Baseline Survey or arrived too late to complete it. Across the four states, data was collected from 51 attendees in QLD, 32 in NSW, 21 in SA, and eight in VIC. All attendees identified gender; 101 said female and 11 said male. Attendees varied in age from 23 to 70 years ($M = 42.4$, $SD = 12.0$). No service providers identifying as Indigenous attended the program, and one CALD participant did not identify their country of birth.

⁹ Two participants provided positive feedback on the Program Satisfaction Survey regarding the venue, saying: *The place and food amazing (Satisfaction Survey_42)*; *Great venue and food! (Satisfaction Survey_51)*.

CALD

Of those for whom there is data, 41 CALD participants including those of mixed race were born overseas (i.e. are first generation Australian). They originated from a wide range of countries including Afghanistan, Armenia, Bosnia and Herzegovina, Brazil, Canada, Chile, China, Colombia, El Salvador, Finland, Former Czechoslovakia, Hong Kong, India, Iran, Ivory Coast, Kenya, Lebanon, Liberia, Malaysia, Nepal, New Zealand, Pakistan, Republic of Korea (South), Sierra Leone, South Sudan, Spain, Sri Lanka, Syria, United Kingdom (UK), and Zimbabwe.

Five of these participants did not speak a language other than English at home. The remainder identified speaking Arabic, Armenian, Croatian, Dari, Dinka, Finnish, German, Greek, Hindi, Kalenjin, Kissi, Korean, Luganda, Mandarin, Maori, Marathi, Ndebele, Nepalese, Persian/Farsi, Pidgen English, Portuguese, Punjabi, Shona, Slovak, Spanish, Swahili, Tamil, Urdu, and Zulu.

Four of these participants did not self-describe their cultural identity. The remainder identified as *Afghan Aussie*, *Armenian-Australian*, *Australian*, *Australian Chinese*, *Australian/Chinese/English*, *Australian-Persian*, *Australia-Syrian*, *Bosnian/Australian*, *Brazilian and Australian citizen*, *Brazilian Australian*, *Chinese*, *Chinese-Australian*, *Colombian*, *El Salvadorean Australian*, *Finnish-Australian*, *of Indian background*, *Indian*, *Iranian/Australian*, *Iranian-German*, *Jamaican/Black/British/Aussie*, *Kenyan Australian*, *Korean*, *Lebanese (legally) and a child of the earth (personally)*, *Lebanese/Australian*, *Maori New Zealander*, *Nepalese-Australian*, *Pakistani Punjabi*, *Sierra Leonean*, *Slovak-Australian*, *South Sudanese Australian*, *Spanish*, *Sri Lankan*, *Sri Lankan Tamil*, *Ugandan-Australian*, and *Zimbabwean-African*.

There were 17 CALD participants including those of mixed race born in Australia (i.e. at least second generation Australian). Eight of these participants spoke a language other than English at home including Arabic, Italian, Greek, Khmer, Serbian, and Spanish. They all self-described their cultural identities as *Australian* (n = 2), *Australian (English and Italian)*, *Australian-Italian*, *Australian of Italian descent*, *Italian-Australian* (n = 2), *Australian with a Greek and Italian background*, *Australian with parts of Greek and French also*, *Australian-Cambodian*, *Anglo/Croatian*, *Australian-Greek*, *Australian-Lebanese*, *Lebanese-Australian*, *Australian Maltese*, *Australian-Serb/bicultural*, *Chilean Australian*, *English/Irish/Polish*, and *Maori/Anglo Australian*.

Anglo

There were nine Anglo participants born overseas (i.e. first generation Australian), and they originated from New Zealand, South Africa, the UK, and United States (US). Eight of these

participants self-described their cultural identity as *American-Australian, Australian, immigrant from UK and identify as Australian, Irish, Kiwi/New Zealander, and Northern (mixed Scots English)*.

There were 44 Anglo participants born in Australia (i.e. at least second generation Australian). One spoke French, and all participants self-described their cultural identity as *Anglo Australian, Australian, Australian of Anglo German heritage, Australian/German, Australian (Dutch), Australian (I have Aboriginal heritage but I do not identify), English, Irish-Australian, Spottish (Spanish, Scottish, Australian), British/Scottish/Irish/German Australian, and white Australian from British/European background*. One of these participants also said:

My partner is from a 'CALD' background. I've lived and worked in developing nations, studied/studying sociology extensively. Struggle identifying as 'Australian' due to these and other intersecting factors. However have a broader understanding of these experiences than other 'Australians' (Baseline Survey_12).

Service provider experience and type

One attendee was a Social Work student, and so was not yet working at a service organisation. The remaining 111 attendees had worked as a service provider or other relevant professional for between <1¹⁰ and 49.5 years (M = 14.1, SD = 11.1).

Of the total sample, 56 identified themselves as a *social worker* or combined social worker and counselor, consultant, cultural support worker, advisor, program trainer or facilitator, program development, student coordinator, team leader, or therapist; 16 as a *counsellor* or combined counselor and clinical supervisor, child consultant, manager, or executive director; 12 as a *psychologist*, provisional psychologist, or combined registered or provisional psychologist and counselor; four as a *researcher* or combined researcher and social worker or policy development; and 24 as *other* including advocacy, caseworker, child witness/victim support volunteer, client services, community services worker, diversity manager, family dispute resolution practitioner, intake assessment, interpreter, policy development, program manager, program trainer or educator, project coordinator, project officer, registered psychiatric nurse, service director, specialist children's worker, support project worker, team leader, transcultural mental health promotion/prevention/early intervention practitioner, trauma client officer (government assistance), VET (vocational education teacher) and early childhood service approved provider, and volunteer coordinator.

¹⁰ This was coded as 0.5 years for analysis.

Organisation type

In total, 53 organisations were represented across the four states. Of these, 47 were service organisations, three were universities, and three were a private practice. Not including the universities, categorisations as to whether the service organisation or private practice was specialised for CALD groups and/or sexual assault were based on the majority of responses provided by employees within an organisation, as some responses between individual employees differed.

Thirteen organisations were categorised as being specialised for CALD groups. Of the remaining 37 not specialised for CALD groups, one identified that CALD individuals are prioritised in their organisation, one identified that a small 'CALD' project is currently being run in their organisation, and two identified that their organisation has CALD-specific programs.

Nineteen organisations were categorised as being specialised for sexual assault and/or domestic and family violence (DFV) which encompasses sexual assault. Of the remaining 31 organisations not specialised for sexual assault, one identified that they do have some sexual assault-specialised programs, and another identified that one of their branch offices specialised in sexual assault. (Note: the final list of organisations has not been identified here to help protect their anonymity; see Appendix A for further information).

Sample power

The final sample size of 112 at baseline fell sizeably short of the target sample size of 240 (60 attendees per city x 4 cities). One reason may be that no medical practitioners (GPs and psychiatrists) registered; which was also seen as unfortunate because they are one of the key target audiences for this program. It further meant that it was not possible to compare data by service provider type; that is, 'medico' cf. 'non-medico'. Thus, future research is required to address this significant methodological limitation, and examine whether size of change over time differs between these two broad practitioner groups.

Another reason may be that interest in the area was overestimated. It was presumed that since no identifiable prior programs had been delivered, the number of attendees to take up this professional development opportunity would be higher. However, after engaging with attendees in the four open 'Q&A' forums, it became apparent that there does already exist substantive 'practice wisdom' in this field, and that small programs are being developed and delivered by local and relevant community organisations. Thus, potential registrants may not have perceived a need to attend.

One participant on the Program Satisfaction Survey also said, *I think there was less of attendance in numbers due to how it was advertised. I feel this even without the CALD component of CSA (Satisfaction Survey_10)*. This highlights that the target sample size may not have been met because the recruitment strategy was not as effective as it could be, but was also facing barriers against discussing child sexual abuse more generally.

A power analysis was conducted to examine whether the sample size could be deemed or was close to being sufficient (Cohen, 1992). Several statistical tests in this study are of differences between two independent means. Thus, to detect a medium effect size (ES) at alpha (α) set to 0.05 a sample of 64 per group is required, and this was nearly obtained (59 CALD and 53 Anglo) but only at baseline. Overall, future replication studies with larger samples do appear necessary.

Follow-up study and sample description

To help address social desirability issues that could compromise validity, the anonymous baseline survey data was collected before the program was delivered, and the anonymous follow-up survey data was collected online six months later. The online survey was developed using LimeSurvey, endorsed and licensed for use by GU because of its secure and encrypted protocols. Data was downloaded in October 2019, after the link had been available for one month to complete (acknowledging their time-poor, crisis-driven work). All attendees were emailed in September 2019 to invite them to complete the follow-up survey (see Appendix F).

Importantly, this is a cohort study; selected from one of the three possible longitudinal designs – trend, cohort, and panel. A trend study compares different samples at different times, a cohort study compares a subset of the initial sample at different times, and a panel study tracks the same sample over time. A trend study would imply that the program was delivered again to a new cohort so is not applicable, and a panel study would require a large sample that links the data sets over time with a unique identifier. For these two latter reasons, a cohort design was selected. It allows the data at both time points (T1 and T2) to be and be perceived as completely anonymous, which was critical because of how sensitive the topic is. Thus, obtaining valid data was seen as more important than having a matched sample over time that would permit repeated measures statistical analyses, especially on a such a small sample. As a result of this important decision on the study design, changes over time have not been statistically tested, only described with speculation about the possible effectiveness of the program in contributing to observed changes.

Tables 2 and 3 also summarise descriptive and frequency data about the sample collected at follow-up. In total, 117 email invitations were sent, two bounced back, 11 automatic replies of either being on leave or having since left the job were received, six opted out, 54 did not respond, and 44 completed the survey. Thus, the valid response rate was 42.3% (44 of 104), and retention across the two waves was 39.3% (44 of 112). Unfortunately, LimeSurvey has a non-removable ‘No answer’ option, unlike the Baseline Survey which was forced choice, slightly compromising the comparability of data across time.

Table 2: Descriptive data about the evaluation study sample (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Age	42.4	12.0	112	23	70	44.5	12.6	42	25	70
Work experience	14.1	11.1	111	0.5	49.5	15.1	10.4	42	2	38

Across the four states, there were 16 from QLD, 12 from NSW, 10 from SA, and five from VIC. Again, most of the sample was female (n = 39, 88.6%), and participants varied in age from 25 to 70 years (M = 44.5, SD = 12.6).

There were 23 CALD participants including those of mixed race. Of these, 13 were born overseas (first generation) including in Brazil, Chile, China, England, Europe, Hong Kong, Iran, Malaysia, New Zealand, Sierra Leone, and Zimbabwe; nine were born in Australia (second or later generation); and one did not say. Most spoke a language other than English at home (n = 18; 78.3%) including Arabic, Cantonese, Farsi/Persian, German, Greek, Italian, Jamaican patois, Khmer, Kissi, Maori, Mandarin, Ndebele, Portuguese, Serbian, Spanish, Shona, and Swahili. They self-identified as: *African; Australian–European; Australian born Italian; Australian/English and Chinese; Australian with Chinese background; Australian with Middle Eastern background of origin; Australian–Serb; Black Jamaican Muslim; Brazilian/Australian; Chinese – Australian; Greek Australian orthodox second generation; I am Australian, my parents were born in Cambodia; I don’t think I have one; Iranian; Italian; Italo-Australian; Lebanese Australian; Kissi by tribe; and New Zealand Maori – ancestry from Scotland, England, Portuguese.*

There were 21 Anglo participants, of which 19 were born in Australia, one was born in the UK, one did not say, and one spoke a language other than English (French). They self-identified as: *Australian; Australian (Anglo); Anglo Celtic; Australian-German; English; Irish Australian; Maori/Australian; I am a white Australian, I grew up in the U.K.; Victorian born Australian; and White, Irish heritage.*

Table 3: Frequency data about the evaluation study sample (T1 and T2)

	T1		T2	
	N	%	N	%
State				
QLD	51	45.5	16	36.3
NSW	32	28.6	12	27.2
SA	21	18.8	10	22.7
VIC	8	7.1	5	11.4
No answer	0	0.0	1	2.3
Total	112	100	44	100
Gender				
Female	101	90.2	39	88.6
Male	11	9.8	4	9.1
No answer ^a	0	0.0	1	2.3
Total	112	100	44	100
Cultural background				
CALD (inc. mixed and all generations)	59	52.7	23	52.3
Anglo (inc. all generations)	53	47.3	21	47.7
Total	112	100.0	44	100.0
Service provider type				
Social worker	56	50.0	23	52.3
Counselor	16	14.3	4	9.1
Psychologist	12	10.7	5	11.4
Other (inc. researcher)	28	25.0	10	22.7
No answer	0	0.0	2	4.5
Total	112	100.0	44	100.0
Organisation type				
Service organisation	47	90.4	29	87.9
University	3	5.8	0	0.0
Private practice	3	3.8	1	3.0
No answer	0	0.0	3	9.1
Total	53	100.0	33	100.0
Specialised for CALD groups	13	26.0	7	21.2
Specialised for sexual assault (inc. DFV)	19	38.0	6	18.2

a – LimeSurvey generates only three categories for gender (Female, Male, No answer), which prohibited being able to insert the option ‘Another response is applicable (e.g. prefer not to say, non-binary/gender conforming, etc.)’.

All attendees had worked as a service provider or other relevant professional for between two and 38 years ($M = 15.4$, $SD = 10.4$). Of these, 23 identified as a social worker, four as a counselor, five as a psychologist, and 10 as other (*executive manager – strategic projects; facilitator/educator/coordinator; project worker/officer; psychologist researcher; nurse practitioner; public servant; senior management; specialist children’s worker/early childhood educator/mental health professional; trainer educator in capability building*).

Of the 29 service organisations identified on the follow-up survey, seven were specialised for CALD groups and six were specialised for sexual assault and/or DFV. Two participants did not name their organisation, so it was not possible to verify if they worked at the same as other participants (thereby preventing double counting), nor whether they were specialised for CALD groups or sexual assault as they had stated. Thus, they have not been included in the data table.

Some participants from organisations specialised for CALD groups also said: *Our team within [org name] works directly with CALD families (Follow up Survey_23); Due to no wrong door policy all women can access [org name] services (Follow up Survey_42); Specialist domestic violence and sexual assault service for CALD women and their children (Follow up Survey_22); and Main role of 3 days per week is all Refugee and CALD focus, 2 days at [org name] mainstream and Aboriginal (Follow up Survey_35).*

Some participants from organisations not specialised for CALD groups also said: *However, the service prioritises clients from CALD backgrounds (Follow up Survey_11); We also have two programs for Culturally diverse communities and an Aboriginal and TSI (Torres Strait Islander) communities (Follow up Survey_20); and We also have specialised CALD practitioners from CALD background, CALD community development workers and therapeutic group facilitators (Follow up Survey_29).*

Some participants from organisations specialised for sexual assault also said: *Child protection does have some staff that specialise (Follow up Survey_13); Domestic and Family Violence Services and 1800 RESPECT (Follow up Survey_20); Part of the organisation is specialised in sexual assault, not my area however (Follow up Survey_12); and Specialist child protection so works with all forms of abuse, neglect, and violence (Follow up Survey_34).*

Some participants from organisations not specialised for sexual assault also said: *For clients with moderate to severe mental health issues (Follow up Survey_14); Is a Homelessness service working with women and children. We work with women escaping domestic violence (Follow up Survey_42); and Our service is not specialized for sexual assault, however our practitioners are all trained to provide trauma-informed and therapeutic interventions for*

clients who experienced sexual assault, including child sexual abuse and institutional sexual abuse (Follow up Survey_29).

Overall, the sample size is considerably smaller at follow-up than at baseline, however the distribution of characteristics is similar in both samples. That is, the follow-up sample appears to be a representative sub-sample of those at baseline, rather than being those most interested in the topic and therefore potentially skewing the data. This boosts confidence in observations exploring change over time, i.e. the longitudinal effectiveness of the program. In all, findings should be treated with some trust (due to sample representativeness) and some caution (due to low power).

Satisfaction with the education program

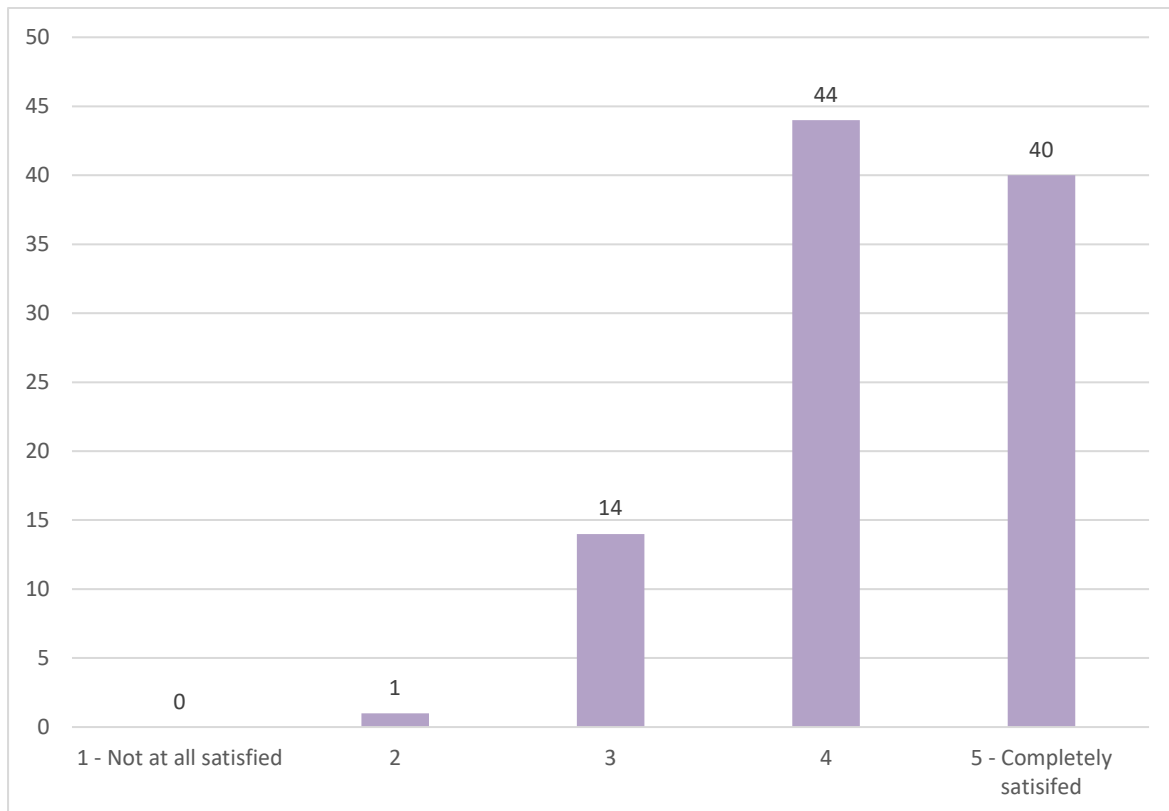
Overall satisfaction and qualitative data

Of the 120 attendees at T1, 100 (83.3%) completed the Program Satisfaction Survey. They were first asked to rate how satisfied they were overall with the education program on a Likert scale of 1 to 5, with 1 = Not at all and 5 = Completely. Scores on this question varied from 2 to 5¹¹, and the mean was 4.2 (SD = 0.7, n = 99). This score indicates high satisfaction and provides supporting evidence for the effectiveness of the program, especially in light of how challenging and sensitive the content is.

One participant said, *When asking to rate knowledge or satisfaction using the upper end as 'completely' may be tricky – as 100% completely is different to rating something 1 to 5 (Satisfaction Survey_67).* It is an important reminder of the limitations of Likert ratings, and may help explain why some of the 44 participants rated the program at 4 rather than 5. Figure 2 summarises the frequency distribution of scores on overall program satisfaction.

¹¹ Five participants rated the program between two possible scores (e.g. 4.5). All such scores were conservatively rounded down to the nearest whole number.

Figure 2: Frequency distribution on overall program satisfaction at T1



Participants were additionally asked to provide an explanation for their overall rating, what they liked best about the program, anything they thought was redundant, and why they chose to attend. They were also asked at both T1 and T2 for any other comments they would like to make, such as information that particularly stood out for them, specific knowledge they feel they have gained, changes they intend or have since made to their practice, or discomforting information or experiences that may have lasted for them.

Responses to these open-ended questions provided contextual qualitative data that helped triangulate the quantitative data. Comments were also received via email after the program and have been included as part of the qualitative data set. Responses obtained at T1 relating to program attendance and process/delivery are documented below, and responses obtained at T1 and T2 relating to program content are discussed in the relevant RQs.

All themes across the qualitative responses have been identified to ensure full representation of participant voices. Such thematic saturation is necessary for empirical rigour in qualitative data analysis, but also reflects the underlying principle of ‘co-design’. One of the key aims of running the education program in person and conducting the open ‘Q&A’ forums at the end of the four program deliveries was to obtain feedback on the content from all 120 attendees before the program was finalised for the online version. This wide and robust consultative

and participatory strategy was used to help ensure that the program met as many needs and interests as possible of service providers working in this field. Indeed, one participant said, *(Liked best?) Training is still developing and left open to impacts (Satisfaction Survey_11)*. Note: for brevity, only exemplar quotes are identified in the body of the report; the full list of remaining qualitative responses is documented in Appendix H.¹²

Program attendance

Of the 100 attendees that completed the Program Satisfaction Survey at T1, 94 responded to the question, *'Why did you choose to attend today's education program?'* Some participants provided more than one reason, and the two most common were for professional development and due to professional relevance. Other non-mutually exclusive reasons included interest in the area, for organisational capacity-building, on recommendation from others, and in acknowledgement of the poor research base. Occasional relevant comments also came from the Baseline Survey. Overall, the results indicate that greater knowledge in this practice field is being sought, and that not all expectations for knowledge-building were met from the program.

Professional development

The most common reason cited for attending the program was professional development (n = 44), reflecting a desire for greater knowledge, awareness, understanding, and practice skills. As examples, participants said:

I felt this area was a gap in my knowledge (Satisfaction Survey_86).

We work with DV victims and are keen to develop a wider skill set/knowledge base (Satisfaction Survey_68).

To understand who I am meeting when we meet 'people of colour' when they use our service (Satisfaction Survey_18).

To improve my work with CALD families and use best practice with these communities (Satisfaction Survey_29).

Working with CALD children, family, and adults, I want to continually add to my cultural competency. This session did just that! (Satisfaction Survey_13).

¹² Appendix H also contains important data not central to the RQs of this study. Thus, data in the Appendix should not be misinterpreted as (being treated as) 'less important' than data in the body of the Report.

I had the opportunity to attend whilst not working. I'm newly returned to Australia and want to keep updated with contemporary Australian context (Satisfaction Survey_78).

Relevance and/or interest

The next most common reason for why participants attended the program was because of interest in the area and/or relevance to their professional work, role, practice, etc. (n = 28), which in turn was sometimes related to being of CALD background themselves. As just some examples, participants said:

Interest and relevance of topic (Satisfaction Survey_50).

I work for a CALD org and work with abuse clients (Satisfaction Survey_32).

Because it's relevant to my role. Because I am from a diverse background (Satisfaction Survey_83).

My organisation works in child abuse prevention/education. I work in migrant and refugee health (Satisfaction Survey_67).

As a CALD staff within my organisation I often get asked to assist my co-workers with some of their CALD clients, therefore I thought it was important for me to increase my awareness (Satisfaction Survey_12).

[Org name] is not a direct clinical service provider. I've attended today due to my own special interests in cultural diversity and how I may apply this to my future work at [org] or elsewhere (Baseline Survey_107).

I work as a National Redress Scheme counselor/caseworker and have not stopped learning in the past six months. How to make the service more accessible – needed to think more deeply about the 'invisibility' of CALD clients in this new scheme (Satisfaction Survey_34).

Organisational capacity-building

Opportunity for organisational capacity-building was also cited as a reason for attending the program (n = 9). Participants said:

To share current research within my current role (Satisfaction Survey_63).

Gaining knowledge to enhance capability of services within my organisation (Satisfaction Survey_8).

To incorporate important CALD issues/barriers into our perinatal mental health training (Satisfaction Survey_1).

Ensuring my practice and organisation is accessible for women from CALD communities (Satisfaction Survey_70).

Interested in tips for organisations to be more able to attract and tailor services and processes for CALD clients (Satisfaction Survey_3).

Hoping to learn as much as possible to share key messages with organisations who are aiming to be “child safe” (Baseline Survey_108).

My organisation is establishing a diversity steering committee – finding out more about providing culturally competent services (Satisfaction Survey_65).

For information I could share with my team and then encourage students to explore this area more as it is a prevalent issue in the CP (child protection) area (Satisfaction Survey_7).

I’m considering to integrate the topic of child sexual abuse into an existing prevention group program designed for CALD adults dealing with the acculturation process (Satisfaction Survey_75).

Recommendation

Some participants attended the program on recommendation from others (n = 5). They said:

On recommendation of management (Satisfaction Survey_96).

Recommended by supervisor at work (Satisfaction Survey_61).

We were referred by a member of our board (Satisfaction Survey_49).

The program was suggested to me. Very happy I attended (Satisfaction Survey_64).

A memo went out by my employer and I was immediately interested in going. I signed up and am glad I attended (Satisfaction Survey_24).

Poor research base

Finally, the attendance of some participants was in acknowledgment of the currently poor research base in the area (n = 8). Participants said:

I liked the flyer – unusual and highly important issue (Satisfaction Survey_9).

Because of the dearth of information/research on this issue (Satisfaction Survey_93).

It is an area that is under-researched and not discussed enough (Satisfaction Survey_27).

It is an interesting topic that I've never heard of being explored in an educational program (Satisfaction Survey_25).

Interest in researcher who is the only one I know of in Australia giving this topic her full attention (Satisfaction Survey_50).

Because I don't think we have enough knowledge of the issues CALD people face when disclosing CSA (Satisfaction Survey_90).

Interested in training that covered CALD and CSA and intersectionality approach. Really appreciate you providing this training to the sector (Satisfaction Survey_41).

It's very relevant to my work and the gaps and deficiencies in my current and previous organisations (FaCS) and their approach to NESB/CALD clients (Satisfaction Survey_33).

Unmet needs and recommendations

Boundaries on the scope of the content had been established before program delivery, and were affirmed again at the end. They explained that the program represented the beginning of “a long overdue conversation”, and so would only be addressing fundamental themes rather than specific, niche, or high-level issues which represent areas for future research. Nevertheless, some participants noted unmet needs or framed their feedback positively in the form of suggestions and recommendations (n = 17; across all responses on the Participant Satisfaction Survey, i.e. not just why participants attended the program). They said:

I didn't learn much about CSA! (Satisfaction Survey_75).

(Any other comments?) Online assault (Satisfaction Survey_28).

(Any other comments?) More on supporting non-offending mothers (Satisfaction Survey_27).

(Any other comments?) We need more research about Muslim communities (Satisfaction Survey_94).

Great background. Perhaps a little more in regards to approach CSA thanks (Satisfaction Survey_1).

A missed opportunity to discuss men's role in combating CSA in the community (Satisfaction Survey_14).

(Any other comments?) Would like to see work on Indigenous and CALD parallels (Satisfaction Survey_86).

I was expecting more, e.g. FGM [female genital mutilation] in relation to child sexual abuse (Satisfaction Survey_55).

I thought it might have more practice ideas of working with clients from diverse cultures (Satisfaction Survey_43).

I hoped for more tools to assist in detecting sexual abuse and working with communities to tackle it (Satisfaction Survey_72).

Certainly lots of links yet to be made with other areas re child sexual development, sexual abuse (familial, child to child, etc.) (Satisfaction Survey_57).

I'd like to hear more about the child sexual abuse element/content and trauma-informed practice, and less on the CALD component (Satisfaction Survey_47).

I would like more time to discuss the issues you stated were relevant though had no allocated time for – marital rape, forced marriages etc. (Satisfaction Survey_40).

I was expecting more information on how to work with some of the cultural and social barriers related to CSA. I got lots of good information still (Satisfaction Survey_58).

I would like more info on what NGOs can do. We are already working with and familiar with cultural issues but need more advice on supporting prevention efforts (Satisfaction Survey_72).

I work predominantly with migrants/refugees and this is a situation/presentation that regularly arises, so I'd hoped to get some useful information to assist in assessment/treatment (Satisfaction Survey_16).

It would have been great to have more practice informed information, e.g. stories, case studies of ways a service might identify and respond to child sexual abuse in a therapeutic and/or case management perspective (Satisfaction Survey_60).

Overall, this feedback is seen as useful because it identifies the needs and interests of service providers. However, they are primarily practice-focused issues so a research-based education program may not necessarily be well placed to address them. It is also a reminder that not all expectations can be met, nor within one program, but that future work can address them.

Program delivery

Of the 100 attendees that completed the Program Satisfaction Survey at T1, 67 responded to the question, *'If you wish to explain your answer to Q1 (overall, how satisfied are you with today's education program), please do so here'*; 93 responded to the question, *'What did you like best about today's education program?'*; 67 responded to the question, *'Was there anything you thought was redundant?'*; and 69 responded to the question, *'Do you have any other comments you would like to make?'* Of the 44 participants that completed the follow-up evaluation survey at T2, 11 responded to the question, *'Do you have any other comments you would like to make?'*

Across all these qualitative responses, dissatisfaction with the program's format and timeframe were noted by several attendees. The lack of time for questions and small group discussions during the program delivery, rather than having to wait till the end for the 'Q&A' forum, was experienced as tiring or as a lack of acknowledgment of the practice wisdom that already exists among attendees. The introduction was also experienced by some as lengthy. Other comments were also made, but overall the presentation of the program was experienced positively.

Format and timeframe

The greatest source of dissatisfaction with the program was its format; namely, that insufficient time had been provided for questions during program delivery, small group discussions at the end of the three discussion points, or case study analyses to work and practice knowledge on. Sixteen attendees noted this as an issue, and it therefore likely contributed to lower ratings of overall program satisfaction. As just some examples, participants said:

(Liked best?) The Q&A and info sharing and discussions at the end (Satisfaction Survey_98).

Method of delivery was challenging, consideration of less didactic manner (Satisfaction Survey_4).

It would have been good to have more opportunities for small group discussions to share views, experiences etc. (Satisfaction Survey_78).

(Any other comments?) Would have liked some table discussion every 20 minutes to anchor the learnings. Too much sitting and listening – sharing practice tips would have been handy (Satisfaction Survey_30).

It was a struggle to stay present under the deluge of information and the one-sided nature of the “conversation”. It was a great beginning to the conversation. There was a wealth of expertise in the room and this could be used to make the session more interactive. Many of us would know individualist/collectivist, the myths and how they work etc. Asking ‘does that make sense?’ is not enough audience interaction. You could design an exercise/worksheet to get us to categorise the victim blaming myths for example. Culturally competent service provision slide = “this is a busy slide” – you could get us to generate the medical vs sociological approach list. While I understand that it was an education session the audience would have responded different. The conversation at the end was a relief – lively and the best part (Satisfaction Survey_93).

This feedback reveals an important disjunction between expectations, but also practical constraints. As this was not a skills-based training program, the expectations of service providers have differed from the intended program format and purpose which was to conduct a research evaluation project of an education program. However due to tight funding conditions, the venues needed to be booked within one week, and therefore after the program cost but before the program content had been finalised. As such, there was no real scope to extend the booking from half- to full-day, which would have at least allowed for questions and small group discussions during program delivery. Indeed, while most participants were able to accommodate the addition of one hour to the program two weeks prior to delivery, one did say (*Explanation for overall satisfaction rating?*) *Changing the length without adequate warning (Satisfaction Survey_87).*

Contrary to the aforementioned feedback, six participants noted that the timeframe for the program and pace of delivery was appropriate. They said:

Perfect time frame (Satisfaction Survey_89).

Pace was great – thank you (Satisfaction Survey _32).

The time seems appropriate for the content (Satisfaction Survey_88).

Well presented, excellent pace, thank you Pooja! (Satisfaction Survey_64).

(Explanation for overall satisfaction rating?) The pace (Satisfaction Survey_8).

I liked the length of the training – not too long and right to the point (Satisfaction Survey_2).

Practice wisdom

One reason why so many participants hoped for greater dialogue was that there already exists a substantive amount of practice wisdom in the field. As examples, participants said:

Probably pitched ok for this audience (Satisfaction Survey_30).

Information while good was already known (Satisfaction Survey_43).

Concepts of 'white privilege' were not new to me (Satisfaction Survey_74).

Today session confirm my knowledge in this area (Satisfaction Survey_11).

Pre-reading could be helpful, to start a higher level of discussion (Satisfaction Survey_50).

The training I attended did not provide new useful information. Very disappointed (Follow up Survey_16).

For me, myths would be shorter – however, it depends on audience so perhaps on average it was well pitched (Satisfaction Survey_67).

(Anything redundant?) Myths section not particularly informative for me due to previous training and work in the space (Satisfaction Survey_100).

There was a lot of information I feel I already knew such a shame and collective societies but it was an interesting overview (Satisfaction Survey_99).

(Anything redundant?) Some basic information is necessary anyway to reach different professionals coming from different backgrounds (Satisfaction Survey_83).

For practitioners working in CALD environments constantly, it could have been good to have more in-depth information about engaging and relating to this group demographic (Satisfaction Survey_58).

Thus, there is a gap among researchers about what practitioners already do or do not know. Moreover, the results of the systematic literature review which informed the program content were rejected 14 times before being accepted for publication due to political sensitivities that journal and funding bodies tend to distance themselves from (Sawrikar, 2018a). These barriers contribute to why so little published research exists in the area, and suggests that the

current literature is not adequately or accurately capturing the knowledge of frontline staff.¹³ Four participants commented on the small body of research literature:

(Liked best?) Gaining insight into the exhaustive lit review/paucity of research surrounding the subject topic (Satisfaction Survey_88).

(Liked best?) Understand how under-researched this topic is, and also how under-resourced systemically we are (Satisfaction Survey_60).

It was interesting to consider CSA specifically in the context of CALD and surprising to hear that there isn't a great deal of research to date in this area, so today was an eye opener for me (Satisfaction Survey_23).

Like what we were talking about before, about cultural differences in parenting practices, there's not a lot of literature on it, (not) writing it down. It just takes being in the communities and understanding how these practices occur. Individual knowledge or knowledge within the team, that's not done (written). There's so much to be said about data collection and the way we manage information (Q&A Forum_Adel).

Nevertheless, more practitioners appreciated the opportunity to learn information that others may have seen as basic, validate their current knowledge in the field, or share or implement program learnings into their practice. Indeed, the divergence in views about the format and timeframe point to the diversity in knowledge among practitioners in the field, and affirm that the program content should not be treated as assumed knowledge. These participants said:

This is a reasonably new topic for me to consider (Satisfaction Survey_76).

It was a lovely reminder of the work we're already doing (Satisfaction Survey_41).

I will take this presentation to my social work team and share (Satisfaction Survey_21).

¹³ Due to white privilege, most senior social work researchers with gate-keeping and decision-making power in Australia and elsewhere are white. They are therefore informed of the Stolen Generations and the unjust and oppressive effects of colonisation on all Indigenous populations world-wide, and (with rightful fear) strive to use their white power and privilege responsibly by protecting CALD communities from the same risk of racist stereotyping and systematic statutory intervention. Unfortunately, this protection occurs by withholding information; most major child protection reports in Australia recycle simplistic and tokenistic lines about there being 'a need for more research in CALD communities'. There are two main effects of these dynamics. The first is that work in this area (such as the contents of this report) may falsely appear as a 'flood' of information. The second is that this work must occur independent from white-privileged systems of knowledge-production, such as the peer-review process.

(Liked best?) The reflection of work I have already been providing (Satisfaction Survey_56).

Validating of some of the work we are currently doing with “CALD clients” (Satisfaction Survey_54).

Great opportunity for reflection and incorporate new and existing knowledge (Satisfaction Survey_64).

Validating, and extended some knowledge re data and differences and similarities, thanks! (Satisfaction Survey_27).

I will provide overview of today’s session to my team to emphasise main points re white privilege, barriers to accessing service, and impacts of collective culture (Satisfaction Survey_99).

A lot of what was covered I felt was covered in my cross cultural course whilst studying social work. It has been a reminder however that there is new words and literature coming through and to keep on reading, developing, and learning (Satisfaction Survey_97).

Really useful and helpful. There’s much we take for granted re practice. I will take back in principle issues to the organisation to develop our multicultural framework to represent more accurately our practice (Satisfaction Survey_41).

It’s interesting to reflect myself or the CALD group I represent, in response to child abuse or any kind of abuse. It (the workshop) allows me to review the content we are delivering now to the community and adopt/adapt to the target client group. I’ll have a short presentation on cultural practice to my coworkers soon (Satisfaction Survey_47).

Introduction

The Introduction went for 90 minutes, and included the following:

- Explanation of the target audiences
- Explanation of CPD certification processes
- Acknowledging funding and registration website support from Griffith University
- Acknowledging Act For Kids for promotional assistance of the program
- Discussion on the limitations of the term ‘CALD’

- Acknowledging participant’s bravery for attending a program that addresses an untouched taboo topic while also emphasising the need to ‘go slow’¹⁴
- Acknowledgment of Country
- Explanation of practical logistics (e.g. bathroom, food provisions, etc.)
- Confirming that participants have signed the registration/attendance form
- Explanation of the Ethics Information Statement
- Completion and collection of the baseline evaluation survey
- Explanation of the purpose of the Q&A forum for finalising the online version of the program
- Background information on how the program content has been informed by the systematic literature review
- Defining the word ‘ethnicity’
- Explanation of how the program fits within the larger three-staged study
- Acknowledging the tension between respectful discussions while not gagging victims/survivors of social injustice for the sake of politeness
- Acknowledging the tension between the liberation of disclosing child sexual abuse while maintaining the risk of triggering traumas for other primary victims or secondary victimisation and therefore psychological safety in the room
- Acknowledging the diversity of expertise in the room, and that not all will have the three overlapping areas of knowledge that the program addresses (child sexual abuse, CALD communities, and good service provision)
- Identifying the three discussion points in the program of learning.

¹⁴ One of the key points made in the Introduction was the need to go slow; to not ‘rip open the lid on the can of worms’, as such an approach would invite further risk to CALD children – the very group of already vulnerable people the program aims to safely reach. In particular, it was stated that the researcher’s fear of sharing knowledge that could invite further racist judgment of CALD communities, as well as fear among white service providers of being culturally insensitive, were in fact positive strategies to help all professionals stay accountable to the protection of the safety of CALD children. However, one participant said on the Satisfaction Survey, *One of the opening comments ‘fear is what keeps us accountable’ makes no sense to me, is antithetical to what we know about CSA (did I hear it wrong?) (Satisfaction Survey_14)*. This comment highlights the risky potential for misinterpretation, and in effect, affirms the need for a slow gentle approach to addressing this taboo topic.

It was evidently lengthy, but all of it was seen as necessary for establishing boundaries and rules for how the shared space was to be used in an appropriate way. Fundamentally, they worked to affirm the importance of honesty, respectfulness, and safety. One participant acknowledged this by saying, *The introduction was really well done, solid research basis and upfront principles for the day (Satisfaction Survey_84)*. Another participant said, *(Liked best?) Some unpacking of the tension between useful but opposing ideas, e.g. respectful dialogue vs emotional communication; objective/subjective (or both) viewpoints (Satisfaction Survey_14)*. Acknowledging these tensions take time. However, more participants found it too long (n = 7), saying:

Introduction too long (Satisfaction Survey_16).

Introductions were a little lengthy (Satisfaction Survey_69).

Maybe just shortening the introduction – cause loved the topic area (Satisfaction Survey_20).

The introduction was very long – content didn't start until 10:30 a.m. (Satisfaction Survey_73).

Opening comments took a long time, maybe try to cut some of this down, but overall excellent (Satisfaction Survey_85).

4.5 score was due to the introduction being a fraction too long for my preference. A video “to set the scene” would be an appreciated addition (Satisfaction Survey_5).

(Anything redundant?) The beginning of the session was a bit too much time spent on basic house rules, basic concepts such as ethnicity and respecting one another etc.

We all work in the sector and feel these topics require less emphasis. It felt a little like being a student at university (Satisfaction Survey_99).

Presentation

Overwhelmingly, most comments about the presentation were positive; highlighting that it was seen as clear, relevant, interesting, informative, informed, comprehensive, well-structured, well researched, and delivered with respect and passion. As examples, participants said:

Interesting and thought provoking (Satisfaction Survey_54).

(Liked best?) Been presented to as colleagues/professionals on an intellectual level and not ‘dumbing down’ the contents (Satisfaction Survey_65).

I have gained a stronger vocabulary in which to discuss this topic. Absolutely fantastic presentation – thank you so much for your time and wisdom (Satisfaction Survey_19).

(Liked best?) Pooja’s knowledge in this area. Really enjoyed the review of current literature re CALD and CSA, and the deconstruction of this data and looking behind the stories (Satisfaction Survey_41).

Loved the acknowledgement of the complexity of the area and your ability to express this – but also propose a way forward. Also loved the addition of data and its strengths/inadequacies (Satisfaction Survey_32).

(Liked best?) Everything. Really enjoyed Pooja’s approach to delivering this information. So engaging and informative. Just wanted to hear more from Dr Pooja. Was so interesting and relevant as a sexual assault counselor (Satisfaction Survey_66).

(Liked best?) Facilitator and content. Refreshing/informative session tapping onto anthropological and psychological concepts that operate on service providers so that we can increase our awareness on unconscious biases when assisting “diverse” people (Satisfaction Survey_62).

Great presentation. Very informative. Lots of learning. Ideas for further personal and professional development. (Liked best?) Information and how it was presented. Was one of the most comprehensive child sexual abuse and cultural competence training I have been to. Got the point across without upsetting white people but giving a need for further learning and reflection (Satisfaction Survey_10).

I thoroughly enjoyed Dr Sawrikar’s presentation. Both enlightening and educational. Content was fleshed out with fact, theory, and experience – awesome event! I commend Dr Sawrikar in starting a difficult conversation. (Liked best?) The resources and group discussion helped to process information. Facilitator’s passion helped to take note and self reflect (Satisfaction Survey_13).

Everything was relevant. Very comprehensive and up-to-date information. Most frank factual approach, especially in relation to societal and other factors/barriers impacting this sector. Very insightful and thorough. Very well delivered. Outstanding presentation style. Impressive session. Addressing sensitive areas/issues with sensitivity and also with absolute honesty (Satisfaction Survey_5).

A small number of negative comments about the presentation, or positively framed and useful suggestions for the future, were noted (n = 7). These participants said:

The section on ‘numbers/prevalence’ too long (Satisfaction Survey_16).

The slides had too much info on them, hard to digest at times (Satisfaction Survey_68).

Lots of PowerPoint notes became difficult to engage in material (Satisfaction Survey_6).

There was a bit of repetition, particularly when discussing data etc. (Satisfaction Survey_60).

(Anything redundant?) The education on stats and research methods (Satisfaction Survey_31).

Putting questions to audience instead of answering them – I don't find it fair for the audience (Satisfaction Survey_55).

Would be good to have a pictorial diagram to go with your CALD explanation and a written slide as I think this would be good to get out to more people (Satisfaction Survey_7).

Overall, the program was designed and delivered consistent with its intentions; to be honest (taking responsibility for 'self' and 'culture' as a person of colour), ethical (taking responsibility for the harmful 'effects' of speaking honestly about CALD communities despite well-meaning intentions), and personable (being humane with researcher power and privilege). Despite this, occasional negative non-constructive comments were received, and serve as an important reminder that it is impossible to please all members of an audience due to their own experiences and projections.

It also highlights that 'danger' can be encountered by client families in spaces that may be assumed 'safe'. In the same way that the program calls for the use of respect and empathy in the way it challenges harmful beliefs and behaviours among CALD communities, the same call needs to be extended to service providers who express attitudes of displeasure. Such attitudes suggest that the program really should have been done differently, and that psychological and cultural vulnerability for speaking honestly about such a sensitive and complex matter was not good enough. By analogy, this stance is dangerous to CALD victims/survivors who against all odds seek help.

Other

Acknowledgment of country

One participant said, *I feel it would be better to have Acknowledgment of Country done first off (Satisfaction Survey_43)*. This was important feedback, and has since been incorporated into the online version of the program. It had been intended for the face-to-face delivery, but

due to tight funding conditions in which the copies of the program PowerPoint for participants needed to be printed within one week (and therefore before the program content had been finalised), later content had to fit within the structures that had been drafted to date.

Gender

One participant said, *With pre-survey when asking 'gender' avoid using terminology "other" where possible (Satisfaction Survey_66)*. This was important feedback, and was to be incorporated into the online follow-up evaluation survey; it was an insensitive and inappropriate oversight that needed addressing. The change from “Female, Male, or Other” to “Female, Male, or Another response applicable (e.g. prefer not to say, non-binary/gender conforming, etc.)” is noted on Question A.1 in Appendix C, but due to constraints within LimeSurvey was not possible to implement.

Evaluation survey

One participant said, *Some of the questions in the questionnaire used very complex English making them very difficult to understand (Satisfaction Survey_4)*. It is not known if this position represents those of others too, but does need to be acknowledged as potentially influencing the validity of responses for some participants. Overall, questionnaire design was informed by the need for clarity/unambiguity in meaning and so provided full and sufficient descriptions within each question, but also the need to keep the total number of questions to a minimum to help reduce participant fatigue.

One participant said:

It was good and informative, it wasn't what I thought I was coming to though. Very useful and helpful, glad I came, but thought we were viewing an education program service providers could use to educate others. Hence I didn't understand how the survey related to me, and did not complete it. Being told not to ask Q's restricted my ability to seek your guidance in understanding more about the survey. After being part of the training, I now understand what the survey was about. Perhaps an Intro slide explaining what you aim to achieve, what the session is about, will help clarify this for anyone who has misunderstood the purpose of the session (Satisfaction Survey_17).

This comment highlights that misunderstandings are always possible, especially since attendees *were* told to ask questions about the survey if they required clarification. Also, as part of good practice in research, explanations about the purpose of a study should be sufficient but not compromise the validity of the data with information that could cause attendees to respond in socially desirable rather than honest ways. Indeed, sufficient information was provided and contributed to the length of the Introduction.

Overall, the evaluation instrument is regarded as valid, given that these were the only two negative comments made about it. One participant also said, *This survey has been really useful in identifying gaps around CALD clients (Satisfaction Survey_60).*

Ethics

Two participants said:

(Anything redundant?) Long talk about ethics clearance – give us docs before in an email (Satisfaction Survey_77).

Ethics for participation could be pre-reading, given this was a professionals rather than community session it was somewhat redundant (Satisfaction Survey_71).

This feedback goes against good practice in research, in which the ethical principles of voluntary participation and informed consent are clearly articulated to potential participants, as well as explanations that all research outputs will be deidentified and pooled as group-based data, permission to record the open ‘Q&A’ forums will be sought first, what exactly is involved for participants if they agree to take part in the study, who to contact if there are ethical concerns or questions about the research project, potential risks and benefits for taking part in the study, and who to contact for additional mental health support if required. Thus, this feedback is simply being acknowledged through representation.

Networking

As the purpose was to deliver and evaluate a research-based education program, it was not an event designed to promote professional networking. Some noted that this was an unintended benefit, whereas others saw it as a missed opportunity:

(Liked best?) Networking/lunch (Satisfaction Survey_42).

Good opportunity for networking also (Satisfaction Survey_15).

Providing space for table discussion also allows more time and chance for professional networking (Satisfaction Survey_88).

RESULTS

RQ1: Do service providers improve on cultural self-efficacy (knowledge, confidence, and sensitivity/respect)?

Background and rationale

Cultural competency at the personal level

Cultural competency is seen to occur at two to three levels: personal, organisational, and institutional; if the organisation is small, then the latter two may be merged (Sawrikar & Katz, 2014, 2008). Cultural competency at the organisational/institutional level is addressed under RQ8. Here, one critical component of cultural competency at the *personal* level is being addressed: service providers having a sense of efficacy to work with CALD clients.

Cultural self-efficacy

‘Cultural self-efficacy’ tends to improve with cultural knowledge, which can then affect confidence to work CALD clients, and self-perceptions of how respectful or sensitive of ethnic diversity the service provider feels they are. It is also related to the degree to which service providers are aware of non-ethnic factors relevant to CALD groups, so that they feel competently able to manage cross-cultural similarities and differences. However, data on this latter component was not collected directly. Thus, program attendees were only asked about the former component – self-rated cultural knowledge, confidence, and sensitivity/respect.

These three components of cultural self-efficacy were also seen to be related to other variables examined in Stage 1 of this project. As such, correlations¹⁵ were conducted with other variables of continuous numeric structure, and the results of these analyses are reported under the relevant RQs. Overall, cultural self-efficacy was a key variable in the evaluation study, and seen to be underlying the other variables explored. When statistically examined, they would help demonstrate the effectiveness of the education program.

¹⁵ All correlations in this study calculated Pearson’s bivariate coefficient.

Measures

Participants were asked to rate themselves on three components of cultural self-efficacy: (i) cultural knowledge (*B.1* – ‘How knowledgeable do you think you are about CALD groups generally?’), (ii) cultural confidence (*B.2* – ‘How confident do you feel to work with CALD victims/survivors of child sexual abuse?’), and (iii) cultural sensitivity (*B.4* – ‘How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel you are in your daily work?’). All three questions were rated on a Likert scale of 1 to 5, with 1 = Not at all and 5 = Completely.

Changes over time

Table 4 contains descriptive data on self-rated general knowledge about CALD groups, confidence to work with CALD victims/survivors of child sexual abuse, and respectfulness of ethnic diversity in daily work, by the cultural background of the service provider (CALD or Anglo). While data for the total sample is provided, descriptions of change over time have been done separately for CALD and Anglo service providers.

Table 4: Descriptive data on cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
General knowledge about CALD groups (<i>B.1</i>)										
CALD	3.7	0.7	59	2	5	4.0	0.6	23	2	5
Anglo	3.0	0.7	53	2	4	3.5	0.7	21	2	5
Total	3.4	0.8	112	2	5	3.8	0.7	44	2	5
Confidence to work with CALD victims/survivors (<i>B.2</i>)										
CALD	3.3	1.1	59	1	5	4.1	0.8	23	3	5
Anglo	2.7	1.0	50	1	5	3.4	1.1	21	2	5
Total	3.0	1.0	109	1	5	3.8	1.0	44	2	5
Respectful of ethnic diversity in daily work (<i>B.4</i>)										
CALD	4.4	0.7	59	2	5	4.6	0.5	23	4	5
Anglo	4.1	0.6	53	3	5	4.4	0.5	21	4	5
Total	4.3	0.6	112	2	5	4.5	0.5	44	4	5

Cultural knowledge

By cultural background of service provider

Scores on cultural knowledge increased for CALD service providers from T1 (M = 3.7) to T2 (M = 4.0), and for Anglo service providers from T1 (M = 3.0) to T2 (M = 3.5). These changes over time provide speculative evidence for the effectiveness of the program in building cultural competency at the personal level for service providers from both cultural backgrounds.

Notably, scores were significantly lower for Anglo than CALD service providers at both T1 ($t(110) = 4.91, p < 0.001$) and T2 ($t(39.5) = 2.05, p < 0.05$).¹⁶ These findings likely reflect tacit cultural knowledge among CALD service providers. Consistent with this, the correlation at T1 between age and cultural knowledge (see Table 5) was stronger for CALD service providers (T1 $r = 0.41^{**}$) than for Anglo service providers (T1 $r = 0.14$).

However, after the program, age had no role for CALD service providers (T2 $r = 0.02$) and an increased role for Anglo service providers (T2 $r = 0.47^*$), indicating that the program reduces the reliance of practitioners on tacit cultural knowledge and increases their reliance on explicit cultural knowledge. The diminished role of age as a co-variate of cultural self-efficacy for CALD service providers is further discussed under ‘Cultural confidence’.

Qualitative data

Despite differences between CALD and Anglo service providers, improvements in cultural knowledge were observed for both. The qualitative data indicates that learning about individualism and collectivism as a framework for understanding the importance of family reputation was seen as particularly useful for developing general knowledge about CALD groups. These participants said:

(Liked best?) The issue of family reputation (Satisfaction Survey_9).

(Liked best?) Individualism vs. collectivism (Satisfaction Survey_1).

(Any other comments?) Individualism vs collectivism (Satisfaction Survey_47).

Reminder about collectivism and individualism – rich discussions (Satisfaction Survey_97).

¹⁶ Independent t-tests comparing CALD and Anglo service providers *within* the T1 and T2 samples are possible, because each data set is treated as cross-sectional. It is only change *over* time that cannot be statistically tested (repeated measures) due to the longitudinal study design being ‘cohort’.

Teasing out the impact of a collectivist culture in this level of detail was helpful (Satisfaction Survey_93).

(Liked best?) Discussion of power/collectivism and its impact on our day-to-day work (Satisfaction Survey_32).

I liked how much detail you went into about the collective and individualistic cultures (Satisfaction Survey_49).

The individualism/collectivist was very helpful, I had knowledge on this topic but you provided excellent examples (Satisfaction Survey_8).

The concepts around individualism and collective cultures and barriers etc. particularly interesting and useful (Satisfaction Survey_100).

In one Q&A discussion, two participants who work in Child Safety also said:

Through the whole presentation, all I kept thinking about was every case I ever worked with, literally every face and situation, and the biggest challenge is that we know and understand that parents won't acknowledge, own up, to the possibility that their child may have been sexually abused by a family member for the need to maintain family face. But that's the exact reason why the children are removed, they are unable to show a level of protectiveness (Q&A Forum_Adel).

... And that creates a problem further down the track. In kinship care, you look for other people to come in, and they don't want to make that admission either. They just couldn't part with the shame (Q&A Forum_Adel).

Similarly, one participant in another Q&A discussion said:

I've been a counsellor for a (CALD) client whose world looks like it's ended because her whole community knew about it and have shamed and rejected her completely. It's tragic. That's actually a secondary abuse that's more impactful than the initial sexual assault (Q&A Forum_Melb).

Cultural confidence

By cultural background of service provider

Scores on cultural confidence increased for CALD service providers from T1 (M = 3.3) to T2 (M = 4.1), as it did for Anglo service providers from T1 (M = 2.7) to T2 (M = 3.4). These changes over time provide further evidence for the likely effectiveness of the education program in building cultural competency at the personal level for all service providers.

Also, scores were significantly lower for Anglo than CALD service providers at both T1 ($t(107) = 2.85, p < 0.01$) and T2 ($t(42) = 2.50, p < 0.05$). Again, this likely reflects tacit cultural knowledge among CALD service providers. Indeed, the correlation between cultural knowledge and confidence (see Table 5) was stronger for Anglo service providers (T1 $r = 0.64^{***}$, T2 $r = 0.74^{***}$) than for CALD service providers (T1 $r = 0.26^*$, T2 $r = 0.55^{**}$), indicating that as explicit cultural knowledge falls for Anglo service providers so too does their confidence. In comparison, as explicit cultural knowledge falls for CALD service providers confidence does not fall to the same extent: implicit cultural knowledge likely works to ‘fill the gap’.

Having said that, the correlation between service provider years and confidence for CALD service providers fell from T1 ($r = 0.26^*$) to T2 ($r = -0.01$). This further suggests that age – a proxy for life and professional experience – was contributing to confidence for CALD service providers before the program but lost its potency after, with extensive complex explicit knowledge about CALD communities taking its place.

Qualitative data

One participant provided qualitative data that demonstrates the relationship between cultural knowledge and confidence. They said, *I really enjoy the morning. I am more aware of myths about sexual abuse and I now feel I can improve my practice on daily basis (Satisfaction Survey_81)*. It is unknown if this participant is of CALD background, but it does show that knowledge and confidence are positively associated: as explicit cultural knowledge increases, confidence to work with CALD victims/survivors of child sexual abuse increases.

Overall, knowledge (and therefore confidence) in this area is desired by practitioners. For example, participants on the baseline survey said:

Need more educational sessions like this on CSA (Baseline Survey_21).

I am unsure of everyone's individual approach to this matter. It is rarely spoken about despite being a settlement service provider (Baseline Survey_25).

I work in an organisation that offers settlement services to CALD groups and I would like to learn more about how to respond to victims/survivors of sexual abuse (Baseline Survey_9).

This is an untouched topic in our program. Sensitive/really challenging topic. It needs to be addressed and there needs to be policies and guidelines around this.

Additionally, although I'm from CALD background (Finnish), I am white, so that adds to the complication for me to start addressing the issue (Maybe??). But this is so important (Baseline Survey_34).

As a specialised CALD organisation (Multicultural Services Unit, DCP) we respond more appropriately to issues affecting families/child where child sexual abuse allegations have been raised. However as a wider agency the responses are often inefficient (Baseline Survey_95).

Cultural sensitivity/respect

By cultural background of service provider

Scores on cultural sensitivity/respect marginally increased for CALD service providers from T1 (M = 4.4) to T2 (M = 4.6), and for Anglo service providers from T1 (M = 4.1) to T2 (M = 4.4). This indicates that the education program was only slightly effective in building this component of cultural competency at the personal level for all service providers.

At T1, the correlation between service provider years and cultural sensitivity/respect (see Table 5) for CALD ($r = 0.09$) and Anglo ($r = -0.07$) service providers were close to zero, suggesting that respect is almost independent of professional experience. This is seen as a positive finding that social work/social justice values begin and remain strong among all service providers regardless of their length in practice. Thus, the program was not likely to be effective in improving cultural sensitivity/respect because this is already high among all service providers.

Although the difference was small scores were significantly lower for Anglo than CALD service providers at T1 ($t(109.93) = 3.33, p < 0.01$), and not significantly different at T2 ($t(42) = 1.51, p > 0.05$). As above, this could reflect tacit cultural knowledge and/or confidence among CALD service providers. Indeed, the correlations at T1 between cultural knowledge, confidence, and sensitivity/respect for CALD service providers (see Table 5) were moderate ($0.19 < r < 0.47^{***}$) but stronger for Anglo service providers ($0.28^* < r < 0.64^{***}$), indicating that these three components of cultural self-efficacy are all associated with one another, but more so for Anglo service providers. That is, as one component decreases for them, the others decrease to a greater extent too.

Thus far, the findings show that CALD service providers have and draw on tacit cultural knowledge in their practice, but that their reliance on this decreased after the program. Consistent with this, the correlation between service provider years and cultural knowledge fell from T1 ($r = 0.37^*$) to T2 ($r = 0.03$). Similarly, the correlation between cultural knowledge and sensitivity/respect fell from T1 ($r = 0.47^{***}$) to T2 ($r = 0.09$).

Qualitative data

Two participants provided qualitative data broadly relating to cultural sensitivity/respect, and their comments show that the program was effective in reminding service providers about its importance:

(Explanation for overall satisfaction rating?) Sparks a conversation and allows workers to continue to be mindful about their cultural competency (Satisfaction Survey_65).

(Any other comments?) Being aware and culturally sensitive when dealing with victims/survivors and thinking broadly about the issues at hand (Satisfaction Survey_59).

Age, work experience, and cultural self-efficacy

Table 5 contains the correlations between age, service provider years, and the three components of cultural self-efficacy. They firstly show, as expected, that age and length of years working as a service provider or other relevant professional are strongly correlated (CALD T1 $r = 0.79^{***}$, Anglo T1 $r = 0.71^{***}$; CALD T2 $r = 0.82^{***}$, Anglo T2 $r = 0.74^{***}$).

They also show that at T1, the correlations between service provider years and cultural knowledge and confidence were moderate (respectively, CALD $r = 0.37^*$, $r = 0.26^*$; Anglo $r = 0.31^*$, $r = 0.34^*$), suggesting that even in a sample with a high average of approximately 15 years work experience and a range that reaches nearly 50 years, cultural knowledge and confidence only somewhat increase with it. This may be attributed to the fact that fewer CALD client families engage with formal services for practitioners to be able to gain critical on-the-job learning. Indeed, one participant said, *Have not worked with CSA victims in CALD space as yet – so unsure re protocols of organisation in this space (Baseline Survey_14).*

Table 5: Correlations between age, work experience, and cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1					T2				
	Age	Service provider years	Cultural knowledge	Cultural confidence	Cultural sensitivity	Age	Service provider years	Cultural knowledge	Cultural confidence	Cultural sensitivity
CALD^a										
SP years	0.79***	–				0.82***	–			
Knowledge	0.41**	0.37*	–			0.02	0.03	–		
Confidence	0.22	0.26*	0.26*	–		0.10	-0.01	0.55**	–	
Sensitivity	0.09	0.09	0.47***	0.19	–	0.06	0.19	0.09	-0.14	–
Anglo^b										
SP years	0.71***	–				0.74***	–			
Knowledge	0.14	0.31*	–			0.47*	0.30	–		
Confidence	0.33*	0.34*	0.64***	–		0.34	0.30	0.74***	–	
Sensitivity	0.09	-0.07	0.28*	0.36*	–	0.10	0.17	0.24	0.28	–
Total^c										
SP years	0.75***	–				0.77***	–			
Knowledge	0.19*	0.24*	–			0.24	0.15	–		
Confidence	0.23*	0.25*	0.49***	–		0.21	0.13	0.69***	–	
Sensitivity	0.05	-0.03	0.46***	0.32**	–	0.06	0.16	0.22	0.16	–

* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 59, T2 21 < n < 23; b – T1 50 < n < 53, T2 20 < n < 21; c – T1 109 < n < 112, T2 42 < n < 44.

Summary

- Cultural competency occurs at the personal and organisational/institutional levels. RQ1 only addressed cultural competency at the personal level; synonymously described here as ‘cultural self-efficacy’, and in turn seen to be made up of three components – cultural knowledge, cultural confidence, and cultural sensitivity/respect. Improvements in cultural self-efficacy were a fundamental indicator of the effectiveness of the program.
- For both CALD and Anglo service providers, scores on cultural knowledge, confidence, and sensitivity/respect increased after the program, demonstrating its effectiveness.
- Generally, CALD service providers have more cultural knowledge, confidence, and sensitivity/respect than Anglo service providers, and all service providers are more respectful than they are knowledgeable or confident.
- CALD service providers were found to rely on tacit cultural knowledge in their practice, but the program increased their reliance on explicit cultural knowledge.
- Although older service providers have more professional experience, they do not have substantially more cultural knowledge or confidence. This is seen to reflect low opportunity to work with this client group, given the low uptake of formal services by CALD communities.
- Changes in cultural sensitivity/respect were marginal, indicating strong social work/social justice values among service providers regardless of their length of professional experience.
- After having attended the program, practitioners report gains in cultural knowledge about individualism/collectivism and family reputation, feel more confident to improve in their daily work practice, and appreciate being reminded of the need to be culturally sensitive and competent.

RQ2: Do service providers more appreciate the difficulty of making sense of cross-cultural prevalence data on child sexual abuse?

Background and rationale

Paucity in research

Nearly twenty years ago, Futa, Hsu, and Hansen (2001) noted that research focusing on child sexual abuse in ethnic minority populations was minimal, and little has changed since. The systematic review that was conducted in 2016 covered literature published between 2000–2016 (to help ensure the review covered recent research), and only located 135 relevant articles. In comparison, over 15,000 research papers on child sexual abuse based on Western samples was found in that same period.¹⁷

The paucity in research on child sexual abuse and ethnic diversity is problematic because prevalence data is often used as a starting point to determine the size of a problem and therefore have justified evidence to address it. It also compromises being able to understand the qualitative psychosocial experience of child sexual abuse, with the effect of falsely universalising it for all cultural groups. These issues directly impact the ability of governments, communities, families, and service providers to protect children from sexual victimisation, re-victimisation, and/or severe mental ill-health.

Ullman and Filipas (2005) say, “because so little research exists on ethnic differences in child sexual abuse, even basic data on prevalence is contradictory and inadequate. (For example, some) studies show more, less, or equal rates of abuse among Hispanic women than among White women (in the US)” (p. 68). Kenny and McEachern (2000) similarly say, “Asian sub-

¹⁷ The comparative data presented here on child sexual abuse research in Western and non-Western samples is crude. A Google Scholar search with ‘child sexual abuse’ limited to 2000–2016 yields 1,070,000 hits. A Google Scholar search with ‘child sexual abuse + ethnic’ limited to 2000–2016 yields 125,000 hits, and a search with ‘child sexual abuse + multicultural’ limited to 2000–2016 yields 19,300 hits. When the systematic literature review was conducted in 2016, 9,560 articles were identified in the first stage of searching but only 135 (1.4%) were finally identified as relevant, albeit with stringent inclusion/exclusion criteria to help ensure the reviewed literature was applicable to the Australian context. Proportionately, 1.4% of 1,070,000 would equate to 15,110 articles and 1.4% of (125,000 + 19,300, acknowledging overlap) would equate to (less than) 449 articles. The differences are stark enough to provide evidence that more Western-based research is conducted, however future research is required to identify precisely how much by.

groups (in the US) are usually all categorised as Asian-Pacific Islander making it difficult to obtain accurate statistics within subgroup populations” (p. 908). These are just some examples of issues encountered with a poor research base. Tishelman and Geffner (2010) importantly note that “culture is pertinent to each case of suspected child sexual abuse but only barely (gets) touched on by existing research” (p. 487).

Difficulty with interpreting prevalence data

Although the research base is scant, two empirically rigorous epidemiological studies have been conducted by Finkelhor (1994) and Pereda, Guilera, Forns, and Gomez-Benito (2009). They summarised research data on reported prevalence of child sexual abuse in a variety of countries around the world. A summary of the data obtained across their studies is in Table 6. The rates of reported child sexual abuse per 100 are rounded to the nearest whole number.

At first glance, it appears that child sexual abuse is substantially high in some countries, and substantially low in others where it could even be considered negligible. For example, in South Africa a number of studies report prevalence of child sexual abuse to vary between 35 and 53 per 100 females and to be as high as 60 per 100 for males. On the other hand, prevalence in France is as low as 1 per 100 children. In countries where data is available in both studies, reported prevalence has sometimes increased (e.g. Australia, Great Britain, Switzerland) and at other times decreased (e.g. Canada, Finland, Spain, USA). Thus, prevalence appears to vary considerably across cultures and time.

‘Sticky’ questions would be: are some countries better at protecting their children from sexual harm than others, and do some countries care more about the safety of their children than others? They appear to be reasonable questions to ask, based on the available data. However, prevalence data is difficult to interpret for a number of reasons.

The first issue is that countries differ in how they define child sexual abuse. For example, France uses a restricted definition that only includes rape and incest, whereas other countries such as Australia include non-penetrative assault.¹⁸ Some countries consider a child to be anywhere up to 18 years, whereas others mark the cut off at 12 years. Also, some countries include the age difference between the victim and perpetrator usually defined as at least five years, whereas others do not. (See Pereda et al. (2009) for full discussion of issues regarding varying definitions of abuse).

¹⁸ Paolucci, Genuis, and Violato (2001) show that the definition of child sexual abuse (touching versus penetration) does not mediate its relationship with negative health and psychological outcomes, indicating that a broad definition of child sexual abuse is justified.

Table 6: Prevalence of reported child sexual abuse per 100 in two international review studies (Finkelhor, 1994; Pereda et al., 2009)

Country	Finkelhor (1994)		Pereda et al. (2009)	
	Women	Men	Women	Men
Australia	28	9	39–45	19
Austria	36	19	N/A	N/A
Belgium	19	–	N/A	N/A
Canada	18	8	13	4
China	N/A	N/A	7–17	4–11
Costa Rica	32	13	N/A	N/A
Denmark	14	7	N/A	N/A
Dominican Republic	33	33		
El Salvador	N/A	N/A	17	–
Finland	7	4	1	1
France	8	5	1	1
Germany	10	4	N/A	N/A
Greece	16	6	N/A	N/A
Great Britain	12	8	13–21	11
Ireland	7	5	N/A	N/A
Israel	N/A	N/A	31	16
Jordan	N/A	N/A	–	27
Malaysia	N/A	N/A	8	2
Morocco	N/A	N/A	9	–
Netherlands	33	–	N/A	N/A
New Zealand	32	–	17	3
Norway	19	9	19	4
Portugal	N/A	N/A	3	3
Singapore	N/A	N/A	16	–
South Africa	34	29	35–53	60
Spain	23	15	15	10
Sweden	9	3	13	3
Switzerland	11	3	19–40	11
Turkey	N/A	N/A	–	28
United States	27	16	17–49	4–14

N/A – Study not conducted in that country at that time.

The second problem with being able to interpret prevalence data confidently has to do with the recall of traumatic events experienced during childhood. Victims may repress the memory for many years before it re-emerges into conscious awareness, thereby hiding it from the statistics. Avoidance, disassociation, and denial can initially develop as adaptations to the threat that child sexual abuse poses to “beliefs in a just world, the status quo, or other worldviews” (Cromer & Goldsmith, 2010, p. 619).

The third issue, and emphasised in this project as particularly significant, relates to the wide number of barriers to disclosure experienced by victims/survivors and their costly associated consequences should they tell. Research on child sexual abuse, based mostly on Western samples, has long identified a range of barriers to disclosure. These include (but are not limited to): embarrassment, shame, guilt, fear of not being believed, fear of not obtaining supportive and protective responses (especially from the victim’s mother), fear of shaming or dishonouring the family name, fear of tearing the family apart, social norms valuing emotional suppression (e.g. ‘stiff upper lip’) as a sign of emotional strength and heightened for males, fatalistic religious beliefs (e.g. the abuse is one’s ‘cross to bear’, forgiving the abuser is a ‘good Christian act’, etc.), the lower social power of children to voice their needs and experiences, lack of awareness regarding child rights to safety, lack of willingness to confront and difficulty understanding the criminal justice system, and death threats from perpetrators for disclosing (Sawrikar & Katz, 2017a).

Cross-cultural similarities and differences in barriers to disclosure

All the aforementioned barriers to disclosure are shared with victims/survivors from non-Western populations. However, the following are discussed in the research literature as particularly pertinent for them: fear of shaming or dishonouring the family name, the lower social power of children to voice their needs and experiences, social norms valuing suppression as a sign of strength in the face of adversity and to avoid conflict and maintain family harmony and cohesion, fear of not being believed and obtaining supportive and protective responses especially from the non-offending mother, and fatalistic religious beliefs (e.g. ‘all things are Allah’s will’, seeking justice is ‘bad karma’, etc.) (Sawrikar & Katz, 2017a).

In addition to these barriers, the research based on non-Western samples also identifies prohibitive social norms on discussing any matters to do with sex including abuse, compromising marriage prospects for all daughters within a family, and community shame and death threats from extended family (‘honour killings’) for divorcing a perpetrator spouse to help protect the child victim (Sawrikar & Katz, 2017a). These barriers were not identified in Western-based research but could potentially be relevant if such research were conducted.

For example, the role of male honour in DFV has been noted as lagging in Western-based samples (Salter, 2014).

In comparison, one barrier was identified as unique to ethnic minorities in Western countries: fear of stigmatising their entire ethnic community. In a small study conducted by Sawrikar (2011) in NSW, in which case files were randomly selected and reviewed, child sexual abuse was substantiated in 11 of 20 (55%) Anglo, 8 of 20 (40%) Aboriginal, 3 of 20 (15%) Vietnamese, 4 of 19 (21%) Pacific Islander (Samoan or Tongan), 1 of 18 (5.5%) Lebanese, and 4 of 20 (20%) Chinese case files. The last four of these groups are considered 'CALD' in Australia, and have substantially lower rates than Anglo or Aboriginal communities. The low rates are attributed to the high degree of silence surrounding child sexual abuse in CALD communities. Many of these relate to the collectivist value for family, and therefore family reputation, community standing, family cohesion, family harmony, and social roles within a family including hierarchal power bestowed to males and older people. However, the unique (and socially unjust) burden of racism also acts to silence CALD victims/survivors of child sexual abuse in Western countries like Australia.

Risky judgements and failure to name social injustice

It is clear that even when research is conducted rigorously, the data is substantially difficult to interpret. Kenny and McEachern (2000) say that "as many as 80% of sexual abuse cases may not be reported". Collings, Giffiths, and Kumalo (2005) estimate nondisclosure to vary from 33–92% for girls and from 42–100% for boys. Mathews, Abrahams, and Jewkes (2013) say that reported cases only constitute the 'tip of the iceberg', and Vermeulen and Greeff (2015) say that many victims/survivors are emotionally manipulated into a 'conspiracy of silence'. In short, there is high under-reporting of abuse, so what can be seen with numbers is not regarded as trustworthy.

Moreover, all countries agree that child sexual abuse is a traumatic experience that should be given considerable clinical and research attention (Walker, Hernandez, & Davey, 2012), and voice strong disapproval of it (Elliot, Tong, & Tan, 1997). Thus, questions about whether some countries care more about and are better at protecting their children than others are not just impossible to answer, they are risky. They place the blame on failure to protect children on culture, and social injustices are permitted to remain unnamed and therefore unaddressed. It is also for this reason that literature based on Western samples cannot and should not be used to make sense of the needs and experiences of CALD communities, which several authors in the field note (e.g. Baker, Gleason, Naai, Mitchell, & Trecker, 2013; Chen & Chen, 2005; Chien, 2013; Elbedour et al., 2006; Gilligan & Akhtar, 2005; Mildred & Plummer, 2009; Reavey, Ahmed, & Majumdar, 2006; Sil & Soo, 2008; Wang & Heppner, 2011; Usta & Farver, 2010).

Philosophical constraints and ethical stances

There are three ways in which the immense number and types of barriers to disclosure among CALD communities could be made sense of. The first is that there are more barriers to disclosure in non-Western samples but they are essentially of the same type, and so the psychosocial experience of child sexual abuse is universal but just experienced more intensely by CALD communities. The second is that the number of barriers to disclosure is roughly equal in Western and non-Western samples but they differ more in type, so the psychosocial experience of child sexual abuse is not universal but the issue is equally severe. The third is that non-Western samples have a different psychosocial experience of child sexual abuse than Western samples and it is worse. The first takes a quantitative lens, the second a qualitative lens, and the third a combination of both. The three alternatives depend on the researcher's relationship with 'truth': whether it is seen to be objectively independent of perception, whether it is seen to be subjectively constructed, or whether they endorse 'critical realism' in which there is a straddling of the previous two positions (Tsang, 2014).

Such debates are important and necessary, but also risk 'arm chair philosophising' at the expense of protecting children. The psychosocial experience of sexual abuse may be worse for CALD children, but it is severe for all victims/survivors. For this reason, the project takes the position that it is better to err on the side of caution and assume that the prevalence of child sexual abuse is higher than the statistics suggest in *all* countries and cultures, and that whether abuse is more or less prevalent in one country compared to another is not as important as equally valuing the safety of every child regardless of their cultural background. That is, protecting a CALD child is no more or less important than protecting a non-CALD child, but understanding a CALD child's psychosocial experience is critical for being able to best meet their needs. Indeed, in South Africa barriers relating to protecting family name may be weaker against the contextual backdrop of poverty which appears linked to the sexual exploitation of children (Capri, 2013). Thus, the wide array of barriers affecting different CALD communities may not be evenly spread, being higher or more intense in some than others, and this is difficult to unpack and know. Overall, the education program aimed to challenge service providers' trust of quantitative data on reported prevalence, and value a need to not universalise the psychosocial experience of child sexual abuse across cultures while still valuing all children's safety as equal.

Measures

Program attendees were asked two questions in relation to RQ2. These were structured in a continuous way to yield informative descriptive data. However, each category was also described in a meaningful way to be able to also explore frequency data.

The first question was, *B.6* – ‘How different do you think cultural groups are on prevalence of child sexual abuse?’ Options varied from 1 = Not at all (the prevalence of child sexual abuse is essentially the same in all cultural groups), 2 = A little bit (some cultural groups have higher prevalence of child sexual abuse than others but not by a substantial amount), 3 = A lot (some cultural groups have higher prevalence of child sexual abuse than others by a substantial amount), and 4 = Completely (some cultural groups have very high prevalence of child sexual abuse and in other groups the prevalence is essentially absent/negligible).

The second question was, *B.7* – ‘How difficult do you think it is to interpret cross-cultural prevalence data of child sexual abuse?’ Options varied from 1 = Not at all (if the research was conducted rigorously, then the numbers are accurate), 2 = A little bit (if the research was conducted rigorously, then the numbers are close enough to being accurate), 3 = A lot (even if the research was conducted rigorously, the numbers will still be substantially difficult to interpret), and 4 = Completely (even if the research was conducted rigorously, the numbers will still be impossible to interpret).

Changes over time

Table 7 contains descriptive data on beliefs about cross-cultural prevalence of child sexual abuse, and beliefs about accuracy of cross-cultural child sexual abuse prevalence data, by the cultural background of the service provider. Descriptions of change over time are separate for CALD and Anglo service providers.

Table 7: Descriptive data on beliefs about cross-cultural prevalence of child sexual abuse and beliefs about accuracy of cross-cultural child sexual abuse prevalence data by cultural background of service provider (T1 and T2)

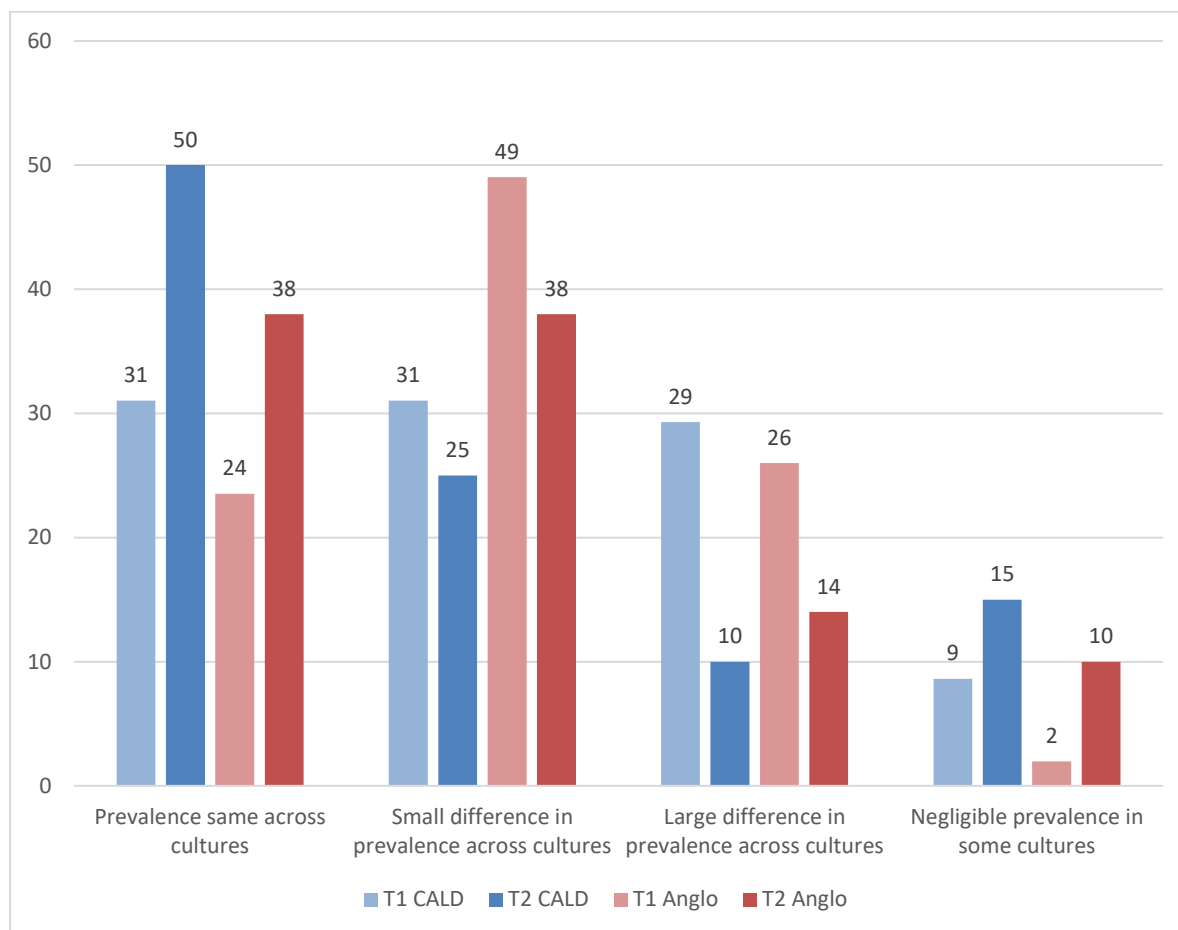
	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Beliefs about cross-cultural prevalence of child sexual abuse (<i>B.6</i>)										
CALD	2.2	1.0	58	1	4	1.8	1.0	20	1	4
Anglo	2.1	0.8	51	1	4	2.0	1.0	21	1	4
Total	2.1	0.9	109	1	4	1.9	1.0	41	1	4
Beliefs about accuracy of cross-cultural child sexual abuse prevalence data (<i>B.7</i>)										
CALD	2.9	0.6	58	2	4	3.0	0.8	22	1	4
Anglo	2.7	0.5	53	1	4	3.1	0.6	20	2	4
Total	2.8	0.6	111	1	4	3.0	0.7	42	1	4

Beliefs about prevalence being negligible in some countries

By cultural background of service provider

As can be seen from Figure 3 (and Data Table G.1 in Appendix G), very few service providers thought that the prevalence of child sexual abuse in some cultural groups is negligible. Indeed, as cells had frequencies less than five, chi-square (χ^2) tests examining whether changes over time were significant were not conducted; and although the proportion of CALD (15%, n = 3) and Anglo (10%, n = 2) service providers selecting this option increased at T2, the cell sizes are too small to be meaningful or treated with confidence.¹⁹

Figure 3: Percentage distribution on beliefs about cross-cultural prevalence of child sexual abuse by cultural background of service provider (T1 and T2)



¹⁹ No χ^2 tests examining change over time were conducted in this study due to the small sample size at T2. Thus, only trends have been described, where potentially meaningful.

Still, it is interesting to note that at T1 (which had a larger sample size) more CALD (9%, $n = 5$) than Anglo (2%, $n = 1$) service providers reported this. It is consistent with the finding from the systematic literature review that CALD community members have a bias toward believing that child sexual abuse is a ‘Western problem’, i.e. that it is not common in theirs. Indeed, the aim of examining the frequency of this category was to explore whether the program effectively challenged any such bias (but was not possible due to the small sample size at T2).

The research indicates that prevalence of (penetrative) child sexual abuse in China could be substantially lower than in other countries (Ji, Finkelhor, & Dunne, 2013). However, the possibility that these CALD participants are reflecting this knowledge could be ruled out by the fact that only one was of mixed Chinese background (the remainder were of Zimbabwean, Afghani, Sri Lankan, and Jamaican background). This suggests that the aforementioned bias could be playing out here.

Consistent with this, it was found that at T1, 31% ($n = 18$) of CALD service providers believed that cross-cultural prevalence was essentially the same, 31% ($n = 18$) believed that differences were not by a substantial amount, and 29% ($n = 17$) believed that differences were by a substantial amount. Thus, their distribution across these three categories was almost equal. However, at T2 the distribution had changed substantially, with most believing that cross-cultural prevalence was essentially the same (50%, $n = 10$) or that differences were not by a substantial amount (25%, $n = 5$). The cell sizes at T2 are too small to conduct statistical analyses with confidence, but the trends do support the notion that any bias by CALD community members to minimise prevalence was effectively challenged by the program, with there now being better awareness of cross-cultural universality in prevalence.

At T1, 24% ($n = 12$) of Anglo service providers believed that prevalence was essentially the same, 49% ($n = 25$) believed that differences were not by a substantial amount, and 26% ($n = 13$) believed that differences were by a substantial amount. Thus, their distribution resembled a normal bell curve. However, after the program their distribution became similarly skewed, with most Anglo service providers believing that cross-cultural prevalence is essentially the same (38%, $n = 8$) or that differences are not by a substantial amount (38%, $n = 8$). That is, the program strengthened awareness of cross-cultural universality in prevalence among Anglo service providers.

Overall, the findings suggest that any bias toward believing that child sexual abuse is a ‘Western problem’ occurs more among the general CALD community rather than among CALD or other service providers. Indeed, mean scores (see Table 7) did not significantly differ between CALD and Anglo service providers at either T1 ($t(107) = 0.57, p > 0.05$) or T2 ($t(39) = -0.49, p > 0.05$). Thus, on average, CALD and Anglo service providers believe

that some cultural groups have higher prevalence of child sexual abuse but not by a substantial amount.

Relationship with cultural self-efficacy

Treating this question with its continuous numeric nature allows correlations with cultural self-efficacy to be conducted. As can be seen from Table 8, correlations between beliefs about cross-cultural equivalence in prevalence of child sexual abuse and cultural knowledge, confidence, and sensitivity are not really related; at both T1 and T2, correlations were only moderate in strength and only one was significant ($-0.30^* < r < 0.29$). This indicates that there is stability over time in the attitudes of all service providers regarding cross-cultural differences in the prevalence of child sexual abuse; namely, that ‘some cultural groups have higher prevalence but not by a substantial amount’.

Still, observing trends can be informative because replication studies with larger samples and therefore better power may detect statistically significant differences between groups and/or across time. For example, it is interesting to note that the direction of correlations at T1 was different for CALD and Anglo service providers. As CALD service providers increased on their self-rated cultural knowledge, confidence, and sensitivity, they decreased on their belief that the prevalence of child sexual abuse is essentially the same in all cultural groups ($-0.22 < r < -0.30^*$), but Anglo service providers increased on this belief ($0.00 < r < 0.14$).

This suggests that CALD service providers somewhat assume that the prevalence of child sexual abuse is different across cultures, and that Anglo service providers slightly assume that the prevalence is essentially equal. The program aimed to challenge both these false beliefs of deflected attention (to prevalence in Western contexts) and uniform universality (across Western and non-Western contexts), which it did for CALD service providers. This is demonstrated by the change from negative to positive correlations for them on cultural knowledge and confidence at T2 ($0.17 < r < 0.29$).

However, positive correlations for Anglo service providers strengthened at T2 ($0.07 < r < 0.25$), indicating that beliefs about universality of prevalence increase as cultural knowledge, confidence, and/or sensitivity increase. This finding overall makes sense in light of the program content, which worked to affirm one fundamental message: that there may be differences in prevalence, but child sexual abuse occurs in all cultures.

Qualitative data

Qualitative data relating to the cross-cultural prevalence of child sexual abuse includes:

(Liked best?) Exploration of data (Satisfaction Survey_4).

Re B.6: I would assume law has an impact (Baseline Survey_44).

(Liked best?) Info about the prevalence of child sexual abuse and the countries (Satisfaction Survey_3).

Re B.6: Depends what you are calling CSA ... FGM e.g. is prevalent in particular groups ... and other groups get media attention. Not sure ?? (statistically) (Baseline Survey_59).

The reasons for my responses to B.8 and B.9 is the substantial public awareness campaigns in US/Australia and other English speaking countries, not inherent cultural differences (Baseline Survey_83).

As stated (in the Q&A forum), I feel there is a massive shift with access to social media. Rallies and protests are emerging and people are fighting for the rights of CALD people and CSA survivors (Satisfaction Survey_24).

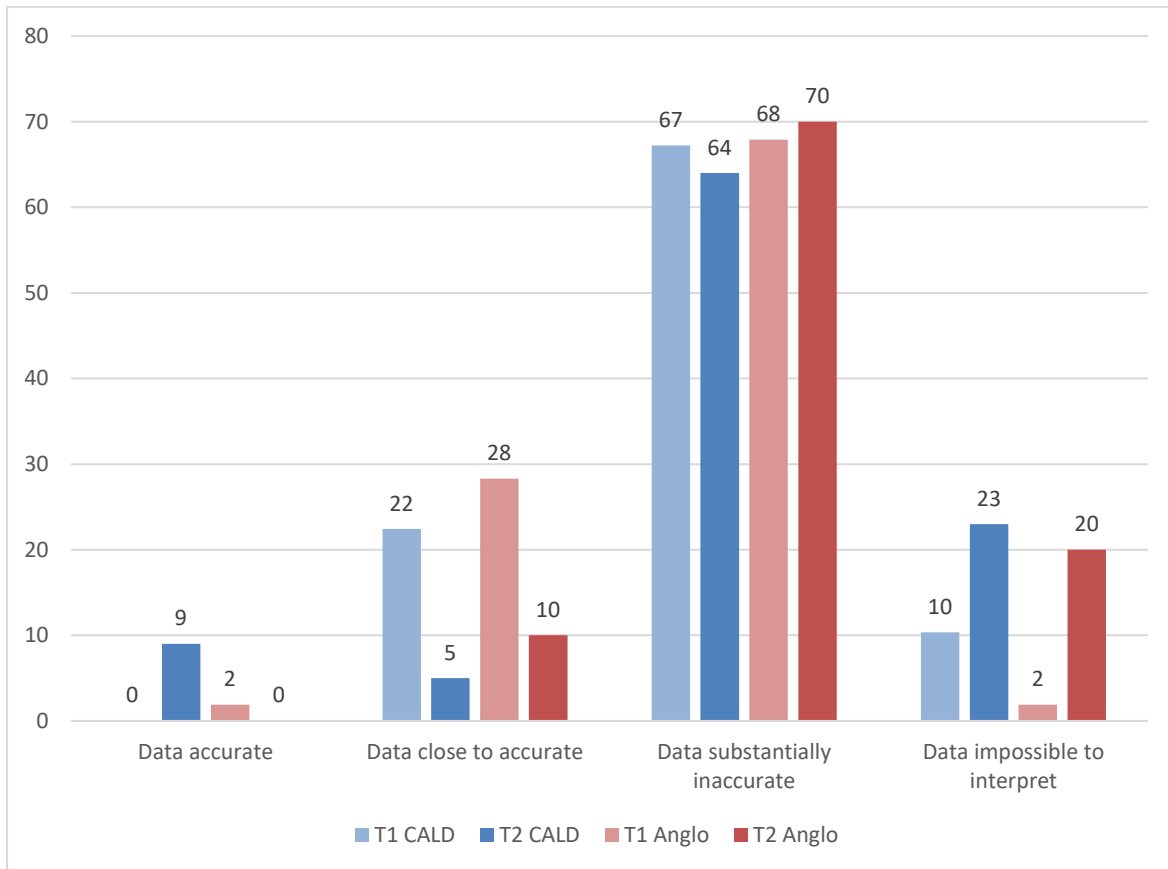
I was unable to answer B.6 – I would have liked an unpacking of ‘different’. My experience has been that it may depend on the longevity or arrival of the individual to Australia. I have worked with recently arrived refugees and migrants which have a different response and idea about sexual abuse in general, but this differs from individuals for the same community who have been residing and living in Australia for a longer period of time (Baseline Survey_45).

Beliefs about accuracy of prevalence data

By cultural background of service provider

As can be seen from Figure 4 (and Data Table G.2), the proportion of CALD service providers who thought that cross-cultural prevalence data is accurate or close to accurate decreased from T1 (0 + 22 = 22%, total n = 13) to T2 (9 + 5 = 15%, total n = 3), as it did for Anglo service providers from T1 (2 + 28 = 30%, total n = 16) to T2 (0 + 10 = 10%, total n = 2). The proportion of CALD service providers who thought that cross-cultural prevalence data is impossible to interpret increased from T1 (10%, n = 6) to T2 (23%, n = 5), as it did for Anglo service providers from T1 (2%, n = 1) to T2 (20%, n = 4).

Figure 4: Percentage distribution on beliefs about accuracy of cross-cultural child sexual abuse prevalence data by cultural background of service provider (T1 and T2)



These movements over time suggest that as a result of the program, service providers more appreciate the difficulty of making sense of cross-cultural prevalence data on child sexual abuse. This is further supported by the changes over time in correlations between beliefs about cross-cultural equivalence in prevalence and accuracy of cross-cultural prevalence data. The correlations at T1 were weak for both CALD ($r = -0.13$) and Anglo ($r = 0.14$) service providers, but increased at T2 (CALD $r = 0.37$, Anglo $r = 0.51^*$). That is, after the program, the less service providers believe that cross-cultural prevalence data is accurate, the less they believe that cross-cultural prevalence is equal.

Interestingly, the correlation at T1 was in opposite directions for CALD (T1 $r = -0.13$) and Anglo (T1 $r = 0.14$) service providers. For CALD service providers, as beliefs about accuracy of prevalence data decreases, beliefs about cross-cultural equivalence in prevalence increases, whereas the latter decreases for Anglo service providers. This is consistent with the previous finding that CALD service providers slightly assume that the prevalence of child sexual abuse is different across cultures, and that Anglo service providers slightly assume that prevalence is essentially equal. These assumptions change when there is a better

understanding of the difficulty interpreting cross-cultural prevalence data, which the program imbues.

Overall, the findings suggest that most CALD and Anglo service providers believe that ‘even if the research was conducted rigorously, the numbers will still be substantially difficult to interpret’. The mean scores are consistent with this (see Table 7); they did not significantly differ between CALD and Anglo service providers at either T1 ($t(109) = 1.73, p > 0.05$) or T2 ($t(40) = -0.46, p > 0.05$).

Relationship with cultural self-efficacy

Table 8 shows that the program does not really affect cultural self-efficacy as service providers change their beliefs about the accuracy of cross-cultural prevalence data; at T1 and T2, most were either not strong or significant ($-0.14 < r < 0.34^{**}$). However, trends can still be described.

The correlation at T1 between cultural knowledge and beliefs about prevalence data being accurate was stronger for CALD ($r = 0.34^{**}$) than Anglo service providers ($r = 0.11$), and the correlation between cultural confidence and beliefs about prevalence data being accurate was stronger for Anglo ($r = 0.28^*$) compared to CALD service providers ($r = 0.02$). This suggests that prior to the program cultural knowledge was more impactful for CALD service providers, and cultural confidence was more impactful for Anglo service providers. However, at T2 this had reversed; confidence was now more impactful among CALD ($r = 0.22$) but not Anglo ($r = -0.08$) service providers, and it is not clear why.

The findings also show that at T1, as beliefs about prevalence data being accurate decrease, cultural sensitivity/respect increases²⁰, and to a similar extent for both CALD ($r = 0.24^{**}$) and Anglo ($r = 0.31^*$) service providers. Thus, the impact of this component of cultural self-efficacy is similar for CALD and Anglo service providers. However, this changes at T2; sensitivity/respect not just falls but reverses for CALD ($r = -0.12$) compared to Anglo ($r = 0.25$) service providers. Again, it is not clear why.

²⁰ The numeric value of the correlation is positive, but the wording of the item is negatively scaled.

Qualitative data

Qualitative data relating to the accuracy of cross-cultural child sexual abuse prevalence data includes:

Re B.7: I'm not sure I 100% understand this question (Satisfaction Survey_44).

Useful explanation of how to consider interpreting data (Satisfaction Survey_78).

I liked the unpacking of 'truth' in relation to current research (Satisfaction Survey_74).

Hard to contextualise level of CSA in CALD community as a whole vs particular sub-groups e.g. those who practice FGM or child marriage (Baseline Survey_101).

(Liked best?) The information about prevalence of sexual abuse and CALD communities and the importance of not reading too much in the statistics (Satisfaction Survey_70).

The content regarding research and prevalence that the training highlighted was powerful and helped in creating a deeper understanding of the issues. Thanks! (Follow up Survey_34).

Table 8: Correlations between beliefs about cross-cultural equivalence in prevalence of child sexual abuse, beliefs about accuracy of cross-cultural child sexual abuse prevalence data, and cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1				T2			
	Beliefs re prevalence	Cultural knowledge	Cultural confidence	Cultural sensitivity	Beliefs re prevalence	Cultural knowledge	Cultural confidence	Cultural sensitivity
CALD^a								
Beliefs about cross-cultural equivalence in prevalence	–	-0.30*	-0.15	-0.22	–	0.29	0.17	-0.29
Beliefs about accuracy of cross-cultural prevalence data	-0.13	0.34**	0.02	0.24**	0.37	0.18	0.22	-0.12
Anglo^b								
Beliefs about cross-cultural equivalence in prevalence	–	0.00	0.11	0.14	–	0.24	0.07	0.25
Beliefs about accuracy of cross-cultural prevalence data	0.14	0.11	0.28*	0.31*	0.51*	-0.14	-0.08	0.25
Total^c								
Beliefs about cross-cultural equivalence in prevalence	–	-0.14	-0.04	-0.07	–	0.23	0.07	-0.04
Beliefs about accuracy of cross-cultural prevalence data	-0.01	0.28**	0.17	0.31**	0.42**	0.02	0.05	0.00

* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 57 < n < 59, T2 19 < n < 23; b – T1 49 < n < 53, T2 20 < n < 21; c – T1 n 107 < n < 112, T2 39 < n < 44.

Summary

- Prevalence data is often used as a starting point to determine the size of a problem and therefore have justified evidence to address it. However, the accuracy of cross-cultural prevalence data is substantially comprised by: (i) differences in how countries legally define child sexual abuse, (ii) repression of traumatic childhood events, and (iii) the wide array of costly barriers to disclosure that lead to significant under-reporting. Even rigorously designed research cannot overcome these issues to provide prevalence data that can be interpreted with confidence. Philosophical issues also affect how prevalence data can be interpreted. Thus, it is best to treat prevalence data with caution.
- Prevalence data also compromises being able to understand the qualitative psychosocial experience of child sexual abuse, with the effect of falsely universalising it for all cultural groups. Thus, understanding and representing the cross-cultural lived experience is seen as better than focusing on numbers. It does not borrow findings from the more developed Western-based data to make sense of the needs and experiences of CALD communities, and this improves the ability of governments, communities, families, and service providers to protect *all* children from sexual victimisation, re-victimisation, and/or severe mental ill-health. That is, the right of all children to safety from sexual harm – regardless of their cultural background – becomes equally valued.
- Focusing on qualitative experience also mitigates the risk of judging some countries as better at caring for and protecting their children than others, which differences in numbers lead people to think. Numbers have the effect of placing blame on failure to protect children on culture, and social injustices and inequalities such as racism and poverty are more likely to remain unnamed and therefore unaddressed. All countries and cultures agree that child sexual abuse is a traumatic experience worthy of clinical and research attention, and voice strong disapproval of it.
- To examine whether service providers more appreciate the difficulty of making sense of cross-cultural prevalence data on child sexual abuse after having attended the program (RQ2), they were asked whether they thought cross-cultural prevalence was equal and whether prevalence data was accurate.
- Overall, CALD and Anglo service providers believe that some cultural groups have higher prevalence of child sexual abuse but not by a substantial amount, and that even if the research was conducted rigorously the numbers will still be substantially difficult to interpret. These attitudes are stable over time, which is why they had little association with cultural self-efficacy. That is, any changes to service providers' cultural knowledge, confidence, and/or sensitivity/respect as a result of the program were negligible in effect on beliefs about cross-cultural prevalence and accuracy of prevalence data.

- The correlation between beliefs about cross-cultural prevalence and accuracy of prevalence data was low at T1 for both CALD and Anglo service providers but strengthened at T2. That is, after the program, the less service providers believe that cross-cultural prevalence data is accurate, the less they believe that cross-cultural prevalence is equal. This shows the program was effective for all service providers in more appreciating the difficulty of making sense of cross-cultural prevalence data.
- At T2, fewer CALD and Anglo service providers believed that if the research was conducted rigorously then the numbers are close enough to being accurate, and more believed that even if the research was conducted rigorously the numbers will still be impossible to interpret. These changes over time also substantiate the effectiveness of the program in supporting RQ2.
- At T2, more CALD service providers believed that prevalence is essentially the same in all cultural groups, and fewer thought that some cultural groups have higher prevalence than others by a substantial amount. These changes over time suggest that any bias toward the false belief that child sexual abuse is ‘a Western problem’ (which occurs in the general CALD community) was effectively challenged by the program, shifting CALD service providers’ awareness of it being prevalent across all cultural groups.
- Overall, there appears to be a slight false assumption among CALD service providers that the prevalence of child sexual abuse is different across cultures, and a slight false assumption among Anglo service providers that the prevalence is essentially equal. The program effectively challenged the former but not the latter, however this was not surprising given its core message – that while there may be differences in prevalence, child sexual abuse occurs in all cultures.

RQ3: Do service providers more appreciate that there may be cross-cultural differences in belief of the myth that most perpetrators of child sexual abuse are unknown to the victim?

Background and rationale

Myth that most perpetrators are unknown

There are several myths about child sexual abuse. In 1997, Collings published his now seminal scale identifying some of these myths (see Table 9). In RQ3, myth #3 is being solely addressed – that most children are sexually abused by someone unknown. The other myths are addressed in RQ4.

The research shows that most perpetrators of sexual abuse are known to the child. In 2006, it was found from the Australian Bureau of Statistics' (ABS) Personal Safety Survey (PSS) that 8.6% of female victims and 18.3% of male victims were sexually assaulted by a stranger. Most perpetrators are fathers or step-fathers (16.5% for female victims, 5% for male victims), another relative such as siblings or cousins (35.1% for female victims, 16.4% for male victims), a family friend (16.5% for female victims, 15.6% for male victims), an acquaintance or neighbour (15.4% for female victims, 16.2% for male victims), and another known person (11% for female victims, 27.3% for male victims). Thus, over 90% of perpetrators are known to female victims and over 80% are known to male victims. The more recent wave of data collection and analysis in 2016 shows either stability or increases over time in findings: the proportion of women that experienced sexual abuse before the age of 15 by someone known to them²¹ was 91% (n = 907,300), and the proportion of men was 98% (n = 715,300). It is a myth that most perpetrators are strangers; most perpetrators are within the child's extended family and community.

²¹ E.g. step-parents, step-siblings, foster carer or other person associated with care placement, family friend, acquaintance/neighbour, doctor or other health professional, teacher, other school related staff, childcare worker, in-home care educator or carer, recreational leader, priest/minister/rabbi/nun/other person associated with place of worship, staff in a children's home/orphanage, corrective services personnel, and other known person.

Table 9: Child Sexual Abuse Myths Scale (CSAMS; Collings, 1997)

1. Sexual contact between an adult and a child which is wanted by the child and which is physically pleasurable for the child cannot really be described as abuse.
2. Sexual contact with an adult can contribute favourably to a child's subsequent psychosexual development.
3. Most children are sexually abused by strangers or by someone who is not well known to the child.
4. Children who act in a seductive manner must be seen as being at least partly to blame if an adult responds to them in a sexual way.
5. Sexual contact between an adult and a child that does not involve force or coercion and that does not involve actual or attempted intercourse is unlikely to have serious consequences for the child.
6. A woman who does not satisfy her partner sexually must bear some of the responsibility if her partner feels frustrated and turns to her children for sexual satisfaction.
7. Child sexual abuse takes place mainly in poor, disorganised, unstable families.
8. It is not sexual contact with adults that is harmful for children. What is really damaging for the child is the social stigma that develops after the "secret" is out.
9. Many children have an unconscious wish to be sexually involved with the opposite sexed parent, which leads them to unconsciously behave in ways that make sexual abuse more likely.
10. Adolescent girls who wear very revealing clothing are asking to be sexually abused.
11. Children raised by gay or lesbian couples face a greater risk of being sexually abused than children raised by heterosexual couples.
12. Boys are more likely than girls to enjoy sexual contact with adults and are therefore less likely to be emotionally traumatised by the experience.
13. Child sexual abuse is caused by social problems such as unemployment, poverty, and alcohol abuse.
14. Children who do not report ongoing sexual abuse must want the sexual contact to continue.
15. Older children, who have a better understanding of sexual matters, have a responsibility to actively resist sexual advances made by adults.

Cross-cultural differences in belief of this myth

In collectivist cultures, where there is strong and normative shared reliance on extended family and community for child-rearing, parents/guardians may unknowingly expose their children to risk of sexual harm if they are left unsupervised with those who are also perpetrators (e.g. fathers, uncles, brothers, neighbours, club staff, etc.). If the extended family and community is particularly large, risk of harm would proportionately increase. Thus, the argument here is that there are not more CALD perpetrators of child sexual abuse, but rather more risk of harm if children are left with perpetrators under the false proviso that they are safe and this risk proportionately increases with the size of the community around that child. It is also the case that matters to do with sex including abuse are not openly discussed, thereby protecting virginal and filial conservativeness, however such prohibitive social norms can make it even more difficult to believe that harm has come from within a network that is stereotypically assumed to be protective; there is little opportunity to at least challenge the myth, and at best debunk it.

To help mitigate the possibility that there is an unknown increased risk of exposure to sexual harm in CALD communities, and therefore better protect their children, CALD carers require accurate knowledge about this myth. The awareness-raising program in Stage 2 of this project addresses this need. It will provide knowledge to CALD carers about child sexual abuse including myths to improve community-empowered prevention; in turn requiring a violation of social norms to not discuss sexual matters, even abusive ones.

However, the purpose of focusing on this myth in Stage 1 was to imbue service providers with an appreciation that the psychosocial experience of child sexual abuse is not universal: belief of the myth that most perpetrators are strangers may be higher in CALD communities because of the cultural collectivist norm valuing the extended family as primary providers of child safety. Indeed, Chen, Dunne, and Han (2007) found that in a sample of 652 parents of elementary school children in China, 56% held views consistent with ‘stranger danger’. Belief of this myth may then be maintained by prohibitive social norms discussing sexual matters. Together, these two socio-cultural trends may cause parents/guardians in CALD communities to be utterly shocked at and disbelieving of their child’s disclosure. (This has implications for whether the parent/guardian offers supportive and protective responses to disclosure and in turn the well-being of victims/survivors; addressed in RQs 4–8).

Limitations of research, risk of systematic state intervention, and ethical stances

Importantly, it may not be possible to determine whether there *are* cross-cultural differences in belief of this myth for the same reason that quantitative cross-cultural prevalence data is

challenging to interpret with confidence: in all cultural groups, there are many barriers to disclosure and therefore much silence. The numbers on those who have told do not come close to painting an accurate picture of the size of the problem, nor do they shed light on how it is experienced by different victims/survivors and why. Qualitative research has some capacity to address the latter issue, but it still requires overcoming all the barriers to disclosure for victims/survivors to take part in such research, meaning that small sample sizes are likely.

Moreover, the validity of qualitative evidence that the experience of child sexual abuse may be worse in CALD communities (even with a sufficient sample size that permits thematic saturation) is open to questioning and criticism from both CALD and non-CALD communities. Some members from CALD communities may appreciate the increased attention that research into the area offers so that their experiences are not continued to be minimised, overlooked, or unnamed, however other CALD community members may take great offence and perceive an attack on their ‘collectivist’ culture. Some members from non-CALD communities may appreciate empirical evidence that validates ‘what they have thought all along’, whereas others may take offence that *their* traumatic experiences are now being minimised.

Formal politics also play a key role in being able to conduct such research, which risks racist government intervention. In the aforementioned study conducted by Sawrikar (2011) in NSW, it was found that child sexual abuse was substantiated in 11 of 20 (55%) Anglo case files and 8 of 20 (40%) Aboriginal case files. The sample sizes per group were small but the case files were randomly selected, thus providing nascent evidence that child sexual abuse in NSW could be highest in Anglo communities. The Northern Territory (NT) is a different socio-cultural context to NSW, and children at high risk do need statutory protection from harm, but ‘the NT intervention’ also highlighted that white-majority governments perceive risk in ways that racialise numbers.

As has been already argued, prevalence data should be treated with healthy caution and scepticism. Numbers are often the first point of reference for determining the size of an issue, but this project is driven by a *value* for child safety rather than an impetus for it. Having said that, the impetus is still there. According to the World Health Organisation (WHO, 2002), the international prevalence rate of child sexual abuse is 20% for females and 5–10% for males, indicating that it not rare despite decreases in substantiated child sexual abuses over the preceding twenty year period by an estimate of 47% (cited in Cromer & Goldsmith, 2010). Thus, the safety of all children from sexual harm is seen as equal. Anglo children could potentially be at greatest risk of child sexual abuse but this does not warrant greater intervention. Certainly, such targeted intervention has not even been experienced to date because of racialised cognitive biases that increase perceptions of risk for criminal behaviour

in the ‘out-group’ and decrease perceptions of risk in the ‘in-group’ (note: the relationship between racism and child sexual abuse has been discussed at length elsewhere; see Sawrikar, 2018b). Instead, it warrants understanding of the psychosocial experience of child sexual abuse in Anglo communities so that intervention is culturally tailored and therefore appropriate.

Finally, it is deeply unethical to conduct research aiming to simply explore and identify cross-cultural differences in the psychosocial experience of child sexual abuse without offering in return culturally appropriate support services. The literature review conducted in 2016 showed that cultural competency was likely to be low in service organisations and therefore developing this was a critical first step before pure qualitative research could be conducted.

For all these reasons, the project did not design a study aiming to find empirical evidence for the possibility that there *are* cross-cultural differences in belief of the myth that most perpetrators of child sexual abuse are unknown to the victim. Instead, it aimed to highlight to service providers that cultural groups *may* differ in their psychosocial experiences – it is not the same for everyone – and collectivism plays a central role in this difference.

If future research is able to establish that the psychosocial experience of child sexual abuse is worse in collectivist cultures, it will not be because there are more perpetrators and therefore a greater need for governments to intervene in CALD communities over other communities. Such a response would be racist. The worse experience will be because of the cultural need to protect family reputation in a highly hierarchical society, which in turn could increase CALD carers disbelieving their child’s disclosure, affirm the child’s fear of not being believed, increase self-blame, and intensify mental illnesses as a result of the trauma (addressed in more depth in RQ4). These all point to the importance of the ‘clinical treatment system’ being ready to receive victims/survivors on their way to becoming more mentally well and empowered, not of the government responding to perceptions of child safety being under greater threat in CALD communities.

As it is not yet possible to identify if there are cross-cultural differences in belief of this myth, while acknowledging that it may never be possible because of the immense gravity of barriers to disclosure, limitations of quantitative and qualitative research, racial cognitive biases, and potential for political power to be used irresponsibly and unethically, this project only aimed to examine movement on the number of service providers who thought that belief of this myth was ‘equally likely’ across cultures. That is, research exploration was on whether perceptions of universality had been successfully challenged. Movement across time in the number of service providers endorsing the other categories of ‘less likely’, ‘more likely’, ‘significantly less likely’, and ‘significantly more likely’ were only explored out of interest.

Measures

Program attendees were asked one question in relation to RQ3: B.8 – ‘One myth about child sexual abuse is that perpetrators are usually strangers. However, the research shows that most perpetrators are known to the victim (e.g. fathers, uncles, siblings, cousins, family friends, neighbours, teachers, priests, etc.). Compared to Western populations (e.g. Anglo Australians), do you think CALD communities are.’ Options varied from 1 = Significantly less likely to believe this myth, 2 = Less likely to believe this myth, 3 = Equally likely to believe this myth, 4 = More likely to believe this myth, and 5 = Significantly more likely to believe this myth.

Changes over time

Cross-cultural belief of myth that most perpetrators are unknown

By cultural background of service provider

As can be seen from Figure 5 (and Data Table G.3), the proportion of CALD service providers who thought that belief of the myth that most perpetrators are unknown is cross-culturally equivalent decreased from T1 (47%, n = 28) to T2 (27%, n = 6), as it did for Anglo service providers from T1 (68%, n = 36) to T2 (55%, n = 11). Also, the proportion of CALD service providers who thought that CALD communities are more or significantly more likely to believe the myth that most perpetrators are unknown increased from T1 (27 + 10 = 37%, total n = 22) to T2 (27 + 14 = 41%, total n = 9), as it did for Anglo service providers from T1 (13 + 0 = 13%, total n = 7) to T2 (15 + 5 = 20%, total n = 4).

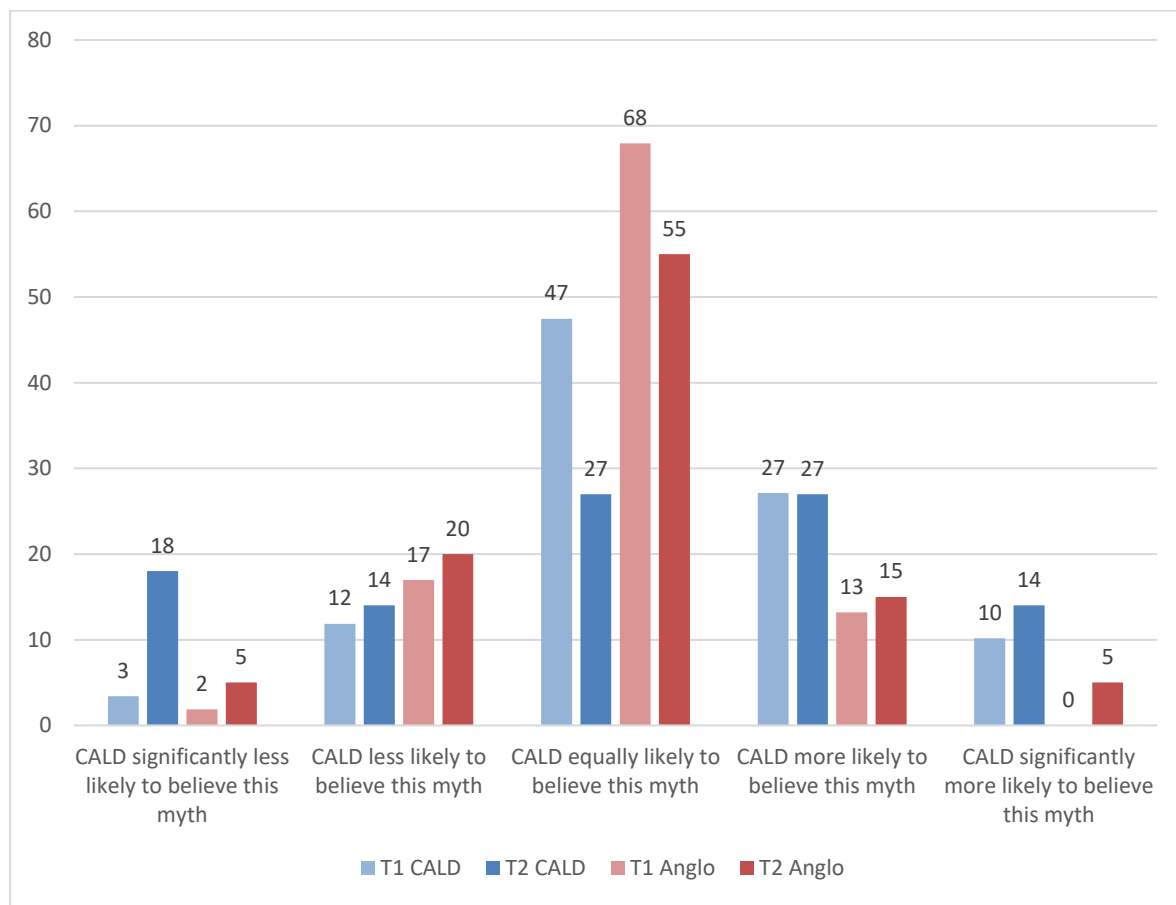
However, the proportion of CALD service providers who thought that CALD communities are less or significantly less likely to believe the myth that most perpetrators are unknown also increased from T1 (3 + 12 = 15%, total n = 9) to T2 (18 + 14 = 32%, total n = 7), as it did for Anglo service providers from T1 (2 + 17 = 19%, total n = 10) to T2 (5 + 20 = 25%, total n = 5). This finding was not expected, and counter to predicted trends; further research is required.²²

Altogether, the changes over time suggest that as a result of the program, service providers are more deeply engaging with cross-cultural differences in the psychosocial experience of child sexual abuse, and less likely to universalise it as if it were essentially the same for all victims/survivors. This is consistent with the intention of the program.

²² It may be similar to findings that show that workplace training on gender equality can sometimes *increase* gender stereotypes, counter to their intention.

Interestingly, the frequency data shows that before the program was delivered, less CALD than Anglo service providers thought that cross-cultural belief of this myth was equally likely, and more CALD than Anglo service providers thought that belief of this myth was more likely or significantly more likely in CALD communities. These findings suggest tacit knowledge among CALD service providers, fear among Anglo service providers in paying attention to culture and cultural differences (i.e. it is safe to appear ‘colour blind’), or both.

Figure 5: Percentage distribution on cross-cultural belief of the myth that most perpetrators are unknown by cultural background of service provider (T1 and T2)



It also highlights the power of examining frequency data, given that the means between CALD and Anglo service providers was significantly different at T1 ($t(101.5) = 2.5, p < 0.05$) but not by a great degree, and not significant at T2 ($t(36.9) = 0.28, p > 0.05$). That is, the descriptive data could mask their differences in cultural knowledge and how white practitioners strive to responsibly use their white privilege (see Table 10).

Table 10: Descriptive data on cross-cultural belief of the myth that most perpetrators are unknown by cultural background of service provider (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Cross-cultural belief of myth that most perpetrators are unknown (B.8)										
CALD	3.3	0.9	59	1	5	3.1	1.3	22	1	5
Anglo	2.9	0.6	53	1	4	3.0	0.9	20	1	5
Total	3.1	0.8	112	1	5	3.0	1.1	42	1	5

Relationship with cultural self-efficacy

Table 11 shows that cross-cultural belief of the myth that most perpetrators are unknown and cultural self-efficacy are not really related; all correlations with cultural knowledge, confidence, and sensitivity were not significant. However, observing trends over time are still informative.

Whereas cultural knowledge was more impactful for CALD service providers at T1 regarding their beliefs about cross-cultural prevalence of child sexual abuse and accuracy of prevalence data (RQ2), cultural knowledge was more impactful for Anglo (T1 $r = 0.18$, T2 $r = 0.31$) than CALD (T1 $r = 0.00$, T2 $r = 0.17$) service providers at both T1 and T2 regarding their understanding of cross-cultural belief of the myth that most perpetrators are unknown. This highlights that it is unknown what exactly constitutes as ‘general knowledge about CALD groups’ (B.1) for CALD and Anglo service providers, and therefore what exactly underlies these relationships.

The correlation between cross-cultural belief of the myth that most perpetrators are unknown and cultural confidence was low to moderate for CALD (T1 $r = -0.11$; T2 $r = -0.05$) and Anglo (T1 $r = 0.10$; T2 $r = 0.35$) service providers, but in opposing directions. This indicates that as belief of the myth that most perpetrators are unknown is seen as more likely in CALD communities, CALD service providers’ confidence to work with CALD victims/survivors of child sexual abuse slightly decreases, but Anglo service providers’ confidence slightly increases. This again seems to reflect a deviation from tacit cultural knowledge among CALD service providers, and a gain in explicit cultural knowledge among Anglo service providers.

Finally, the results show that cross-cultural belief of the myth that most perpetrators are unknown does not really affect cultural sensitivity/respect among Anglo service providers (T1 $r = 0.07$, T2 $r = -0.08$), but that at T1 as belief of the myth that most perpetrators are unknown is less likely in CALD communities increases, the less culturally sensitive/respectful CALD service providers are ($r = -0.21$). This is an important finding.

It suggests that CALD service providers tend to believe that CALD communities are more susceptible to this myth, because of the normative reliance on extended family and community in collectivist cultures (and therefore the cultural, not just personal, violation of beliefs about where children are safest), and because of social taboos that prohibit openly discussing any matters to do with sex including abuse (to protect female purity and family honour), but that such knowledge does not ‘excuse’ parents/guardians from lacking accurate knowledge about child sexual abuse, which in turn would allow them to take responsibility for protecting their children from risk of sexual harm. It is consistent with other reported findings that CALD service providers can sometimes be more judgmental of CALD client families because of their cultural knowledge.

However, this changed after the program with the correlation becoming positive ($r = 0.32$), suggestive of an empathic easing of expectations of CALD communities. Indeed, cultural norms that may not intend to minimise responsibility for the protection of children but still have that effect, need to be addressed but within a holistic understanding of the complex interplay between variables relating to culture, migration, and racism.

Qualitative data

Some participants offered important qualitative data regarding the myth that most perpetrators are unknown. For example, one said:

I think that myth about stranger danger being more prevalent [in CALD communities] reflects a time issue. Thirty, forty, fifty years ago, in the Anglo communities, that was a myth, and it's moved on because of community awareness and education (Q&A Forum_Syd).

This comment highlights and fortifies the need for *persistent* awareness-raising campaigns. That is, a search for ‘quick wins’, such as in the form of cost-effectiveness analyses, work against rather than with the protective purpose such myths serve and why they are so difficult to challenge.

Additionally, other participants said:

I believe culture has very strong protective elements to it (Q&A Forum_Bris).

I have confidence in CALD communities that they do protect their kids, they just won't utter a word (Q&A Forum_Adel).

I was just curious if anything came up in the literature around the protective mechanisms of CALD communities around sexual abuse? So my particular community, it's not spoken about but there are rules about who can sleep where, with whom, and why. So you knew, as a kid, what it was about, you just never uttered the

words. I think that's important for us to talk about. There are communities that do quite safe protective parenting and decision making around children, but because the word 'child sexual abuse' is not used, we think it's [protective parenting] not there. It's there, it's just not there in a 'in-your-face' way (Q&A Forum_Syd).

A similar conversation played out a Q&A discussion:

What strategies are there to overcome those (barriers) and invite them into conversation, so that we can get knowledge of what those protective factors are, so that they can be accounted for in decision-making? (Q&A Forum_Adel).

To tell you the truth, the cases I've worked, where the family know me, I don't think we get to the crux of what really happened until years later. So I've had a case since 2006 or 2007, and (only) through getting to know people, they'll be like, "this and this happened, this is why we were all acting like this". So it's trust, it's time. Trust, and community education as much as possible. Communities have champions, people who are real sticklers for child abuse, it's really tapping into those community protections (Q&A Forum_Adel).

These comments importantly highlight that although social taboos prohibit open discussion of matters to do with sex including abuse, this does not mean that unspoken protection is not occurring. It also means that cross-cultural differences in the myth of stranger danger may not be as great as the social taboo might suggest.

Table 11: Correlations between cross-cultural belief of the myth that most perpetrators are unknown and cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1			T2		
	Cultural knowledge	Cultural confidence	Cultural sensitivity	Cultural knowledge	Cultural confidence	Cultural sensitivity
CALD^a						
Cross-cultural belief of the myth that most perpetrators are unknown	0.01	-0.11	-0.21	0.17	-0.05	0.32
Anglo^b						
Cross-cultural belief of the myth that most perpetrators are unknown	0.18	0.10	0.07	0.31	0.35	-0.08
Total^c						
Cross-cultural belief of the myth that most perpetrators are unknown	0.15	0.02	-0.04	0.22	0.13	0.17

* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 59, T2 n = 22; b – T1 50 < n < 53, T2 n = 20; c – T1 109 < n < 112, T2 n = 42.

Summary

- The purpose of RQ3 was to examine whether it effectively imbued service providers with an appreciation that the psychosocial experience of child sexual abuse is not universal; specifically, that belief of the myth that most perpetrators are strangers may be higher in CALD communities because of the collectivist norm valuing the extended family as primary providers of child safety, and maintained by prohibitive social norms discussing sexual matters, even abuse, to protect female and family honour. These two socio-cultural trends may cause parents/guardians in CALD communities to be utterly shocked at and disbelieving of their child's disclosure, which then has implications for whether they offer supportive and protective responses to disclosure, and in turn the well-being of victims/survivors (addressed in RQs 4–8).
- It may not be possible to find valid evidence for whether belief of the myth that most perpetrators are strangers *is* higher in CALD communities, because the many barriers to disclosure that lead to silence and under-reporting compromise capacity to obtain representative data and therefore verify such a trend with confidence. Rigorous qualitative data may be able to identify a link between belief of this myth, responses to disclosure, and mental health among CALD victims/survivors of child sexual abuse and their families and communities, but it risks vilifying collectivist cultures, minimising the trauma of non-CALD victims/survivors and their families and communities, and inviting racist government intervention.
- In this study, only change over time in the number of service providers who thought that belief of this myth was cross-culturally equal was examined. Supporting evidence was found for both CALD and Anglo service providers, demonstrating the effectiveness of the program in challenging assumptions of universality. However, service providers did not just move toward believing that this myth is more likely or significantly more likely in CALD communities; some also thought that it was less or significantly less at T2. This latter finding was not predicted, and is difficult to explain, because it is inconsistent with the intention of the program.
- Prior to program delivery, more CALD than Anglo service providers thought that belief of this myth was more likely or significantly more likely in CALD communities. This could reflect the tacit cultural knowledge of CALD service providers, and/or fear among Anglo service providers to appear 'colour blind' as a way of using white privilege responsibly.
- Correlations between cross-cultural equivalence in belief of this myth and cultural self-efficacy were low to moderate and not significant, indicating they are not really related. However, three observed trends among the correlations are potentially informative.

- The first is that cultural knowledge was more impactful for Anglo than CALD service providers regarding their cross-cultural equivalence in belief of the myth that most perpetrators are unknown, however it is unclear what specific cultural knowledge underlies this relationship.
- Secondly, as belief of the myth that most perpetrators are unknown is less likely in CALD communities increases, CALD service providers' confidence to work with CALD victims/survivors of child sexual abuse slightly decreases, but Anglo service providers' confidence slightly increases. This seems to reflect a deviation from tacit cultural knowledge among CALD service providers, and a gain in explicit cultural knowledge among Anglo service providers, as a result of the program.
- Finally, as belief of the myth that most perpetrators are unknown is more likely in CALD communities increases at T1, CALD service providers' cultural sensitivity/respect decreases. This suggests that because of their tacit cultural knowledge, CALD service providers can sometimes be more judgmental of CALD client families. Specifically, cultural knowledge and understanding are not seen as valid reasons for lacking accurate knowledge about child sexual abuse, which in turn increases ability to take community responsibility for the protection of children from risk of sexual harm. By T2, the program seemed to have imbued CALD service providers with an easing of judgement within a holistic context that takes into account the complex interplay of culture, migration, and racism.
- Overall, there is a need for *persistent* national awareness-raising campaigns against the myth of stranger danger because this myth serves a protective function in all communities about perceptions of where children are and are not safe.
- Child protection from potential intra-familial perpetrators may also be occurring within CALD communities in an unspoken way, and further research on such protective parenting is required.

RQ4: Do service providers more appreciate that there may be cross-cultural differences in belief of myths about child sexual abuse that shift culpability to the victim?

Background and rationale

Myths shift culpability to the victim

The CSAMS does not assess all myths about child sexual abuse (Cromer & Goldsmith, 2010), but is a reliable and valid measure designed to assess “false or overgeneralised beliefs that create a climate hostile to victims” (Collings, 1997, p. 672); attitudes that “effectively condone, justify, or excuse sexual assault” (Collings et al., 2009, p. 9). Extensive research has shown that acceptance²³ of myths about child sexual abuse is associated with increased attributions of blame to victims and decreased perceptions of offender culpability (Collings, 1997).

Cross-cultural differences, limitations of research, and implications for mental health

Only one study examining the cross-cultural validity of the CSAMS was identified (Collings et al., 2009), indicating that it is not currently known if cultures differ in their beliefs of myths about child sexual abuse and therefore the extent to which they may be ‘victim-blaming’. The authors themselves note the paucity of work in this area, saying:

There has been no systematic attempt to examine the extent to which the instrument provides an adequate measure (of belief of myths about child sexual abuse) across

²³ The literature uses the phrase ‘*acceptance* of myths about child sexual abuse’, however this project has chosen to use the phrase ‘*belief* of myths about child sexual abuse’ to help acknowledge that endorsement is not always conscious. The word ‘accept’ could imply that a person has first considered a myth but then still agrees with it, and therefore does not allow for unconscious cognitive errors relating to attributions of culpability. For example, if a child places herself at risk of revictimisation out of fear of the perpetrator for not complying with demands to make herself available again, others may see that the revictimisation is her fault and therefore less the perpetrator’s. Perceptions of culpability relate to a normal human cognitive error of over-estimating another person’s sense of agency (including a child’s) within any (traumatising and power-abusing) circumstance (Sawrikar, 2018c). The phrase ‘acceptance of myths about child sexual abuse’ has only been used in this project when citing other literature.

different national or cultural groups. The omission is surprising in light of findings which indicate marked cross-cultural differences in attitudes towards important social issues ... Westerners typically view the self as autonomous and independent, find self-relevance primarily in self-enhancing opportunities, and emphasise dispositional characteristics (when making causal attributions of social behaviour), and Easterners typically view the self as interdependent and grounded in social interrelationships, find self-relevance primarily in self-criticism opportunities, and emphasise social or situational explanations of social behaviour (p. 10).

Interestingly, in this preliminary investigation of three countries, it was found that for the South African sample (94% black African, $n = 200$), the mean score for males was 33.58 and for females 29.97; for the South Korean sample (100% Asian, $n = 200$), the mean score for males was 38.79 and for females 36.19; and for the Swedish sample (100% Caucasian, $n = 200$), the mean score for males was 25.99 and for females 19.71. It was also found that in the South Korean sample, 180 respondents (90%) “strongly agreed” with one or more of the 15 items on the scale, whereas there were 149 such respondents (74.5%) in the South African sample and only 70 respondents (35%) in the Swedish sample.

These descriptive statistics point to a possibility that Easterners are more believing of myths about child sexual abuse than Westerners. However, Collings et al. (2009) caution against such an inference because the results of the factor analyses showed that child sexual abuse is conceptualised across cultures in incomparable ways. Specifically, the items loading onto each factor, the ensuing names assigned to each factor, and the amount of variance each factor accounted for, differed such that there was no real resemblance or overlap between the three groups.

In the South African sample, Factor 1 (Blame Diffusion) accounted for 15.9% of the variance and was comprised of items 6, 9, 10, 11, and 14; Factor 2 (Denial of Abusiveness) accounted for 15.1% of the variance and was comprised of items 1, 2, 4, 5, and 15; and Factor 3 (Restrictive Stereotypes) accounted for 11.5% of the variance and was comprised of items 3, 7, 8, 12, and 13. In the South Korean sample, Factor 1 (Social Responsibility) accounted for 21.0% of the variance and was comprised of items 3, 6, 7, 8, and 13; Factor 2 (Child Responsibility) accounted for 10.5% of the variance and was comprised of items 4, 9, 10, 11, 14 and 15; and Factor 3 (Denial of Harm) accounted for 8.9% of the variance and was comprised of items 1, 2, 5 and 12. In the Swedish sample, Factor 1 (Sexual Mutuality) accounted for 37.7% of the variance and was comprised of items 1, 2, 4, 5, 9, 12, and 15; Factor 2 (Family Responsibility) accounted for 8.9% of the variance and was comprised of items 3, 5, 6, 10, 11, 12, and 14; and Factor 3 (Social Responsibility) accounted for 8.2% of the variance and was comprised of items 3, 7, and 13.

Because of the lack of construct comparability, score comparability becomes invalid. Thus, more research in the area is required, however similar obstacles may be encountered: there is a universality in the experience of child sexual abuse which warrants and permits cross-cultural comparisons, but *attitudes* about child sexual abuse especially in relation to how much the victim is seen to be at fault may be too culture-specific to allow cross-cultural comparisons to be made with confidence.

Assuming it is possible to find evidence that belief of myths is greater in collectivist cultures, then the processes of fear of not being believed, increased self-blaming when the fear is affirmed with non-supportive and protective responses to disclosure from carers, and severe mental ill-health – already identified in the Western-based literature – could be intensified in CALD communities. When the ‘collectivist’ lens is overlaid on these processes, prohibitive social norms discussing sexual matters and an utmost need to protect family reputation which can then lead to a de-prioritising of the individual victim’s need for support and protection, could intensify it again; qualitatively, quantitatively, or both. CALD groups additionally experience many barriers to formal services, even if this was a supportive and protective response that carers considered taking up for their child and/or themselves.

For all these reasons, there is a chance that the proportion of CALD victims/survivors of child sexual abuse who experience severe mental illness is higher than non-CALD victims/survivors and/or that their symptoms are worse. Again, such a possibility does not warrant greater intervention from the state but rather greater support from services. It also does not negate the severity of the consequences of child sexual abuse in non-CALD victims/survivors because (in this project) all victims/survivors are equally valued. It is description and understanding of their unique psychosocial experience that is being pursued so that support services are appropriately tailored.

Selecting exemplars

The work of Cromer and Goldsmith (2010) shows that there are five types of myths about child sexual abuse: (i) those that minimise the extent of harm posed to victims, (ii) those that minimise the prevalence of child sexual abuse, (iii) those that blame the victim or others (e.g. non-offending mothers), (iv) stereotypes about perpetrators, and (v) stereotypes about child sexual abuse itself. All myths can serve to make it difficult to believe a child’s disclosure, which then has implications for (legal processes in which juror attitudes and beliefs influence trial outcomes – not of focus in this study, and) psychological processes in which victims’ likelihood of self-blame and therefore mental ill-health are affected. Although there is no data in the current literature to empirically support it, these myths are likely to be correlated with each other, so ‘victim-blaming’ beliefs may be higher among those who also believe the other myth types.

For the purposes of this evaluation study, where brevity was critical, two exemplar items were selected for the question examining service providers' beliefs about cross-cultural belief of myths that shift culpability to the victim: 'Adolescent girls who wear very revealing clothing are asking to be sexually abused' (Q10) and 'Children who do not report ongoing sexual abuse must want the sexual contact to continue' (Q14). In the study by Collings et al. (2009), these items loaded onto Factor 1 (Blame Diffusion) for the South African sample, Factor 2 (Child Responsibility) for the South Korean sample, and Factor 3 (Family Responsibility) for the Swedish sample. The findings show that 'victim blaming' is not independent of 'offender or other blaming'; they are negatively correlated – the more victim-blaming a person is, the less offender-blaming they are. Thus, all myths about child sexual abuse could in some directly or indirectly causal way shift culpability to the victim. Structural equation modelling on a large nationally representative longitudinal data set collected using rigorous methods would be required to explore this possibility empirically. Here, the argument is being made that any two exemplar items could have been selected for the evaluation study.

Summary (including barriers to formal services)

Figure 6 summarises the hypothesised relationships between belief of myths that shift culpability to the victim and severe mental ill-health among CALD victims/survivors of child sexual abuse. It begins with the suggestion that all myths about child sexual abuse have the capacity to shift culpability to the victim to a greater or lesser extent; essentially reflecting "the climate of hostility to victims" (Collings, 1997).

Belief of myths could be higher in CALD communities because emphasis on social relatedness might mean that more blame for child sexual abuse is assigned to "social problems such as unemployment, poverty, and alcohol abuse" (Q13 CSAMS) or "poor, disorganised, unstable families" (Q7 CSAMS) – a finding in the Eastern South Korean sample of the study by Collings et al. (2009), and contrary to the findings of Cromer (2006) where less than 10% of participants (college students in the US) agreed with these statements. Blaming 'bad families' makes sense within the collectivist framework, and aids in indirectly shifting culpability away from the perpetrator and toward the victim. In counter-argument, belief of myths that shift culpability to the victim could be higher in 'individualistic' cultures because of the emphasis on the dispositional characteristics of individuals when making attributions about social behaviour. That is, 'something about the victim has caused the crime to occur'. Thus, vastly different reasons may underlie cross-cultural belief of myths about child sexual abuse, and therefore it may not be possible to identify whether they are greater in collectivist than individualistic cultures.

In collectivist cultures, norms prohibiting discussion on matters to do with sex reflect value for a woman's virginal purity, which may also be related to the extent to which significant males (e.g. fathers, brothers, etc.) are able to protect the sexual honour of women. These norms are higher in overtly patriarchal cultures (Sawrikar, 2018). When even sexual assault is not openly discussed because it then denotes the lack of a woman's sexual purity and therefore tarnishes men's honour and the family name, it becomes particularly challenging to debunk myths that shift culpability to the victim.

The psychological process of interpreting the self as blameworthy for the crime and experiencing fear of not being believed upon disclosure is cross-culturally universal, as is the tendency for primary carers (usually the mother) to respond to their child's disclosure in ways that are not supportive or protective (e.g. believing the disclosure, providing informal emotional support, accessing formal services, and/or preventing opportunity for the perpetrator to re-victimise the child) because it can suggest she has failed in her responsibility to protect the child. However, within the collectivist lens, carers are likely to be driven by an utmost need to keep the family together at all costs and therefore protect family reputation, thereby intensifying non-supportive and protective responses. That is, the needs of the individual victim are de-prioritised to the needs of the family.

If a CALD carer does wish to access formal support services they may still need to overcome a range of barriers, grouped here into three types: non-cultural, migratory/aculturative, and cultural. Non-cultural barriers occur for people from all cultural backgrounds, migratory/aculturative barriers occur for CALD groups but do not 'belong' to them, and cultural barriers do not just occur after migration.

Three types of non-cultural barriers are identified. The first is lack of awareness of services, which occurs because people are unlikely to know what is available in the local community unless there is a need for it (Allimant & Ostapiej-Piatkowski, 2011). However, this barrier could interact with the migratory barrier of low English proficiency and cultural barrier of shame for seeking support from outside of the family for CALD groups, and so is not wholly a non-cultural barrier for them.

Another non-cultural barrier is lack of worthiness and wanting to forget. As Mathews et al. (2013) say, "victims may not see themselves as deserving of formal help due to low self-esteem or self-blame. They may also fear being 'taken back' to events they want to 'forget' in the therapeutic process. Caretakers may also want the child to forget about the abuse, move on, and not talk about it" (p. 651).

Finally, fear of children being removed may prevent all families from accessing formal services. However for CALD families, fear of authorities is heightened because of poor experiences in the country of origin such as abuses of power by police (Taylor & Putt, 2007)

or collectivist value for deference to hierarchical authorities (Sawrikar, 2018). If a CALD family does access services, it is critical that they are aware that service providers are mandatory reporters, that not all children who are sexually abused are removed from the home (many factors are involved in this decision), and that after assessment a child protection worker may recommend formal service uptake to demonstrate supportive and protective responses for the victimised child. Thus, again, this ‘non-cultural’ barrier can interact with migratory and cultural factors making it not wholly non-cultural for CALD communities.

Two types of migratory/aculturative barriers are identified. The first is fear of deportation. If CALD victims believe that seeking professional help will endanger their immigration status, then they are not likely to access it (Allimant & Ostapiej-Piatkowski, 2011). The second barrier is low English proficiency (which only occurs after migration). If interpreters or bilingual staff are seen to not be available, then this compromises good practice with CALD families (Sawrikar, 2015).

Finally, three cultural barriers are identified. The first is fatalistic or religious beliefs. For example, some groups may not utilise mental health services because of a fatalism inherent in the religious belief that ‘God is the cause of all that is’ (Haboush & Alyan, 2013). Some groups may also seek help from spiritual leaders instead of Western-based formal services, and so have their needs for support met within that religious context (Kanukollu & Mahalingam, 2011).

Another cultural barrier to formal service uptake is normative reliance on the family for emotional support. In fact, “the idea of seeking help from strangers could be quite strange and bewildering to them” (Nesci, 2006, p. 44). There is also, in Western psychotherapies, a focus on the individual paying attention to themselves – their thoughts and feelings – for emotional insight, which then in turn asks for value for the self, honest disclosures, and an ability to be verbally expressive. These may go against Eastern values placed on showing deference, respect, and obedience to the superior (in this case, the therapist) – especially if they are older and male to maintain hierarchical expectations, and keep disagreements and any negative feelings to themselves to demonstrate emotional control that maintains social harmony (Kanukollu & Mahalingam, 2011).

Thirdly, there is the issue of shame for seeking support outside of the family. Doing so may be seen as a sign of weakness, and it goes against cultural values for self-control, suffering, and perseverance in the face of adversity (Futa et al., 2001). While shame for seeking help is also a barrier in Anglo populations, that shame extends to all members of the family in CALD collectivist cultures. For this reason, some women have reported they would rather be killed than have their experiences and contact with a sexual assault service publicly disclosed in the community (Allimant & Ostapiej-Piatkowski, 2011).

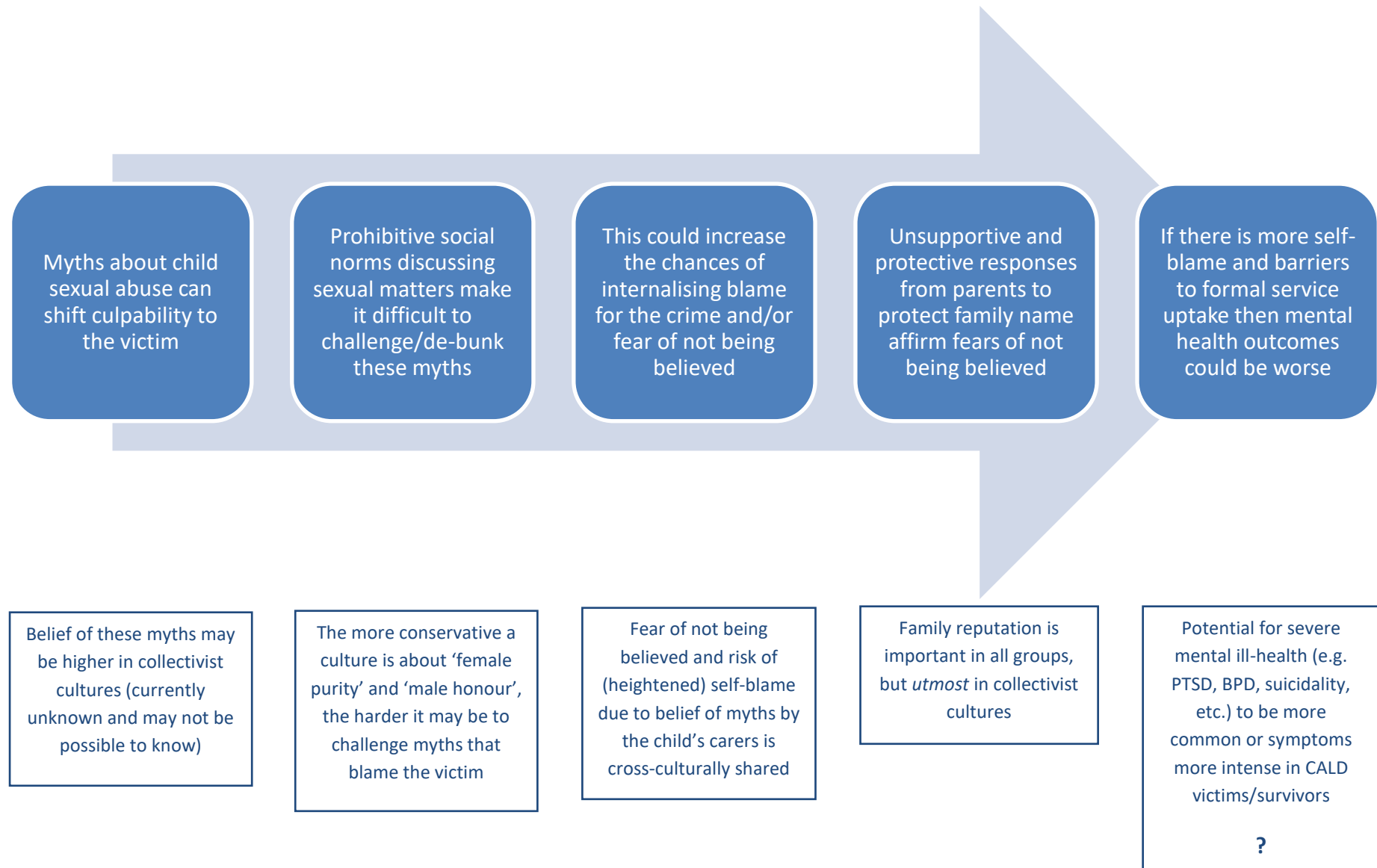
While acknowledging that formal services are not essential to becoming a resilient, empowered survivor (addressed in more depth in RQ7), they do offer a critical opportunity for victims/survivors to not remain isolated in their trauma and its effect on their mental well-being. Sharing the trauma and developing skills and strategies on managing any mental ill-health have the capacity to reduce the intensity of symptoms (Cromer & Goldsmith, 2010).

In short, the aim of this study was not to find empirical evidence for the possibility that CALD groups may be more believing of myths about child sexual abuse that shift culpability to the victim (especially since it may not even be possible), and therefore a possible link to even worse mental ill-health (intensity of symptoms or number of victims with severe mental illness). Instead, the aim was to imbue service providers with an appreciation that there *may* be cross-cultural differences in belief of such myths because the psychosocial experience of child sexual abuse is not universal, and that collectivism, patriarchy, and migration would have a role in explaining why.

Measures

Program attendees were asked one question in relation to RQ4: *B.9* – ‘One effect of myths about child sexual abuse is that they can shift culpability (i.e. blameworthiness) from the perpetrator to the victim. Two examples of such myths are: (i) “Adolescent girls who wear very revealing clothing are asking to be sexually abused”, and (ii) “Children who do not report ongoing sexual abuse must want the sexual contact to continue”. Compared to Western populations (e.g. Anglo Australians), do you think CALD communities are:’ Options varied from 1 = Significantly less likely to believe myths about child sexual abuse that shift culpability to the victim, 2 = Less likely to believe myths about child sexual abuse that shift culpability to the victim, 3 = Equally likely to believe myths about child sexual abuse that shift culpability to the victim, 4 = More likely to believe myths about child sexual abuse that shift culpability to the victim, and 5 = Significantly more likely to believe myths about child sexual abuse that shift culpability to the victim.

Figure 6: Summary of hypothesised relationships between myths that shift culpability to the victim and severe mental ill-health among CALD communities



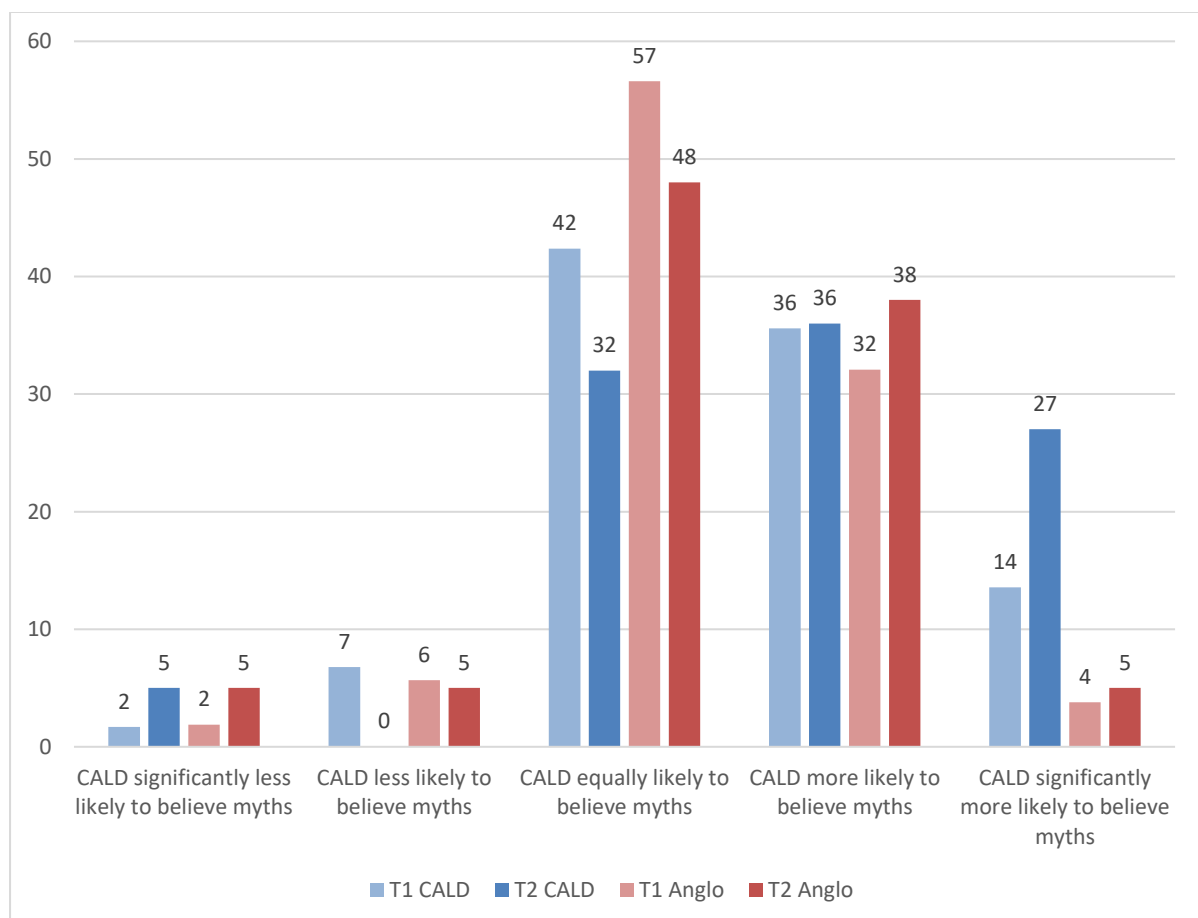
Changes over time

Cross-cultural belief of myths that shift culpability to the victim

By cultural background of service provider

As can be seen from Figure 7 (and Data Table G.4), the proportion of CALD service providers who thought that belief of myths about child sexual abuse that shift culpability to the victim is cross-culturally equivalent decreased from T1 (42%, n = 25) to T2 (32%, n = 7), as it did for Anglo service providers from T1 (57%, n = 30) to T2 (48%, n = 10). Notably, the proportion of Anglo service providers is higher than CALD service providers at both T1 and T2. This suggests a tendency toward assumptions of universality in experience among Anglo service providers and/or a need for them to appear ‘colour blind’. It is consistent with the means (see Table 12), which show no movement on this item among Anglo service providers from T1 to T2 (M = 3.3).

Figure 7: Percentage distribution on cross-cultural belief of myths that shift culpability to the victim by cultural background of service provider (T1 and T2)



The proportion of CALD service providers who thought that CALD communities are significantly more likely to believe myths about child sexual abuse that shift culpability to the victim increased from T1 (14%, n = 8) to T2 (27%, n = 6), as it slightly did for Anglo service providers from T1 (4%, n = 2) to T2 (5%, n = 1). Notably, the proportion of CALD service providers is higher than Anglo service providers at both T1 and T2. This likely reflects tacit cultural knowledge among CALD service providers. It is consistent with the means (see Table 12), which are higher than Anglo service providers at T1 (CALD M = 3.5, Anglo M = 3.3) and T2 (CALD M = 3.8, Anglo M = 3.3).

Interestingly, the proportion of CALD service providers who thought that CALD communities are more likely to believe myths about child sexual abuse that shift culpability to the victim did not really increase from T1 (36%, n = 21) to T2 (36%, n = 8), nor for Anglo service providers from T1 (32%, n = 17) to T2 (38%, n = 8). This suggests that there is already knowledge among all service providers that CALD communities may be more believing of myths that shift culpability to the victim.

Overall, these changes over time suggest that as a result of the program, service providers are engaging more with cross-cultural differences in the psychosocial experience of child sexual abuse, and so are less likely to universalise it as if it were essentially the same for all victims/survivors. That is, leanings toward cross-cultural equivalence lessen after the program, with service providers more appreciating that CALD communities may be more likely to believe myths that shift culpability to the victim.

Table 12: Descriptive data on cross-cultural belief of myths that shift culpability to the victim by cultural background of service provider (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Cross-cultural belief of myths that shift culpability to victim (B.9)										
CALD	3.5	0.9	59	1	5	3.8	1.0	22	1	5
Anglo	3.3	0.7	53	1	5	3.3	0.9	21	1	5
Total	3.4	0.8	112	1	5	3.6	1.0	43	1	5

Relationship with cultural self-efficacy

As can be seen from Table 13, the correlation between cross-cultural belief of myths that shift culpability to the victim and cultural knowledge, confidence, and sensitivity were not significant and all close to zero at T1. At first glance, these results suggest assumptions of universality among all service providers; the independence of cultural self-efficacy indicates that prior to program delivery practitioners were not aware that there may be cross-cultural

differences in belief of myths that shift culpability to the victim. However, the frequency and descriptive data counters this, showing that service providers do have some cultural knowledge regarding this. Thus, the lack of association is more likely to suggest that this practice wisdom does not translate into conscious self-ratings of cultural self-efficacy.

At T2, the correlations remained not significant but did increase in strength. Two trends across time are particularly noted. The first is that for both CALD (T1 $r = 0.02$, T2 $r = 0.19$) and Anglo (T1 $r = -0.05$, T2 $r = 0.18$) service providers, confidence to work with CALD victims/survivors increased after attending the program the more they thought CALD communities were more likely to believe myths that shift culpability to the victim. This finding supports the effectiveness of the program in relation to RQ3; imbuing service providers with an appreciation that there may be cross-cultural differences in belief of myths that shift culpability to the victim.

The second observation was for CALD service providers at T2 ($r = -0.24$); after attending the program, the more they thought CALD communities were more likely to believe myths that shift culpability to the victim, the more cultural sensitivity/respect decreased. Similar to previous findings in this study, this result demonstrates a tendency toward higher judgment of CALD communities by CALD service providers. Combined with the concurrently opposing result of high empathy for CALD communities among CALD service providers, the results tell a larger story of internal conflict. This conflict is marked by both a greater expectation for CALD communities to take self-determined responsibility and disappointment when this fails to occur, with empathy for their people and the barriers they face which make such self-determination difficult if not impossible.

Qualitative data

All qualitative data relating to cross-cultural belief of myths (RQs 3, 4) includes:

(Liked best?) Debunking myth (Satisfaction Survey_18).

Good refresher on the myths etc. (Satisfaction Survey_78).

(Liked best?) Review myths in CSA (Satisfaction Survey_42).

(Liked best?) Providing and discussing myths (Satisfaction Survey_1).

(Liked best?) Myth connection and link to CALD community (Satisfaction Survey_57).

(Liked best?) Further explanation around sexual assault myths in CALD communities – great explanation (Satisfaction Survey_40).

Dispelling the myths of child sexual abuse is paramount to making the male perpetrator accountable (Satisfaction Survey_52).

It helped reaffirm my knowledge – we work as a specialist service which services diverse communities and so need to respectfully challenge myths and unhelpful beliefs which people state are ‘cultural’ (Follow up Survey_34).

It’ll be interesting to see the Royal Commission, and the issues of what’s coming out of the Catholic Church, and the impact of sexual abuse, whether that’s a driver for communities exploring what child sexual abuse actually is in terms of the myths (Q&A Forum_Syd).

Table 13: Correlations between cross-cultural belief of myths that shift culpability to the victim and cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1			T2		
	Cultural knowledge	Cultural confidence	Cultural sensitivity	Cultural knowledge	Cultural confidence	Cultural sensitivity
CALD^a						
Cross-cultural belief of myths that culpability to the victim	0.01	0.02	-0.02	0.06	0.19	-0.24
Anglo^b						
Cross-cultural belief of myths that culpability to the victim	-0.01	-0.05	-0.04	0.10	0.18	0.04
Total^c						
Cross-cultural belief of myths that culpability to the victim	0.06	0.03	0.01	0.15	0.25	-0.04

* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 59, T2 n = 22; b – T1 50 < n < 53, T2 n = 21; c – T1 109 < n < 112, T2 n = 43.

Summary

- Myths about child sexual abuse refer to false or overgeneralised beliefs. The more they are believed by others, the more victims are seen to be at fault for the crime rather than the perpetrator. This then has implications for the mental health trajectory of victims. Specifically, myths about child sexual abuse create a hostile climate for victims which increase their fear of not being believed and/or likelihood of self-blaming. If these are affirmed with non-supportive and protective responses to disclosure from carers, it becomes associated with severe mental ill-health.
- It is not currently known if there *are* cross-cultural differences in belief of myths about child sexual abuse, and therefore differences in ‘victim-blaming’ and severity of mental ill-health, because extensive research in the area has not been conducted to date. However, it may not be possible to make such cross-cultural comparisons because differences between Western cultures that value autonomy and independence and Eastern cultures that value social relatedness and interdependence, may create very different attributions about culpability. Thus, there is some universality in the psychosocial experience of child sexual abuse which warrants and permits cross-cultural comparisons, but there are also limits that compromise making such comparisons with confidence.
- After accounting for this limitation, there is still a possibility that victim-blaming and therefore severity of mental ill-health among victims is higher in collectivist cultures, which needs to be acknowledged. Such a possibility does not warrant greater intervention from the state but rather greater support from services, and is being acknowledged in the spirit that unique cross-cultural descriptions and understandings of experience allow support services to be appropriately tailored. It is not being put forward to minimise the severity of consequences of child sexual abuse among non-CALD victims/survivors.
- The heightened risk of victim-blaming in collectivist cultures is brought about because of prohibitive social norms on discussing any sexual matters including abuse, to protect female purity and male honour and therefore family reputation. This in turn makes conversations that strive to at least challenge but at best debunk myths about child sexual abuse near impossible.
- The heightened risk of severe mental ill-health among CALD victims is brought about by a de-prioritising of the individual’s needs to those of the family (namely, keeping the family intact and therefore protecting its reputation at all costs), as well as barriers to formal help-seeking which could assist with alleviating the symptoms of mental ill-health.

- Barriers may be non-cultural, migratory/acculturative, and/or cultural in nature. Non-cultural barriers include lack of awareness of services, lack of worthiness and wanting to forget, and fear of children being removed. Migratory/acculturative barriers include fear of deportation and low English proficiency. Cultural barriers include fatalistic or religious beliefs, normative reliance on family for emotional support, and shame for seeking extra-familial support.
- Thus, the purpose of RQ4 was to examine whether it effectively imbued service providers with an appreciation that the psychosocial experience of child sexual abuse is not universal; belief of myths that shift culpability to the victim, and therefore severe mental ill-health, may be higher in CALD communities due to the roles of collectivism, patriarchy, and migration.
- In this study, only change over time in the number of service providers who thought that belief of myths that shift culpability to the victim was cross-culturally equal was examined. Supporting evidence was found for both CALD and Anglo service providers, demonstrating the effectiveness of the program in challenging assumptions of universality; by T2, less service providers thought that belief of myths that shift culpability to the victim is cross-culturally equal, and more service providers thought that they were significantly more likely in CALD communities.
- Due to practice wisdom (and tacit cultural knowledge among CALD service providers), both CALD and Anglo service providers believe that CALD communities are more likely to believe myths about child sexual abuse that shift culpability to the victim.
- However, Anglo service providers may lean toward reporting cross-cultural equivalence in belief of myths that shift culpability to the victim as an attempt to use white privilege responsibly, with the effect of appearing ‘colour blind’ and therefore universalising the psychosocial experience of child sexual abuse across cultures.
- Indeed, service providers seemed to lack confidence in their practice wisdom, leading to a lack of association with cultural self-efficacy, with the program affirming their knowledge and therefore confidence to work with CALD victims/survivors.
- Thus, it seems that service providers already appreciate that there are cross-cultural differences in belief of myths that shift culpability to the victim, but that the program content – explicitly discussing and linking myths to culture – gives ‘permission’ to acknowledge it.
- The most troubling finding was for CALD service providers, for whom across all the results of the study thus far, show a deep internal conflict marked by juxtaposed disappointment with and understanding of the strengths and needs of their culture and the responsibilities and barriers faced by their cultural group.

RQ5: Do service providers more appreciate the need for cultural self-awareness to help take responsibility for racial power?

Background and rationale

Fundamental Attribution Error (FAE) and white privilege

Service providers may believe that most or all barriers to disclosure and uptake of formal services among CALD victims/survivors of child sexual abuse are ‘cultural’ (and so belong to the group), rather than also taking into account ‘non-cultural’ factors (which are shared cross-culturally), or confusing cultural factors with ‘migratory’ ones (which occur for CALD groups but only *after* migration, including racism). Failing to take into account cross-cultural similarities (which should neither be over- nor under-stated), or understanding racialised power dynamics in broader white-majority society (in which a CALD individual exists and manages pressures to assimilate and cede authentic identity), carry the effect of localising understanding *of* the client *to* the client; ‘everything about CALD groups is cultural, so it is something about them that explains them’.

This cognitive bias reflects the fundamental attribution error (FAE; Ross, 1977), in which causal reasoning for a behaviour is tipped toward dispositional factors (i.e. characteristics of the person) even when situational factors in the external environment are clear causal contenders (Vaughan & Hogg, 2002). Research has long ago also shown that the FAE is more prevalent in Western/individualistic societies (Miller, 1984), because of the personal agency (valued and) bestowed with having the right and responsibility to be independent, autonomous, and self-sufficient.

Thus, if Anglo Australian service providers fail to appreciate that in the dyadic clinical relationship, the CALD client is seeking and receiving services from a perceived representative (consciously or otherwise) of that white-majority society in which their ethnic group has lower power (social, cultural, economic, and political; Giddens 1997), then there is a risk that those professionals may not be aware of and therefore take responsibility for their racial power inherited from Anglo Australian group membership. That is, if a professionals’ understanding of Australian racial politics excludes the role of group-level power, solely focuses on individual prejudices as the cause of racism, makes every effort to work with all clients in a non-racist way, and therefore believes that race is not really a critical variable to

be aware of in the clinical setting, then an unintended abuse of racial power could occur. As Fontes and Plummer (2010) write, “cultural humility refers to self-awareness and habits of self-reflection (Tervalon & Murray-García, 1998) ... (that are critical for good practice because) even when professionals are unaware of (racial) biases and assumptions, clients often perceive them (Perez Foster, 1999)” (p. 509).

Professional differences, client differences, and ethnic-matching

Social workers receive education in their curricular on social justice and therefore sociological conceptualisations of racism. Within the discipline of sociology, racism is defined as the combination of prejudice plus power and therefore does not only discuss prejudicial cognition the way the discipline of psychology does. Thus, there is a risk that psychologists miss vital education on understanding CALD clients as ‘ethnic minorities’ in Australia. Medical practitioners such as GPs and psychiatrists may also miss the vital education psychologists receive about cognitive errors that lead to racial prejudice.

At the same time, CALD client victims/survivors may be seeking Anglo Australian service providers precisely for their assumed *lack* of cultural knowledge and self-awareness; it could be perceived as the vehicle to being treated as just a person like any other, with no special knowledge or accommodations required or wanted. Indeed, with greater knowledge come more questions, so lack of racial awareness can also simplify the clinical setting rendering it more effective.

CALD client victims/survivors, like any other group of clients, will be diverse in their needs and expectations about services. For this reason, racial self-awareness by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as group-level power inherited from group membership and therefore independent of personal cognitions, was seen in this project to enhance the quality of services but not essential for them to meet basic needs in the clinical setting with CALD victims/survivors.

Research has shown that there is a tendency for CALD service providers to be seen as best placed to engage with CALD clients because they will have tacit cultural knowledge that allows them to better understand ‘where they are coming from’ (Sawrikar, 2013). While racial similarity does increase empathy because of biased stereotypes socialised for different others (Xu, Zuo, Wang, & Han, 2009), it can also increase judgement or risk of harm. For example, (especially male) interpreters may abuse their power and tell (especially female) victims of DFV to return to their spouse and spare family shame (Sawrikar, 2015). Feared breaches of confidentiality with CALD service providers, in turn threatening community standing, are a substantial barrier to service uptake, and can lead CALD victims/survivors to seek what they see as a culturally neutral and therefore safe space with an Anglo Australian. Thus, CALD clients will not necessarily want an ethnically-matched service provider, leading

to an onus for the whole Australian mental health and sexual assault workforce to be trained in cultural competency and not just leave ‘CALD matters’ to CALD workers.

In short, all service providers have different and expert knowledge that together allows them to meet the diverse range of needs CALD victims/survivors may present with. Those that are clinically unwell can benefit from liaising with a psychiatrist with the professional power to administer appropriate medications. GPs are an appropriate point of referral to psychiatrists, psychologists, social workers, and counselors, all of whom work to talk through and share trauma with the aim of reducing the symptoms of emotional distress. Good engagement with a GP also has the power to act as a sign of good engagement with other professionals whose work encompasses recovery from sexual assault. All services providers differ in the extent to which they receive education in social justice, and this may sometimes be of benefit to CALD victims/survivors and at other times not. However, this project errs on the side that while ‘ignorance may be bliss’ it is also dangerous; it is better to have cultural and racial self-awareness and use it accordingly than to not have it and risk adding to abuses of power already incurred by the victim and therefore good clinical outcomes. As the education program was not centrally about ‘white privilege’²⁴, it only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program.

Measures

Program attendees were asked two questions in relation to RQ5. The first was, *B.3* – ‘How self-aware of your own cultural background do you feel you are?’ with options varying from 1 = Not at all to 5 = Completely. The second question was, *B.5* – ‘Have you ever heard of the phrase ‘white privilege’?’ with options Yes or No.

Changes over time

Cultural self-awareness

By cultural background of service provider

As can be seen from Table 14, scores on cultural self-awareness only marginally increased for CALD service providers from T1 (M = 4.2) to T2 (M = 4.4), and for Anglo service providers from T1 (M = 3.9) to T2 (M = 4.1). These lack of substantial changes over time

²⁴ In the literature, ‘white privilege’ can sometimes be capitalised and an author’s choice warrants consideration and explanation. In this project, the lower case ‘w’ has been selected to denote skin colour not race. By analogy, ‘Black’ is not a race, ‘black’ is a skin colour. It also works within a decolonial framework, removing the power of a capital letter.

indicate that cultural self-awareness is already high among all relevant service providers, and therefore that the program was not likely to be effective in improving it. Indeed, scores were significantly lower for Anglo than CALD service providers at T1 ($t(109) = 2.82, p < 0.01$) but not by a great margin, and not significantly different at T2 ($t(42) = 1.56, p > 0.05$).

On the other hand, had medical practitioners such as GPs and psychiatrists been involved in the evaluation study, differences between service provider types ('medicos' cf. 'non-medicos') may have been observed. Specifically, improvements in cultural self-awareness may have been observed among medicos as a result of taking part in the program, thereby demonstrating its effectiveness on this necessary component of being able to provide services in ways that responsibly use racial power. Arguably, counselors and social workers, and then psychologists or other indirectly related professionals, are likely to receive training in social justice in their curricular and/or daily work practice and therefore their need of exposure to such information is lower than for medical practitioners.

Table 14: Descriptive data on cultural self-awareness by cultural background of service provider (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Cultural self-awareness (B.3)										
CALD	4.2	0.7	58	3	5	4.4	0.6	23	3	5
Anglo	3.9	0.7	53	2	5	4.1	0.6	21	3	5
Total	4.1	0.7	111	2	5	4.3	0.6	44	3	5

Relationship with cultural self-efficacy

The correlations between cultural self-awareness and cultural self-efficacy (knowledge, confidence, and sensitivity) are in Table 15. They show that for both CALD and Anglo service providers, the correlations were moderate and positive (if not significant) at both T1 ($0.13 < r < 0.45^{***}$) and T2 ($0.18 < r < 0.53^{***}$). Thus, independent of the program but as expected, service providers increased on their self-rated cultural self-awareness as they increased on their self-rated cultural knowledge, confidence, and sensitivity. Importantly, it is not clear if or to what extent *cultural* self-awareness reflects *racial* self-awareness.

Qualitative data

Qualitative data about the program promoting cultural self-awareness was not extensive, perhaps because it is already high among this service provider group. Still, important and relevant comments were obtained:

Excellent information re importance of family reputation and racism to disclosing CSA (Satisfaction Survey_15).

Great opportunity to reflect about my own understanding (of) cultural competency and racism (Satisfaction Survey_61).

(Liked best?) Awareness and reflection of white privilege and power, important to reflect on this (Satisfaction Survey_99).

Excellent to see sociological approach to working with CALD communities, revisiting and highlighting the importance of white privilege. Thanks very much for valuable and needed contributions to practice in this field (Satisfaction Survey_88).

Great presentation, glad to see patriarchy in the mix and mention of feminism/intersectionality/social justice in service delivery. Raising awareness of white privilege is a good starting point to develop cultural competency (Satisfaction Survey_64).

Thus, the program was seen to promote self-reflection, which in turn is a critical component of self-awareness. However, further research would be required to examine what exactly constitutes as cultural self-awareness for Anglo and CALD service providers, and how this translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.

In comparison, much more qualitative data was generated on the issue of racism itself – as opposed to the role it plays for CALD victims/survivors in disclosing abuse and accessing clinical services, which was the primary aim of RQ5 (this discussion is documented in the following section on ‘white privilege’). Only one such relevant comment was made:

I learnt the importance of understanding how cultural norms can influence the ability for child’s sexual abuse victims’ to report the perpetrator(s). The most interesting learning for me was about groups and sub groups and how they like to protect their own, which then explains why most victims or victim’s parent do not report sexual abuse to protect either the victim or perpetrator. This has given me space to be impartial when dealing with CALD victims of child sexual abuse or their families (Follow up Survey_5).

Finally, a discussion between two colleagues demonstrated the preference for a non-ethnically matched service provider, and therefore the need for a fully trained workforce rather than one in which ‘CALD matters’ are left to ‘CALD workers’. One practitioner sought further clarification on how to implement confidentiality in a statutory setting, and the other provided that clarification by pointing out that it is not confidentiality from other workers but from other members of their CALD community that is sought:

I’m from the Department of Child Protection, and you were talking about confidentiality and how crucial that is for clients. That can be really difficult for us. Confidentiality with who? We might have to tell the Court, we have to report to our supervisors and our seniors on certain points, so confidentiality in a statutory organisation can be very blurred (Q&A Forum_Adel).

I work for the Department of Child Protection, within a team called Multicultural Services. I think communities are mainly concerned around confidentiality within their community, so they don’t really mind us talking to police or to doctors, but their fears are ‘don’t tell the pastor at my church’, or ‘what if they tell my sister or my cousin?’ (Q&A Forum_Adel).

Table 15: Correlations between cultural self-awareness and cultural self-efficacy by cultural background of service provider (T1 and T2)

	T1			T2		
	Cultural knowledge	Cultural confidence	Cultural sensitivity	Cultural knowledge	Cultural confidence	Cultural sensitivity
CALD^a						
Cultural self-awareness	0.45***	0.13	0.35**	0.48*	0.18	0.26
Anglo^b						
Cultural self-awareness	0.32*	0.32*	0.22	0.52*	0.40	0.33
Total^c						
Cultural self-awareness	0.45***	0.26**	0.34***	0.53***	0.34*	0.33*

* p < 0.05, ** p < 0.01, *** p < 0.001; a – T1 n = 58, T2 n = 23; b – T1 50 < n < 53, T2 n = 21; c – T1 108 < n < 111, T2 n = 44.

White privilege

All but one service provider reported being aware of the phrase ‘white privilege’ at T1 (n = 111/112; 99%); herself of CALD background. As mentioned previously, had medical practitioners (GPs and psychiatrists) been involved in the evaluation study, more substantial differences between service provider types and therefore change over time may have been observed, thus demonstrating the effectiveness of the program in promoting self-awareness and therefore responsible use of racial power in professional settings. Such differences, if they were to occur, would likely be the result of curricular on social justice and daily work practice reflecting its pursuit. Three themes related to ‘white privilege’ – terminology, skin colour, and intersectionality – are discussed below.

The term ‘CALD’

During the Introduction, an explanation of the use of the term ‘CALD’ in the program and project was provided; namely, that it is only being used for consistency with terminology used by Australian governments, but that it suffers two critical issues: (i) while it celebrates ‘the diverse’ it hides that it is really about ‘the different’, and (ii) it does not allow discussion and therefore recognise a fundamental experience for those who belong in this group – racism.

This discussion was seen favourably by many of the participants (n = 30), and none reported unfavourable responses or saw it as redundant. As examples, they said:

Diverse -> different (CALD) (Satisfaction Survey_3).

Loved challenging term “CALD” (Satisfaction Survey_51).

Also liked the discussion re CALD title (Satisfaction Survey_32).

(Liked best?) CALD – explanation (cause division) (Satisfaction Survey_42).

I also feel that the term CALD is not useful – and is othering (Satisfaction Survey_34).

Wonderful work you are doing! Well done and loved your critic of the word “CALD” (Baseline Survey_79).

(Liked best?) The initial talk about the CALD acronym and its lack of transparency (Satisfaction Survey_6).

The “D” stands for ‘different’ rather than diverse was great – I’ll use that! (Satisfaction Survey_93).

Really got a huge amount out of the critique of CALD terminology and appreciate the invitation to think about this differently (Satisfaction Survey_66).

CALD – D = different; this is a great way to think about this and something I will explore with my team and pose as a discussion point in training (Satisfaction Survey_7).

Racism is so important to mention, we need to name it. You were clear you were talking about clinical settings (Q&A Forum_Bris).

You discussed with us the inappropriateness of the term CALD, and how it reasserts to further marginalise. I'd love to know your thoughts on what you propose would be a more equitable term (Q&A Forum_Bris).

If you talk about CALD communities, where to draw the line? Because the second generation or third generation may not want to consider them [as CALD], see my daughter, she'll say, 'I'm Australian', whereas I consider myself Sri Lankan even though I'm an Australian citizen. There is a barrier between a migrant and a second and third generation, that's an issue as well (Q&A Forum_Syd).

CALD is a term developed by government. To make it easier we use NESB. But that (still) excludes international students, women on tourist visas, women on temporary visas whose children have been sexually assaulted or in situations of domestic violence. So how we name people, I guess a name is a name, but who we include and who we exclude for supports because of their immigration status, that shouldn't happen (Q&A Forum_Bris).

I think the term ethnicity is really limited. When we talk about culture, we define that in the context of ethnicity, language, and faith. We did some consultation with kids, and many of them identify themselves as Australian-Vietnamese, Australian-Greek, Australian-Turkish, and I think for me CALD is relevant and 'ethnic minority' doesn't do it to me, I'm from a CALD background, I'm second generation, my kids are third generation, and they identify themselves as CALD, so there's a sense of the breadth and depth of the migration experience in this term (Q&A Forum_Syd).

Thanks so much. I have been thinking lots about your intro and the discussion about the term CALD. I was impressed with the idea of D as different not diverse and carrying a negative judgement. I wonder what difference it makes to your intro now that, for young people in Victoria, we now have more than 50% with one or both parents born overseas? That first large circle becomes a nonsense and is the first part of the deceit. That and the fact that there were 75 different cultures on the first boats coming over from England 200 years ago also mask the idea that 'we were all

white(right) until the 'foreigners' started coming. I have decided to revamp my training intro based on these ideas. Thanks for the inspiration (T1_Email).

Two participants noted that while the discussion on the limitations of the term CALD were good, they still required further thinking through. Specifically, the role of religion needs to not always be subsumed within the role of culture, and the false synonymous use of culture and ethnicity needs to be called out:

Would have been good if culture and religion we're not group together all the time as it can be really powerful to be able to understand that some things are not the same as each other (Satisfaction Survey_25).

The concept of CALD is diverse/not one group – references to migration etc. but I think is an issue if not unpacked further. Reference to ethnicity which captures culture, and inference that culture is part of ethnicity – yet term culture used more generally (Satisfaction Survey_45).

Discussions about terminology were only a 'foreword' to the program, but research centred on language for 'racial others' and on child sexual abuse in minority groups, are inextricably linked. Thus, these comments are seen as useful suggestions, and further research can progress such goals.

Skin colour

Throughout the program, skin colour – namely, white, black, and brown – was used to talk about racial diversity. It was anticipated that this would cause discomfort for some people, and was therefore acknowledged and encouraged to be shared on the Program Satisfaction Survey. Three participants took this encouragement up, saying:

I believe you assume racism is only between whites and non-whites when there is also between us, brown to brown (Satisfaction Survey_75).

The use of black and white would have been said differently. The speaker identified herself as brown and the session seems to refer to white or black when referring to racism (Satisfaction Survey_11).

Talking in reference to "brown" woman is almost suggesting the issues are only for people with brown skin. This is not an issue of skin it's a cultural issue which goes beyond colour (Satisfaction Survey_6).

There is indeed validity in all three comments, which primarily serve to highlight the complexity of the issue of racism. Nevertheless, more attendees appreciated and were comfortable with the use of this language (n = 6). They said:

Less PC which was very refreshing (Satisfaction Survey_21).

Excellent presenter from 'CALD' community (Satisfaction Survey_67).

I appreciated the "openness" of the conversation (Satisfaction Survey_76).

(Liked best?) The instructor was very honest in the way she addressed the issues of concern (Satisfaction Survey_59).

I could sense the brown comment made some uneasy, but I personally had no issue and agree that colour is the first thing people see and then make a judgment on (Satisfaction Survey_7).

I enjoyed hearing about the concerns that CALD members face. As a white Australian, I do my best to acknowledge the cultural differences but I will never really know so seeing that and hearing that makes a difference (Satisfaction Survey_24).

Intersectionality

Many participants appreciated the intersectional approach of the program. They said:

(Liked best?) Unpacking the complexity (Satisfaction Survey_18).

(Liked best?) Exploration around power (Satisfaction Survey_25).

(Anything else?) Introduction to the term of 'misogynoir' (Satisfaction Survey_82).

(Liked best?) Intersectionality – culture, gender, person, trauma (Satisfaction Survey_54).

(Liked best?) Thoughtful. Talked about racism and feminism – and still culturally appropriate (Satisfaction Survey_67).

Engaging talk and nuanced discussion about racism, intersectionality, sexism, and survivor experiences (Satisfaction Survey_48).

I came across the word intersectionality only a couple of months ago listening to a Ted Talk. Thanks, great presentation with excellence and knowledge (Satisfaction Survey_97).

In comparison, one participant did not appreciate the intersectional approach of the program. They said:

A fair bit of intersectional-focused material seemed unhelpful in terms of supporting individuals. 'White privilege', 'patriarchy' are such fuzzy ideas (you could substitute

'evil' and not lose much information). I'm not sure these concepts help clients, and the presentation wasn't persuasive with regards to this (Satisfaction Survey_14).

The relevance of intersectionality became manifest in several comments made by program attendees. For example, one noted that 'white feminism' is not the same as 'brown feminism'; calling for responsible use of language and (an inexplicit) reminder of the need for and importance of self-determination:

I think we have to be very sensitive when we're trying to educate people on feminist language, that we're not imposing our own ideology on them, because it's important to us I think, but it might not be important to them. Some of them want to adhere to their own version of feminism, and that will also take them out of their community (Q&A Forum_Adel).

Another participant extended this point, saying:

I think the reality is that for a lot of women, they do stand up, because they have to, to survive, not be murdered, whether that's around domestic violence or sexual assault that sits within that, the fact that they leave that relationship and get help, that can ostracise them completely, so they've already made a statement and stood up to stuff. And then learnt that sexual assault is against the law here in Australia, but they didn't know that through their marriage, and can't cope with it anymore ... (Q&A Forum_Adel).

The discussion then swung back to a reminder that although some women do break from tradition, the social expectations are nevertheless strong and pervasive:

... But often they don't leave their marriages, and they won't disclose to be honest, they're so afraid of organisations (Q&A Forum_Adel).

The issue of legal rights is really important. All the CALD women I've worked with, either they don't believe they have the same rights as other white people or they believe if they exercise their rights, their partners or the abuser will actually put them down. I have heard dozens of times, "my husband said if I go to the police, the police will lock me up because I'm complaining about my husband. If I go to a housing estate, they will throw me out because the lease is in his name". Even really well educated European women have extensive legal battles in family court because they don't understand our system, or they don't have confidence that our system will treat them the same and respect their rights. So there's a lot of work to actually build up their understanding and esteem, to say, 'we will work with you, the community legal system will support you, will walk you through it' (Q&A Forum_Adel).

Two opposing but equally valid comments offered by white women perhaps best demonstrate the need for an intersectional lens. One made the point that the same cultural beliefs that contribute to difficulties for victims/survivors of sexual assault in accessing services can be held by workers within multicultural organisations, undermining the quality of the support they might offer. The other made the point that sometimes no matter how much training white service providers receive they cannot really understand ‘the lot’ of a woman of colour, who navigates two systems of oppression (race and gender), and due to the FAE is at risk of being labelled as ‘behaving badly’ and without genteel the way passive feminine women ‘should’ when she expresses and experiences rage at their combined injustice.

That is, lack of institutional safety can come from both white and brown spaces; white feminists may not have solidarity with CALD women because of an inability to understand and relate to the experience of racism, and CALD feminists still operate within patriarchal cultural norms that can be suffocating. The dialogue was a reminder that ‘safety’ from a good service worker cannot ultimately or wholly be predicted by her (or his) skin colour, and why all service providers require training:

I just wanted to make mention, particularly for mainstream services, risk around connecting with culturally diverse service providers, particularly sexual assault specialist organisations. The risk for those organisations where they also hold those myths, those values, the trauma of the people that we work with, is because they have tried their faith leader, they’ve tried their migrant service, they’ve tried bilingual workers, and it’s that additional trauma that the service system has given, so there is a risk in saying, ‘please connect with cultural community groups’. We very much need to respect that, but we then also need to challenge our colleagues, our co-workers, and other organisations that are faith-based, community-based, religious-based, to then highlight child sexual abuse as an issue, that is an issue across the board. So I just wanted to put that out there, because I do want people to be mindful that when they run to their local CALD services, they’re going to be hit with this, because they are also part of the community. That it’s not just the clients that hold these views, the service system holds these views (Q&A Forum_Syd).

One of the concerns I have, working on the [name of not diverse local area], [is that] I work a lot with [CALD] women who go through domestic abuse, and it’s really hard the way they are treated in refuges. They tend to get a different treatment to what other people might have, and that causes me great concern. We need cultural awareness training to understand cultural differences, however what we still are up against is that, still those individuals have their own belief systems, and you can’t change that, it’s just embedded, and that does still come out in the services they provide. So I think that’s difficult. It doesn’t matter how much training they might get,

that does not mean they will see things differently. Maybe at the surface, but there are other issues (Q&A Forum_Syd).

Summary

- CALD client victims/survivors of child sexual abuse are diverse in their needs and expectations about services. Some will want services that appear to have cultural knowledge, sensitivity, and regard for cultural safety, whereas others will want a ‘colour blind’ service that appears to make no accommodations for their cultural differences from the mainstream and treats them ‘like any other’.
- This diversity is not seen to justify lack of cultural knowledge among service providers, but rather an onus for them to have cultural and racial self-awareness and use it according to an individual’s emerging preferences. This is because lack of such knowledge could lead to an unintended abuse of racial power, which then adds to the abuses of power the victim/survivor of sexual abuse has already incurred, and alienates them from accessing services that could be highly beneficial for their mental well-being.
- Awareness of racial power takes the form of understanding that white practitioners benefit from white group membership by virtue of their higher social power in broader society, which then impacts on power dynamics in the clinical setting. This further assists with understanding that not all barriers experienced by CALD victims/survivors are due to ‘their own culture’, as if they are responsible for all parts of their needs and barriers (the fundamental attribution error).
- As the education program was not centrally about ‘white privilege’, RQ5 only aimed to examine change over time in the number of service providers who were now aware of the concept after having taken part in the program. It was predicted that more counselors and social workers would have heard of this phrase than psychologists due to social justice curricular, who in turn would be more aware of it than medical practitioners due to daily clinical work in which the relevance of at least cognitive errors underpinning racial prejudice would be apparent. Support for this hypothesis could not be found as there were an insufficient number of psychologists to compare with counselors and social workers, and no medical practitioners, in the sample. Thus, almost the entire sample had heard of white privilege, and so the program was not going to be effective in providing this knowledge.
- Nevertheless, the qualitative data did show that participants appreciated the discussions on white privilege and saw them as useful for framing how best to understand and engage with this client group. In particular, the program was seen to promote self-reflection which in turn is a critical component of self-awareness. Terminology when talking about ethnic minorities, acknowledging the role of skin colour in racism, and identifying its complex intersecting role with other structural disadvantages were also

seen as fruitful for service providers working in this space (especially differentiating ‘white feminism’ from ‘brown feminism’).

- It was also found that cultural self-awareness was high for both CALD and Anglo service providers at both T1 and T2. However, further research is required to examine what exactly constitutes as cultural self-awareness for each of them, and how it translates to better self-understanding and engagement with clients of all backgrounds, and appreciation of cross-cultural similarities and differences in daily work practice.
- Correlational data showed that as service providers increase on cultural self-awareness, they increase on cultural knowledge, confidence, and sensitivity, but that these correlations did not strengthen after the program. It is also unclear if or to what extent *cultural* self-awareness reflects *racial* self-awareness.
- Overall, racial self-awareness – by virtue of being critically reflective on one’s own cultural norms, traditions, values, and beliefs, as well as group-level power inherited from group membership and therefore independent of personal cognitions – is not seen as essential for meeting *basic* needs in the clinical setting, but is seen to enhance the quality of services for CALD victims/survivors.
- Moreover, the need to develop this cultural competency and racial self-awareness is growing with Australia’s expanding diversity. Combined with a fear of breached confidentiality and therefore preference for a non-ethnically matched worker, as well as risk for increasing harm from judgmental CALD workers or interpreters, there is a rising onus for the whole Australian mental health and sexual assault workforce to be appropriately trained and not just leave ‘CALD matters’ to CALD workers.
- Given that psychiatrists can assist clinically unwell victims/survivors, GPs can model good engagement with other professionals and provide referrals, and psychologists, social workers, and counselors can talk through and share trauma with the aim of reducing the symptoms of emotional distress, the relevant workforce is as diverse as the client group.

RQ6: Do service providers more appreciate the need to be aware of a medical versus sociological approach to the treatment of mental illness to help take responsibility for gendered power?

Background and rationale

Cross-cultural differences in the stigma of mental illness

The stigma associated with mental illness is cross-cultural; people fear, shun, and denigrate those with mental illness in all cultures (Corrigan, Druss, & Perlick, 2014). In individualistic cultures some of this stigma is particularly associated with being perceived as weak, and in collectivist cultures some of this stigma is particularly associated with marring family reputation (Sawrikar, 2005). As collectivist cultures are hierarchal, CALD families ascent in community standing only when their family name remains intact. Mental illness brings that name into disrepute, and is therefore seen as shameful.

Somatizing mental illness in collectivist cultures

To avoid shaming the family name, people from CALD communities with mental illness may somatise their symptoms of emotional distress (Ferrari et al., 2015). For example, they may present to a medical doctor with insomnia rather than depressive sadness. Transferring mental pain into physical pain becomes a culturally acceptable means of seeking help because it does not disturb the family name.

Accessing help from such highly educated professionals also aligns with the hierarchical nature of collectivist cultures; they are respected and esteemed, making seeking their help acceptable and their service and interventions valued. Migrants often move to Western countries to gain access to these esteemed opportunities that may not be in their country of origin to the same extent, forsaking cultural safety or accepting ‘second-class citizenship’ in the process. Such socioeconomic processes make medical intervention even more valued; medical practitioners symbolise the migrant’s success against the ‘sticky mud’ of racism. While accessing psychiatrists would necessarily imply admission of mental ill-health, they are still highly esteemed medical professionals with the ability to prescribe medication if required, and therefore work within a model that can physicalise mental illness and thus preserve family name.

In comparison to GPs and psychiatrists, psychologists, social workers, and counselors do not carry the same professional authority or reverence.²⁵ As such, engaging with such ‘non-medical talk therapists’ may first require the referral of a GP, who can use their professional power to help allay any shame or stigma the mentally unwell client and their family fears, and which the veil of accessing medical professionals helps cover (Haboush & Alyan, 2013).

Talk therapists require the client to value their own feelings (and be verbally expressive about them; discussed under RQ4). In a family-based cultural context, valuing the needs of the ‘self’ over the needs of the ‘family’ requires a complete turning-upside-down of the fundamental and defining feature of collectivism. Within the additional lens of overt patriarchy and traditional gender roles, women are particularly vulnerable to social exclusion and shaming from the community or physical danger in the form of threats or actual harm from the immediate family should they disclose to a public community member their personal needs and experiences. The more they have internalised their self-worth as dependent on the fulfilment of social roles (‘I am a good person because I am a good wife, daughter, and/or daughter in law’²⁶), the harder it may be for them to value their right to psychological safety. Going through the process of discovering the benefits of being able to share their trauma and value their future wellbeing could come at the cost of breaking up the family; a risk they may be scared to face because family cohesion protects family reputation and is therefore in utmost need of protecting. Thus, it is an immense stretch of an expectation for a CALD woman to engage with psychologists, social workers, and counselors. Arguably, victims/survivors only access such forms of help when their life is under threat and/or no other family capital is available (perceived or actual) to provide emotional support.

Talk therapists and sociological approach to mental illness

Although talk therapists may be culturally challenging to access, they offer a critical component of the ‘healing process’ toward empowerment, resilience, and a survivor rather than victim identity: foremost, they do not physicalise the mental illness. Instead, mental ill-health is interpreted within a social framework as the result of social injustice. Sexism is centrally named; it is not overlooked or minimised. Although labels such as ‘post-traumatic stress disorder’ (PTSD) legitimate psychological difficulties as a result of child sexual abuse, they also localise and individualise the problem and therefore responsibility or onus to

²⁵ This trend is not just true within CALD communities, but all communities within Australia. This is at least given by the incomes that each of these professions can command.

²⁶ Females in all cultures experience a burden of separating personal worth and fulfillment from social worth and fulfillment; grappling with the challenge represents a fundamental component of becoming a feminist. These processes are likely to be more pressured, intensified, and difficult within cultural contexts that strongly or overtly endorse traditional gender roles.

address it within the victim, who also risks being labelled ‘crazy’ or ‘mad’ (Reavey et al., 2006).

Thus, a sociological approach to treatment acknowledges the gendered ratio of reported prevalence; higher among females by a factor of three to four times (Chen, Dunne, & Han, 2004; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Thornton & Veenema, 2015; and Wang & Heppner, 2011). It also acknowledges that the silence that surrounds child sexual abuse in all cultural groups protects and preserves the patriarchal status quo because perpetrators – vastly male – are systematically spared from being accountable for their crime.

Problems with a purely medical model

Physicalising mental illness has its place. For example, a common quote expressed by participants in mental health research is ‘*I wish people reacted to mental illness the same way they react to a broken leg*’ (Sawrikar & Muir, 2018). Such a widespread and unquestioning understanding that neurochemical processes do contribute to mental ill-health has immense capacity toward destigmatising mental illness. Indeed, a primarily medicalised approach may be in the best interest of a CALD female client victim/survivor because it may simply be too difficult for her to engage with therapies that take a sociological approach to treatment; which ask her to care for herself above that of her care for the family, and enough to actually and simply speak about what her needs are and experiences have been. Getting some help, in ways that are culturally acceptable, may be better than getting no help at all.

It is for this reason that this project took the position that the use of a sociological approach to treatment was not essential, but that awareness of it was. The use of a purely ‘medical’ approach combined with a lack of awareness about a sociological approach is seen to be an irresponsible use of gendered power and therefore problematic for meeting the needs of clients well. Lack of awareness of a sociological approach, especially among male professionals, both medical and non-medical, risks unintended abuses of gendered power, which would only give the client cause to withdraw from clinical engagement. Given how challenging it is for the CALD client to even access the service, it is a risk the service provider and their organisation cannot and should not afford.

Summary

Overall, it is seen that GPs are a critical point of referral. A CALD client victim/survivor is likely to present to a GP with somatic symptoms of mental illness. The GP would need to be able to recognise and respect when this is occurring, and arguably is higher among CALD GPs because of tacit cultural knowledge about the need to save face. All GPs would need training in how to sensitively screen for a possible history of child sexual abuse. If abuse is disclosed, they can then refer them to other relevant professionals. If the mental illness is

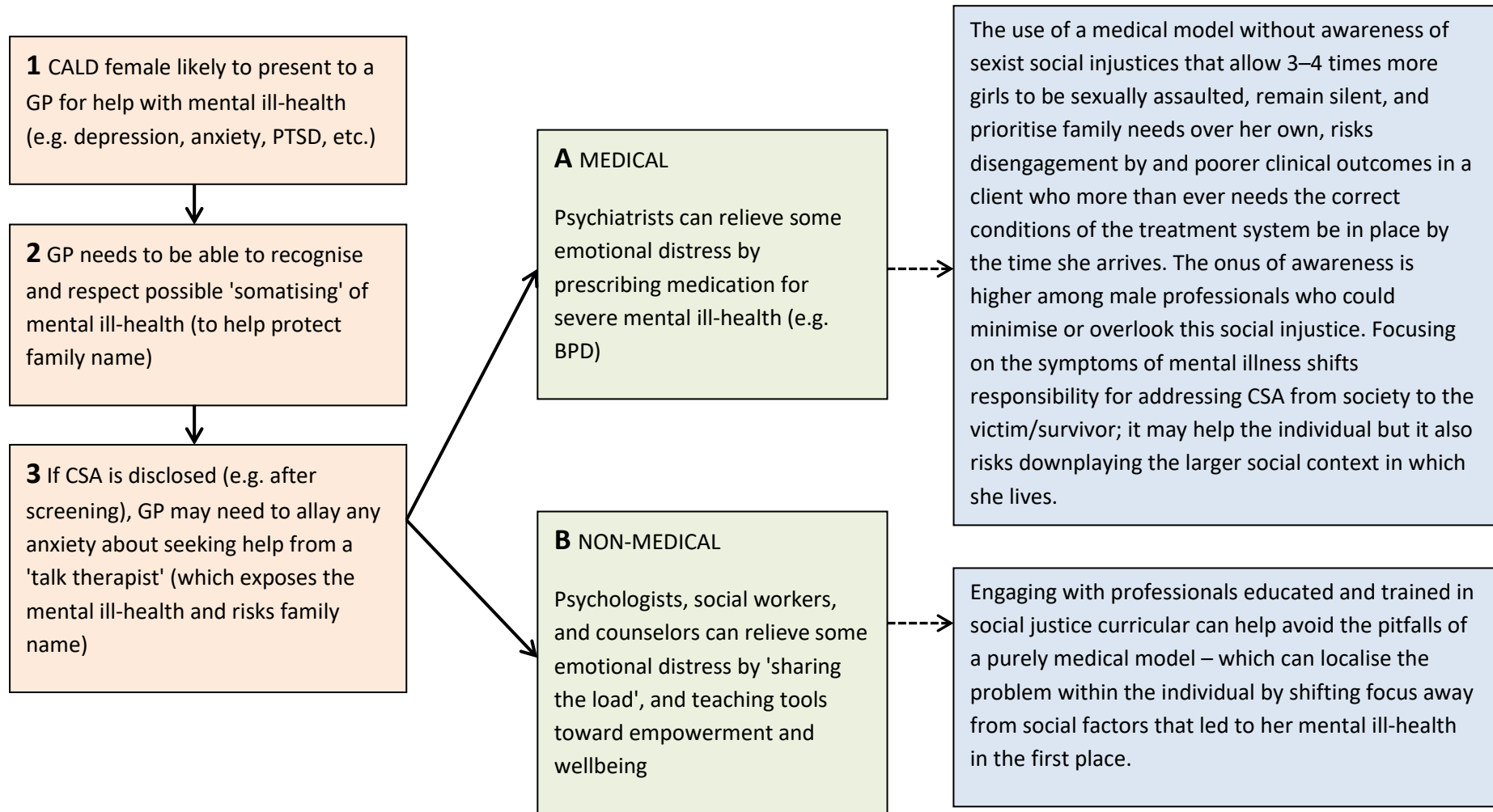
severe, psychiatrists play a critical role in being able to prescribe medication and thus provide relief from the symptoms of emotional distress associated with depression, anxiety, PTSD, borderline personality disorder (BPD), etc. In taking a primarily medical approach, they offer assistance to victims/survivors that are mentally unwell as a result of the abuse, help preserve family name if sessions prioritise discussion on specific psychiatric symptoms in need of address rather than the traumatic event itself, and help destigmatise mental illness.

Psychologists, social workers, and counselors play a critical role in enabling a sense of agency among victims/survivors, who are given tools on how to interpret their thoughts and feelings and reappraise them in ways that can better wellbeing. They can also ‘sit with’ the victim/survivor in *their* narrative about their traumatic abuse and the social injustice – specifically, sexism – that allows it to occur, go mostly unpunished, and be intensified across the life span (sometimes to the point of ‘suffocating silence’; Shalhoub-Kevorkian, 2000) by social pressure to fulfill female social roles that expect and train her to deprioritise the self. While each type of service provider has a unique and vital role, it is critical that they are also aware of the limits of their profession and which others help address that gap, so that appropriate referrals best tailored to a CALD individual can be made. A summary of the key processes and variables is provided in Figure 8.

Measures

Program attendees were asked one question in relation to RQ6: *B.10* – ‘A ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse acknowledges differences in social power across groups in society (e.g. by race, gender, class, disability, etc.). That is, it tries to understand the individual client as a member of broader society. It is also known as a ‘social justice’ approach. Which of the following is true for you?’ Options varied from 1 = I believe that a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse is useful or effective because trends in society do play a substantial role in understanding an individual, 2 = I do not believe that a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse is useful or effective because trends in society do not play a substantial role in understanding an individual, and 3 = I am not sure; I would like to learn more about what a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse entails.

Figure 8: Summary of proposed relationships between types of service providers, medical and sociological approaches to the treatment of mental illness, and responsible use of gendered power



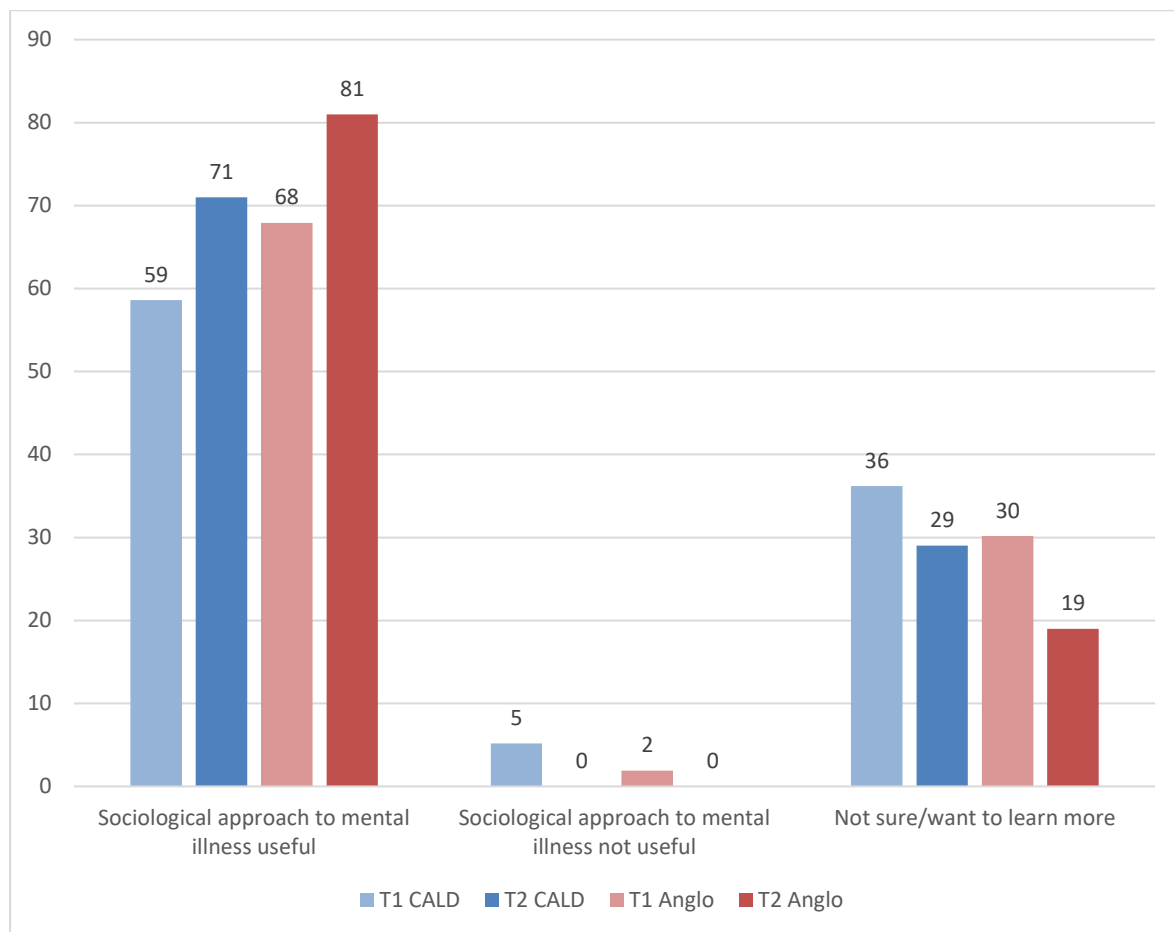
Changes over time

Usefulness of sociological approach to treatment of mental illness

By cultural background of service provider

At T1, all but one participant responded to B.10, who instead said *I believe that there is no empowerment without social justice, however I am not sure if one approach is enough, maybe a combination?* (Baseline Survey_48). It is indicative of nuanced understanding, but also highlights the forced choice nature of the question, which was intentionally designed to ascertain the number of service providers willing to commit to beliefs about the utility of a sociological approach. Two participants did not respond to this question at T2.

Figure 9: Percentage distribution on beliefs about the usefulness of a sociological approach to treatment of mental illness by cultural background of service provider (T1 and T2)



As can be seen from Figure 9 (and Data Table G.5), very few service providers thought that a sociological approach to the treatment of mental illness as a result of child sexual abuse is not useful or effective (CALD T1 5%, T2 0%; Anglo T1 2%; T2 0%); most thought it was useful or effective, or were not sure and wanted to learn more first.

The proportion of CALD service providers who believe that a sociological approach is useful or effective increased from T1 (59%, $n = 34$) to T2 (71%, $n = 15$), and the proportion who would like to learn more decreased from T1 (36%, $n = 21$) to T2 (29%, $n = 6$). The proportion of Anglo service providers who believe that a sociological approach is useful or effective increased from T1 (68%, $n = 36$) to T2 (81%, $n = 17$), and the proportion who would like to learn more decreased from T1 (30%, $n = 16$) to T2 (19%, $n = 4$). These changes over time suggest that the program was effective in helping all service providers take further responsibility for gendered power in their practice.

Relationship with cultural self-efficacy

The results in Table 16 show that at T1, CALD service providers who believe that a sociological approach is useful or effective did not have significantly different scores to those who wanted to learn more about a sociological approach on cultural knowledge ($t(53) = 0.60$, $p > 0.05$; $M = 3.7$, $M = 3.6$ respectively) or sensitivity/respect ($t(53) = -1.01$, $p > 0.05$; $M = 4.4$, $M = 4.6$ respectively). Anglo service providers who believe that a sociological approach is useful or effective did not have significantly different scores to those who wanted to learn more on cultural knowledge ($t(50) = 0.42$, $p > 0.05$; $M = 3.0$, $M = 2.9$ respectively) or confidence to work with CALD victims/survivors ($t(47) = 0.69$, $p > 0.05$; $M = 2.7$, $M = 2.5$ respectively). These findings suggest that their cultural self-efficacy is generally similar, and that they only really differ in their confidence to commit to beliefs about the utility of a sociological approach when presented with a forced choice question.²⁷

It was also found that CALD service providers who believe that a sociological approach is useful or effective had significantly higher scores ($t(53) = 2.03$, $p < 0.05$) on cultural confidence ($M = 3.4$) than those who wanted to learn more about a sociological approach ($M = 2.9$). This finding suggests that CALD service providers' confidence to work with victims/survivors of child sexual abuse is higher when their confidence to commit to beliefs about the utility of a sociological approach is stronger. This is interesting because it means that their understanding of child sexual abuse as a gendered crime patterned at the sociological level, rather than one that is localised to the behaviour of an individual within a specific situation, improves their work practice. It also seems to tell of a story of the CALD

²⁷ ANOVA tests were not conducted at T1 with service providers who believe that a sociological approach is not useful or effective, nor for data obtained at T2, due to the small sample sizes and therefore insufficient variability in the cells.

service provider becoming a feminist against highly valued traditional gender roles in collectivist cultures.

Finally, it was found that Anglo service providers who believe that a sociological approach is useful or effective had significantly lower scores ($t(50) = -2.47, p < 0.05$) on cultural sensitivity ($M = 3.9$) than those who wanted to learn more ($M = 4.3$). This finding suggests that Anglo service providers are more culturally sensitive/respectful when they are unsure about how useful a sociological approach may be for CALD victims/survivors of child sexual abuse. That is, there could be an underlying fear of being seen to judge highly patriarchal societies, and therefore a 'pulling back' on commitment to beliefs about the utility of a sociological approach. In doing so, they are striving to demonstrate respect for difference.

Table 16: Descriptive data on beliefs about sociological approach to treatment of mental illness and cultural self-efficacy by cultural background of service provider (T1)

	Sociological approach useful					Sociological approach not useful					Not sure/want to learn more				
	M	SD	N	Min	Max	M	SD	N	Min	Max	M	SD	N	Min	Max
CALD															
Cultural knowledge	3.7	0.7	34	2	5	3.7	1.5	3	2	5	3.6	0.7	21	2	5
Cultural confidence	3.4	1.0	34	1	5	3.3	0.6	3	3	4	2.9	1.1	21	1	5
Cultural sensitivity	4.4	0.6	34	3	5	4.0	1.7	3	2	5	4.6	0.6	21	3	5
Anglo															
Cultural knowledge	3.0	0.7	36	2	4	4.0		1	4	4	2.9	0.7	16	2	4
Cultural confidence	2.7	1.0	34	1	5	4.0		1	4	4	2.5	0.8	15	1	4
Cultural sensitivity	3.9	0.5	36	3	5	5.0		1	5	5	4.3	0.6	16	3	5
Total															
Cultural knowledge	3.4	0.8	70	2	5	3.8	1.3	4	2	5	3.3	0.7	37	2	5
Cultural confidence	3.1	1.1	68	1	5	3.5	0.6	4	3	4	2.7	1.0	36	1	5
Cultural sensitivity	4.2	0.6	70	3	5	4.3	1.5	4	2	5	4.5	0.6	37	3	5

Summary

- To avoid shaming the family name, people from CALD communities with mental illness may somatise their symptoms of emotional distress. Accessing help from highly educated medical professionals also aligns with the hierarchical nature of collectivist cultures; they are respected and esteemed, making seeking their help acceptable and their service and interventions valued. Migrants also often move to Western countries to gain access to such esteemed opportunities, making medical intervention even more valued; medical practitioners symbolise the migrant's success despite the sacrifice of having to endure racism. While accessing psychiatrists would necessarily imply admission of mental ill-health, they are still medical professionals and therefore highly esteemed, with the ability to prescribe medication if required and therefore work within a 'somatic approach' to mental illness that preserves family name.
- In comparison, psychologists, social workers, and counselors do not carry the same professional authority or reverence. Thus, engaging with these non-medical 'talk therapists' may first require the referral of a GP, who can use their professional power to help allay any shame or stigma the mentally unwell client and their family fears, and which the veil of accessing medical professionals helps cover.
- Thus, the GP is seen as a critical point of referral. They need to be able to recognise when a CALD client victim/survivor is somatising their mental illness, respect that this is occurring to save family face, sensitively screen for a possible history of child sexual abuse, and if disclosed refer them to other relevant professionals.
- In taking a primarily medical approach, psychiatrists can prescribe medication that is able to provide relief from the symptoms of severe emotional distress, help preserve family name if sessions prioritise discussion on specific psychiatric symptoms rather than the traumatic event itself, and help destigmatise mental illness. In this context, getting some help in ways that are culturally acceptable, may be better than getting no help at all. She does not need to engage with therapies that take a sociological approach to treatment, and therefore explicitly ask her to care for herself as if that self-care was in tension with the care she has for her family; a challenge that may be just too great for her. In particular, it may be seen as a risk to breaking up the family, or she may be vulnerable to social exclusion and shaming from the community or physical danger in the form of threats or actual harm from immediate family should she disclose to a public community member her personal needs and experiences; pressures bore of traditional gender roles, which are intensified in collectivist cultures that overtly value them because they are seen to serve definitively prioritised family goals. Indeed, she may only access psychologists, social workers, and counselors if her life was under threat and/or no other family capital was available to provide emotional support.

- Thus, talk therapists are culturally challenging to access, but they are also critical for enabling a sense of agency among victims/survivors when given tools on how to interpret their thoughts and feelings and reappraise them in ways that can better wellbeing, and ‘sit’ with *their* narrative (a client-centred approach) about their trauma, abuse of power, and social injustice. That is, they can speak about and centrally name sexism, unlike in broader society that allows it to occur, go mostly unpunished, and intensify across the life span due to traditional gender roles that suffocatingly expect and socialise females to deprioritise the self. It is in *not* physicalising the mental illness that she is relieved from the burden of being labelled ‘mad’, and the cause of her own emotional distress which she is then responsible for addressing.
- In short, each type of service provider has a unique and vital role, but it is also critical that they are aware of the limits of their profession and which others help address that gap, so that appropriate referrals best tailored to a CALD individual can be made. That is, the use of a sociological approach to treatment is not seen as essential, but awareness of it is. The use of a purely ‘medical’ approach without awareness of a sociological approach is seen to be an irresponsible use of gendered power and therefore problematic for meeting the needs of clients well.
- Lack of awareness of a sociological approach, especially among male professionals (medical and non-medical), risks unintended abuses of gendered power, which would only give the client cause to withdraw from clinical engagement. Given how challenging it is for the CALD client to even access the service, it is a risk the service provider and their organisation cannot and should not afford.
- At T1, most service providers thought that a sociological approach to the treatment of mental illness as a result of child sexual abuse is useful or effective, and some wanted to learn more. Hardly any thought it was not useful or effective. After the program, the proportion of service providers who thought a sociological approach was useful or effective increased, the number who were unsure reduced, and the number who thought it was not useful or effective was nil. These findings contribute empirical evidence of the effectiveness of the program in further increasing their responsibility for gendered power within their practice. The study would need to be replicated with medical practitioners to examine how different changes across time are for them as a result of the program.
- Generally, the cultural self-efficacy of CALD and Anglo service providers who believe that a sociological approach is useful or effective compared to those who are not sure, is similar. Thus, they only really seem to differ in their confidence to commit to beliefs about the utility of a sociological approach when presented with a forced choice question.

- However, it does appear that CALD service providers' confidence to work with victims/survivors of child sexual abuse is higher when their confidence to commit to beliefs about the utility of a sociological approach is higher. In turn, this speaks of their journey of becoming a feminist against highly valued traditional gender roles in collectivist cultures. In comparison, it appears that Anglo service providers are more culturally sensitive/respectful when they are unsure about how useful a sociological approach may be for CALD victims/survivors of child sexual abuse. In turn, this speaks of a way of not judging highly patriarchal societies and therefore demonstrating respect for difference.

RQ7: Do service providers more appreciate the need to avoid omnipotence to help take responsibility for professional power?

Background and rationale

Professional omnipotence

In the same way that lack of awareness of racial and gendered power risks unintended but still irresponsible and unethical outcomes, practitioners also have an onus to take responsibility for their professional power. If this is left unchecked, it could lead to a false belief in their omnipotence, and in turn threaten good outcomes for the client.

Belief in formal services

There are several ways that professional omnipotence could manifest. One, for example, is when service providers believe that formal services are the only way victims/survivors can ‘recover’ from their trauma. However, for some victims the mental ill-health as a result of childhood sexual abuse may be irreparable, and at best managed, such as some cases of BPD.

Self-help, family, and group therapy

Service providers may also believe that the clinical setting is more effective than self-help strategies. Previous research shows that online resources such as books and articles preserve the victim/survivor’s confidentiality (Chien, 2013), and that self-directed music, art, and narrative therapy have roles in developing self-empowerment (Lenette & Sunderland, 2016; Madigan, 2011). If service providers do not suggest these to the client in conjunction with their formal services, it could reflect a bias that reflects the power of their profession over the individual’s power. Encouraging additional self-help assists with putting power back in the hands of victims on their journey toward becoming an empowered survivor.

Finally, family or group therapy can be suggested to the client to help avoid any assumption by the service provider that their assistance is more valuable than the support offered by other family members and other victims/survivors of child sexual abuse. Family therapy is additionally beneficial for the victim/survivor’s carers. While the child is the primary victim, families can also experience secondary victimisation (Royal Commission Final Report, 2017). This could be marked by sadness or helplessness that the abuse has occurred at all, or

anger at themselves for not being aware of the abuse at the time and therefore able to protect their child (Taylor & Norma, 2013). As such feelings can interfere with the child getting the support they need, it is critical that in addition to accessing services for the child victim, the family also obtain clinical support. This provides an outlet for them to receive help regarding their own secondary victimisation, but it also represents an opportunity to learn about and develop strategies for protecting their child in the future so that they are not subject to further re-victimisation.

Measures

Program attendees were asked two questions in relation to RQ7. The first was, *B.11* – ‘In addition to the one-on-one service you provide to clients, do you suggest to them additional...?’ (a) Self-help strategies (e.g. reading relevant books or online resources; engaging in music, art, or narrative therapy; etc.), (b) Family therapy, (c) Group therapy, (d) None of the above, and (e) N/A (I am not a service provider). Participants could tick all that were relevant, and option D provided an internal check on the logical consistency of participants’ responses. The second question was, *B.12* – ‘Do you think that all mental illnesses can be successfully treated with formal clinical services (e.g. psychiatrists, psychologists, social workers, counselors, etc.)?’ with forced options Yes or No.

Changes over time

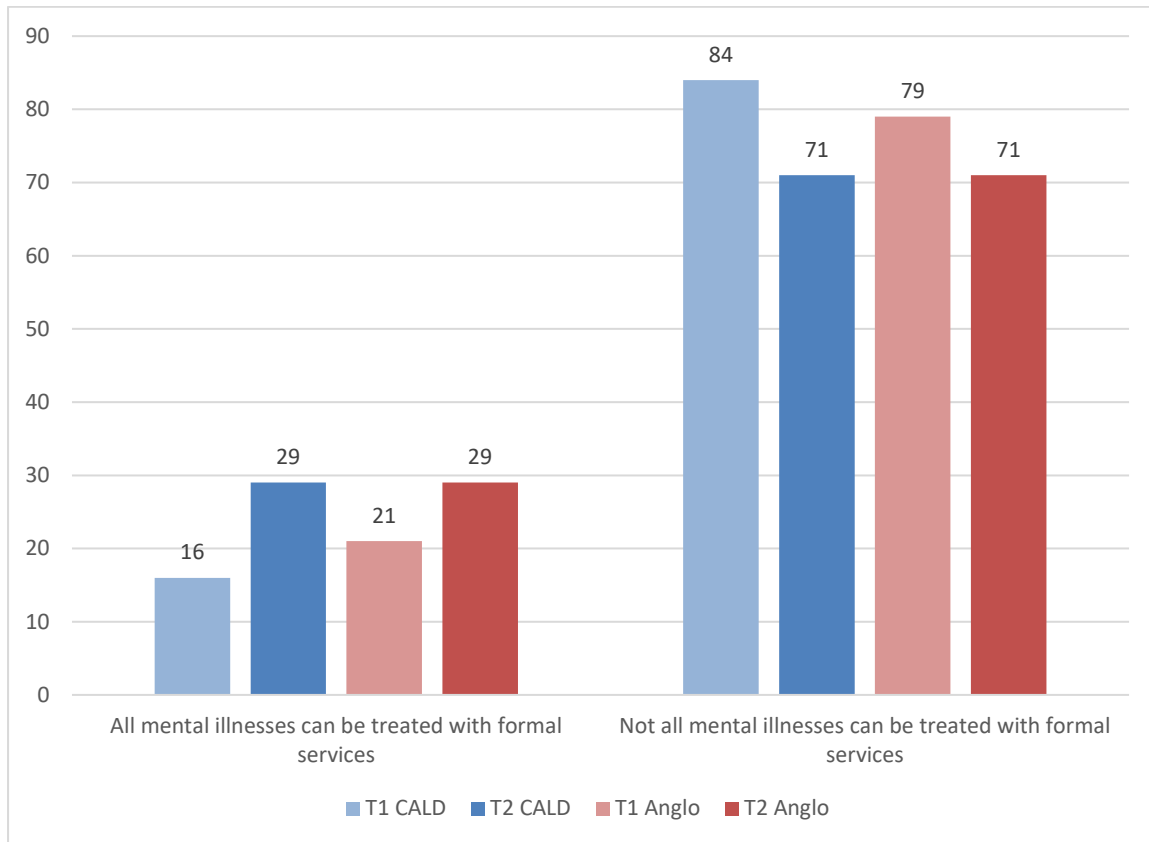
Belief in formal services

By cultural background of service provider

In relation to B.12, one participant at T1 did not answer the question instead saying ‘N/A’, and two participants ticked both Yes and No. One of these said, *Undecided (Baseline Survey_94)* and the other said *Some people do not feel comfortable to go to counselors (Baseline Survey_54)*. Thus, these three participants were henceforth excluded from analyses. Two participants at T2 did not respond to this question.

As can be seen from Figure 10 (and Data Table G.6), most service providers at both T1 and T2 do not think that all mental illnesses can be successfully treated with formal services (CALD T1 84%, CALD T2 71%; Anglo T1 79%, Anglo T2 71%). This suggests that these beliefs are strongly held among service providers from both cultural backgrounds. Nevertheless, they proportions decreased over time, suggesting that as a result of the program, hope for and belief in the effectiveness of formal services for their clients increased (counter to the main message of the program that not all mental illness can be effectively treated).

Figure 10: Percentage distribution on whether all mental illnesses can be successfully treated with formal services by cultural background of service provider (T1 and T2)



Qualitative data

The relevant qualitative data was sparse but important for elucidating the views of service providers who do think that all mental illnesses can be successfully treated with formal services. They said:

“Mental health may never recover” – this is not trauma informed. We must always give hope (Satisfaction Survey_87).

Please rewrite the point about borderline personality disorder. Your verbal explanation was better but the [illegible] stigmatising [illegible] that recovery is possible. See ProjectAir.org²⁸ (Satisfaction Survey_31).

My answer to B.12 is ‘no’ as I believe that spiritual/religious/social connections are very powerful for healing and recovery – I don’t think current MH (mental health) services interventions are holistic enough. But I do believe strongly in the ability for

²⁸ This suggestion was followed up for the online version of the program.

people to recover and be successfully treated with culturally appropriate, safe, respectful services and interventions. I hold a lot of hope. Our current MH interventions do not necessarily support victims the way it's needed – medical model etc. (Baseline Survey_58).

This project took the position that some mental illnesses may be chronic in the same way that physical illnesses could be (such as life-long asthma). Using this analogy, false hope of recovery could be an ‘enabling disservice’. Instead, it is seen as better to provide an understanding to clients that the mental illness is not their fault – and in this way, use a trauma-informed approach that further takes responsibility for the FAE by locating its cause to the traumatic event rather than personal failure to manage its traumatic consequences – but that the resulting episodic or cyclical symptoms of severe emotional distress can be managed.

Moreover, the focus was on service providers’ beliefs about formal services as a way of mitigating the risk of professional omnipotence; to help ensure they do not believe that formal services are the only way victims/survivors can improve their mental well-being. It was not about removing hope for clients.

Undoubtedly, this is difficult terrain to navigate ethically. Although most service providers do seem to understand that formal services are not the only way victims/survivors can improve their mental well-being, there is a conflation among some about its role in giving hope and how that hope can or should be given. Importantly, the service space serves many different and sometimes opposing functions depending on the client and their needs. Thus, any ‘debate’ about the role of hope in the service setting may not need to be resolved, but simply described comprehensively.

Overall, the findings show that many professionals are already using their professional power responsibly (most especially in relation to self-help), and that positively there were no real reductions in this as a result of the program (see section on ‘Self-help, family, and group therapy’). However, the role of age or work experience was further explored to help unpack the data (while acknowledging the unbalanced or small sample sizes). As can be seen from Table 17, there is a small observable trend that practitioners who do not believe that all mental illnesses can be treated with formal services are older and have more work experience.

Table 17: Descriptive data on belief in formal services, age, and work experience for total sample (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
All mental illnesses can be treated with formal services										
Age	39.6	12.3	20	23	70	39.6	9.5	11	28	66
Work experience	12.0	8.7	19	1	33	12.1	6.4	11	2	20
Not all mental illnesses can be treated with formal services										
Age	42.7	12.0	89	23	66	45.6	12.7	29	25	70
Work experience	14.0	11.3	89	0.5	49.5	17.3	11.0	29	2	38

Self-help, family, and group therapy

Three participants of the total sample²⁹ at T1 did not answer B.11, and one of these said *I can ask this team but am not part of this team (I'm in education) (Baseline Survey_44)*. This indicates that they did not answer the question because it was not relevant to their direct line of work, which may have also been the case for the other two participants. At T1, 6% selected 'N/A' and therefore explicitly indicated that they were not in relevant frontline service delivery. One of these participants did say, *N/A (I do very little 000 work but suggestions will depend on literacy, person, etc.) (Baseline Survey_48)*. Similarly, 3% selected N/A at T2.

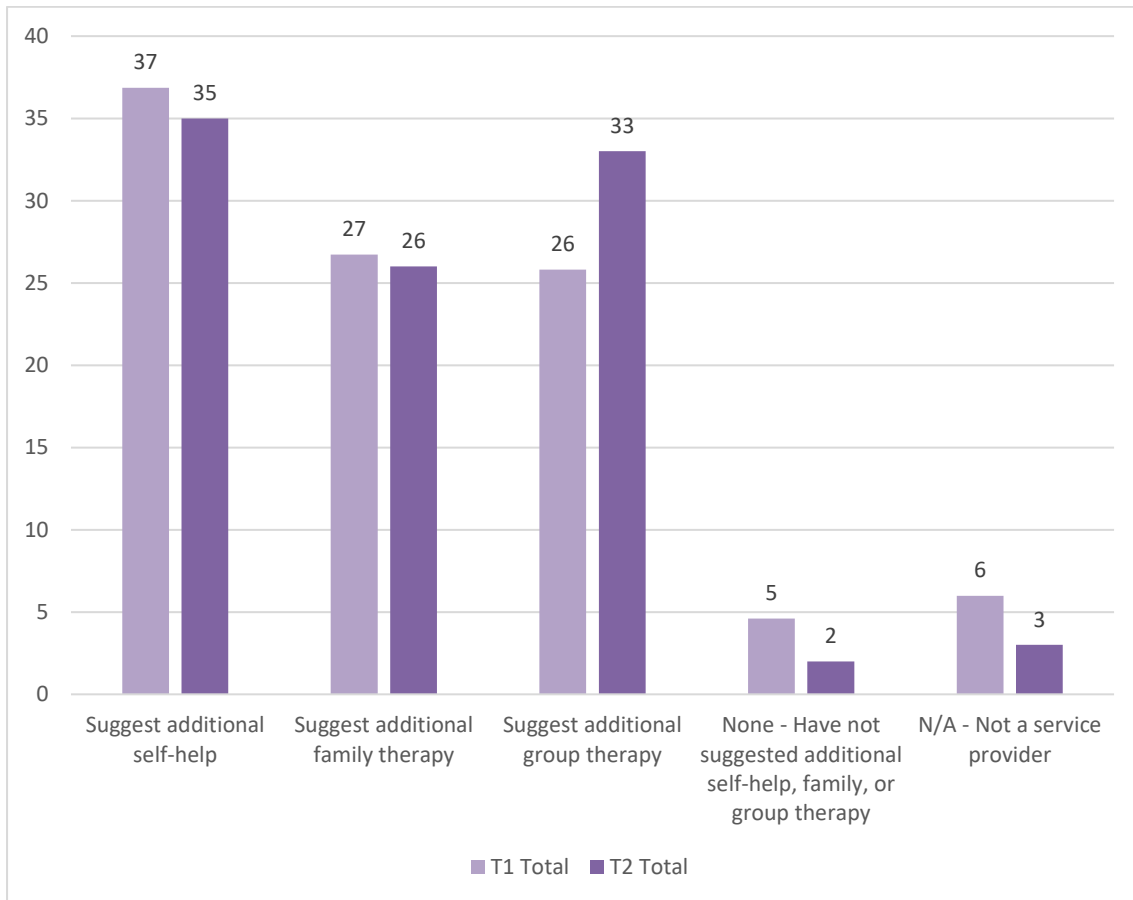
Only 5% selected 'None of the above' at T1, which had further reduced to 2% at T2.³⁰ This positively indicates that many service providers (between 26–37%) use professional power responsibly by sharing it with clients in ways that could empower them rather than seeing themselves as omnipotent in the therapeutic process.

As can be seen from Figure 11 (and Data Table G.6), the proportion of service providers who suggest additional self-help strategies did not really change from T1 (37%) to T2 (35%), nor the proportion who suggest additional family therapy from T1 (27%) to T2 (26%). However, the proportion who suggest additional group therapy did increase from T1 (26%) to T2 (33%), suggesting that the program was somewhat effective in promoting this form of responsible use of professional power.

²⁹ Data has been presented here for the total sample, rather than by the cultural background of the service provider, because the cross-cultural differences are negligible (see Data Table G.6).

³⁰ Statistical tests examining if this change over time is significant has not been conducted due to the small numbers.

Figure 11: Percentage distribution on measures of professional omnipotence for total sample (T1 and T2)



Qualitative data

Overall, service providers appear less willing to implement responsible use of professional power when it is in a group-based setting. Participants said:

Yes (suggest additional family therapy) – (but) without perpetrator (Satisfaction Survey_14).

Talk about family therapy within collectivism may require additional attention (Satisfaction Survey_45).

Yes (suggest additional family therapy) – counseling with survivor and non-offending family members (Satisfaction Survey_54).

Yes (suggest additional family and group therapy) – with non-offending family members (Follow up Survey_34).

Yes (suggest additional group therapy) – (but it) depends on the client stage, never in the beginning (Follow up Survey_4).

Some clients will not be ready to engage in any formal counselling so self help is the best place to start (Follow up Survey_5).

Yes (suggest additional group therapy) – This is a tricky one also, however, as levels of shame will determine group disclosure (Follow up Survey_23).

Yes (suggest additional family and group therapy) – (but it) depends on the specific needs/risk and protective factors of the clients (Satisfaction Survey_29).

Unable to answer this (B.11) as the therapy needs to fit the victim in the context of culture and family. There is intersectionality (Satisfaction Survey_102).

Yes (suggest additional family therapy) – (but) only if they wish to include other victim's sisters and brothers/cousins together. I refer to a CSA specialist team who do family therapy/healing together if wanted (Satisfaction Survey_104).

Thus, it appears that a substantial proportion of service providers are aware of their professional power and willing to use it responsibly by avoiding omnipotence, but that group-based help may be seen to increase risk of harm to clients rather than empower them. In-depth future research examining when and why service providers suggest additional family and group therapy to CALD victims/survivors is evidently required.

Finally, two participants highlighted the issue that some CALD women may not engage with any talk therapies, and that the evidence for its effectiveness is currently lacking and also calls for important future research:

Re talking therapies: love to have review about the evidence of those for CALD (even just one slide) re those with no evidence vs some evidence with CALD communities (Satisfaction Survey_32).

Yes (suggest additional family therapy) – however, “therapy” in itself is not always the answer for CALD communities. It can be a strange concept and needs to be provided by a specialist CALD service provider (Follow up Survey_23).

Summary

- Practitioners have an onus to take responsibility for their professional power, or it could lead to a false belief in their omnipotence. For example, they may believe that formal services are the only way victims/survivors can ‘recover’ from their trauma, but this is not always the case. Sometimes it is not possible to recover from mental illness (e.g. some cases of borderline personality disorder), and informal self-help strategies (e.g. music, art, or narrative therapy) may also be effective because they are empowering. Assistance from family members during family therapy and other victims/survivors of child sexual abuse during group therapy may also be effective; and family therapy can additionally assist secondary non-offending victims.
- Most service providers (approximately 75%) do not believe that all mental illnesses can be treated with formal services, and are thus using their professional power responsibly. This attitude was independent of cultural background, but somewhat related to age and work experience, and the proportion did not substantially change over time as a result of the program, indicative of it being a strongly held view.
- Service providers who do believe that all mental illnesses can be treated with formal services seem to view this attitude as an implementation of a trauma-informed, hope-inspiring, approach. It highlights that how hope is given within clinical service differs between practitioners, and that resolution of any such debate including conflicting and opposing attitudes about the role and nature of hope would be challenging if not impossible.
- This project took the position that some mental illnesses may be chronic, so false hope of recovery would be an enabling disservice. Instead, it was seen as better to provide clients with an understanding that their mental illness is not their fault – it is the result of trauma – but that severe emotional distress can still be managed. In this way, a trauma-informed, hope-inspiring, approach is still being used, while also mitigating the risk of professional omnipotence – that formal services ‘can fix everything’.
- Approximately a third of service providers suggest additional self-help strategies, but there appears to be reluctance to suggest additional family and group therapy, as ways of using professional power responsibly and avoiding omnipotence. This suggests that group-based help may be seen to increase risk of harm to clients rather than empower them, and that in-depth future research is required.

RQ8: Do service organisations more appreciate the need to support their staff to provide a good service for CALD victims/survivors of child sexual abuse?

Background and rationale

Cultural competency at the organisational/institutional level

As stated earlier under RQ1, there are three levels to cultural competency within the social services sector: personal, organisational, and institutional. The implication of this is that good service provision does not all belong to the frontline service provider, who is often and falsely seen as most or more important for delivering cultural competency than the local organisation in which they work on a daily basis or the larger institution to which they belong. As has been argued elsewhere (Sawrikar, 2017), these three tiers are seen to be equally responsible for delivering cultural competency; the likelihood of good outcomes among clients is increased when service providers are supported structurally by their service organisation and institution.

Mandatory

In this project, the following organisational/institutional support was seen as essential for delivering services high in cultural competency for CALD victims/survivors of child sexual abuse (derived from the systematic literature review conducted in 2016):

- using interpreters trained in matters to do with sexual assault, and service organisations providing such training to interpreters
- having an ethnically diverse workforce, including in management positions
- providing regular ‘cultural competency’ training, to address staff turnover and respond to new and emerging communities
- using ‘a multicultural framework’, and thus fundamentally valuing cultural differences
- mandatorily collecting data on all ethnicity-related variables

Ideal

In this project, two elements of cultural competency were ultimately categorised as ideal but not essential. The first was that organisations use visual images of a target client group that is ethnically diverse in their promotional materials (e.g. pamphlets, website, etc.). This element was not identified as essential in an attempt to recognise the severe lack of resources common within the social services sector. However, it could also be counter-argued that even within finite and pressured funding constraints, decisions that reflect investment in ethnic diversity do not implicitly condone ‘white privilege’ as if poor resourcing is an acceptable justification. Overall, larger organisations with greater financial power are seen to be more responsible for delivering on this element than smaller organisations who may not have the financial capacity to rebrand their website and other promotional materials if required.

The second element identified as ideal for cultural competency was having strong links with local CALD community members and organisations. This element was not seen as essential to help acknowledge in advance that not all communities across Australia have high CALD densities, and therefore links with such organisations would/should reflect the local milieu and respond accordingly.

Measures

Program attendees were asked a number of questions that measured cultural competency at the organisational/institutional level. In regards to use of interpreters, participants were asked: (i) *C.5* – ‘Does your organisation only use bilingual staff or interpreters trained in matters relating to sexual assault when required for the client?’ with options Yes, No (We use any CALD staff member or interpreter that is available at the time we need them, whether they are trained in matters relating to sexual assault or not), or N/A (I do not work at a service organisation) (ii) *C.6* – ‘Does your organisation run training sessions for interpreters on matters relating to sexual assault?’ with options Yes, No, or N/A (I do not work at a service organisation), (iii) *C.7* – ‘Does your organisation pre-brief interpreters before meeting a client with a matter relating to sexual assault?’ with options Yes, No, or N/A (I do not work at a service organisation), and (iv) *C.8* – ‘Does your organisation de-brief interpreters after meeting a client with a matter relating to sexual assault?’ with options Yes, No, or N/A (I do not work at a service organisation).

In regards to CALD staff representation, participants were asked: (i) *C.10* – ‘Does your organisation have service provider staff from CALD backgrounds (including those of mixed ethnicity)?’ with options Yes, No, or N/A (I do not work at a service organisation), (ii) *C.11* – ‘If yes, (a) how many in total? _____; (b) how many of these are in management positions? _____; and (c) what is the total service provider staff size of your local

office? _____ (i.e. please do not include administrative staff), and (iii) C.12 – ‘If yes, does your service organisation offer CALD client victims/survivors of child sexual abuse choice about whether they would like an ethnically-matched service provider?’ with options Yes, No, or N/A (We have no CALD clients).

In regards to cultural competency training, participants were asked: C.9 – ‘Have you ever received training on culturally appropriate service provision for CALD client victims/survivors of child sexual abuse while working at your organisation?’ with options Yes (If yes, by whom? e.g. another staff member, a local community organisation, etc.? _____), No, or N/A (I do not work at a service organisation).

In regards to the use of a ‘multicultural framework’, participants were asked: (i) C.3 – ‘How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel your organisation is *in principle* (e.g. in mission statements, philosophy, practice frameworks, etc.)?’ with options varying from 1 = Not at all to 5 = Completely, and (ii) C.4 – ‘How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel your organisation is *in practice* (i.e. daily work)?’ with options varying from 1 = Not at all to 5 = Completely.

In relation to data collection, participants were asked: (i) C.1 – ‘Does your organisation collect data on ethnicity-related variables for its CALD clients?’ with options Yes, No, N/A (We have no CALD clients), or N/A (I do not work at a service organisation), and (ii) C.2 – ‘If yes, which ones?’ (*Please tick all that are relevant*) with options (a) Languages spoken at home, (b) Need for interpreter, (c) Country of birth, (d) Citizenship (e.g. Australian, permanent resident, temporary resident, refugee, asylum seeker, etc.), (e) Religion, and (f) Other.

Links with local CALD organisations was measured by asking participants: C.13 – ‘How strong would you rate the links of your organisation with other local CALD community organisations and/or members within them?’, with options 1 = Not at all strong (we have no links with local CALD community organisations or members of such organisations), 2 = Somewhat strong (we have had some contact with local CALD community organisations or members within them but it is not regular), 3 = Quite strong (we have regular contact with local CALD community organisations or members within them), and 4 = Very strong (our links with local CALD community organisations or members within them could be described as excellent).

Finally, the homepage of the websites of all 57 organisations that attended the education program were explored for their visual inclusiveness, just prior to the program being delivered in that city and then again six months later. Thus, data on this element of organisational/institutional cultural competency was not collected from the participants. This

helped ensure accurate data was collected, not subject to the issues associated with potentially poor recall.

Changes over time

Interpreters

Data Table G.7 summarises interpreter engagement for the total sample, by the cultural background of the service provider, whether the service provider works at a mainstream or non-mainstream organisation, and whether the service provider works at an organisation specialised for sexual assault or not.³¹ Specifically, it identifies the number of service providers that only use interpreters trained in matters relating to sexual assault, that train interpreters on matters relating to sexual assault, and that pre-brief and de-brief interpreters when meeting about matters relating to sexual assault. As participants within the same organisation provided different responses to each other, the unit of analysis became the service provider rather than their organisation.

Only using trained interpreters

At T1, two participants did not answer C.5; six said ‘Not sure’; nine said ‘N/A – I do not work at a service organisation’; 67 said ‘No – We use any CALD staff member or interpreter that is available at the time we need them, whether they are trained in matters relating to sexual assault or not’; and 27 said ‘Yes’. At T2, eight participants did not answer this question; three said ‘N/A’; 20 said ‘No’; and 13 said ‘Yes’.

Several participants at T1 and T2 also said:

No – We only use NAATI³² Level IV (Baseline Survey_51).

I’m not aware of our sexual assault policy (Follow up Survey_9).

I am unaware of the guidelines for programs in this area (Follow up Survey_20).

We use any interpreters but not staff members/family members (Follow up Survey_14).

³¹ In this report, ‘non-mainstream’ organisations are interchangeably described as ‘CALD-specialised’ organisations, and organisations ‘not specialised for sexual assault’ are interchangeably described as ‘generalist’ organisations.

³² National Accreditation Authority for Translators and Interpreters.

No – We can only use TIS³³ due to funding agreement, not able to choose (Baseline Survey_42).

Yes – if client consents having someone from original culture or language (Baseline Survey_35).

We are a legal service, we also have social workers. Some of our solicitors are bilingual and we will match clients appropriately to them – however we most often use interpreters (Follow up Survey_11).

I don't know as I don't work in this area. However, I would assume sometimes there are no interpreters (particularly for some languages) that have this training (Follow up Survey_12).

All bilingual staff are trained/have experience providing sexual assault support services. Interpreters are not always trained in particular areas. However, [org name] has provided a professional development session targeting interpreters on interpreting in sexual assault support settings (Follow up Survey_22).

Thus, not including the participants who selected N/A (i.e. those who do not work in frontline services), 26% of the total sample at T1 only used an interpreter trained in matters relating to sexual assault. This marginally increased to 32% at T2, somewhat demonstrating the effectiveness of the program on this element (see Figure 12).³⁴

The data shows that more CALD (T1 33%, T2 38%) than Anglo (T1 17%, T2 25%) service providers, and more service providers in non-mainstream (T1 43%, T2 42%) than mainstream organisations (T1 18%, T2 32%), only use interpreters trained in matters relating to sexual assault. There was also little difference on this between service providers who work at organisations specialised for sexual assault (T1 27%, T2 20%) and those who do not (T1 24%, T2 41%) at T1 only, suggesting that the program may have been effective on this element among service providers who work in organisations not specialised for sexual assault.

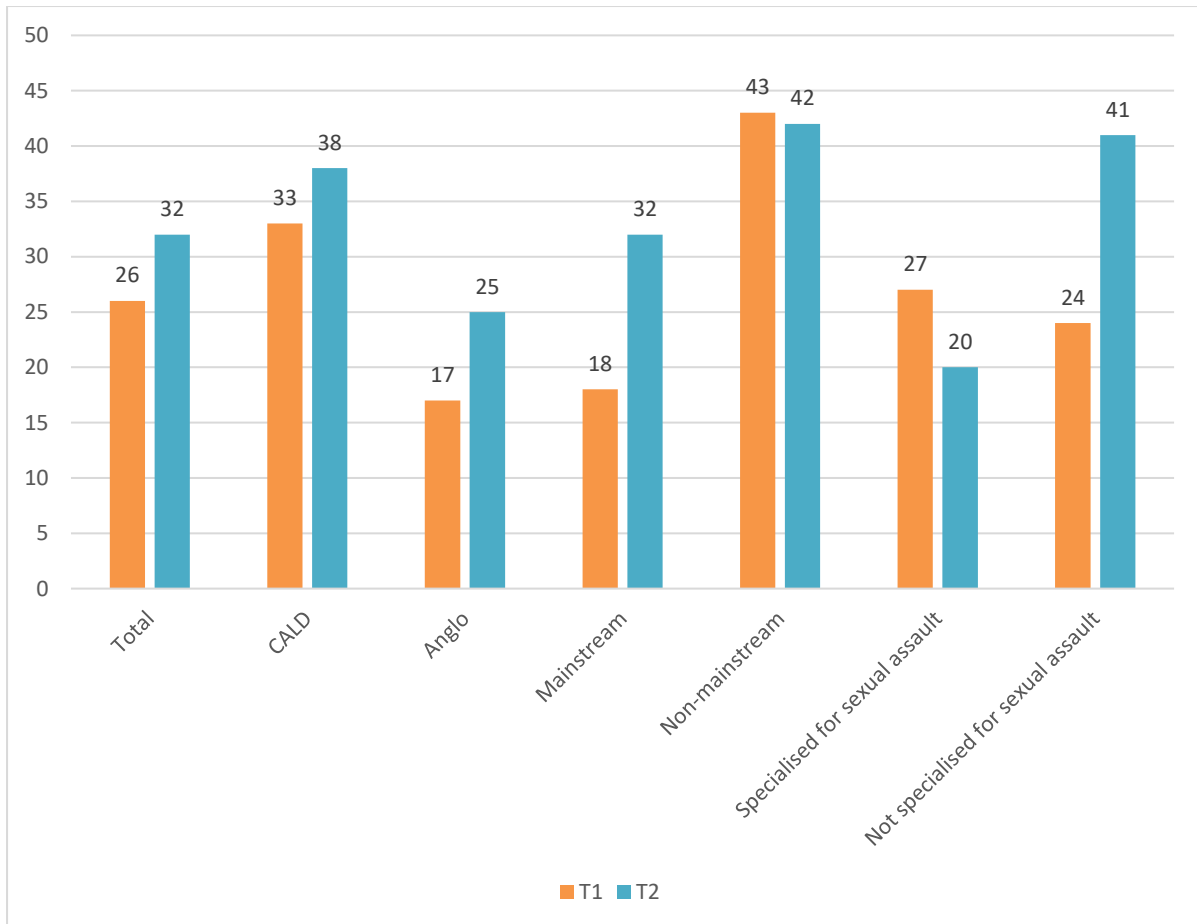
Overall, the results show that service providers are either unaware of relevant policies, or unable to only use interpreters trained in matters relating to sexual assault when required due to resource constraints. Organisational policies about which interpreters can be used may also limit choice. Generally, CALD staff, and staff working in organisations formally designed to support CALD clients, are more likely to implement this aspect of effective interpreter

³³ Translating and Interpreting Service.

³⁴ The total sample, and numbers within the cross-tabulated cells, are too small at T2 to conduct χ^2 statistical analyses, so only trends have been described.

engagement. By corollary, the program appears to have been most effective for Anglo service providers, and service providers in mainstream and generalist organisations.

Figure 12: Percentage distribution on only using interpreters trained in matters relating to sexual assault by cultural background of service provider and types of service organisation (T1 and T2)



Training interpreters

At T1, five participants did not answer C.6; six said ‘Not sure’; nine said ‘N/A – I do not work at a service organisation’; 78 said ‘No’; and 14 said ‘Yes’. At T2, three participants did not answer this question; three said ‘N/A’; 33 said ‘No’; and three said ‘Yes’.

Participants at T1 and T2 also said:

Unsure – new to org (Baseline Survey_79).

No – I wish we could (Baseline Survey_99).

Yes – we will in a few weeks (Baseline Survey_48).

Yes – this is what I do, my role (Baseline Survey_44).

We are not a specialist service for sexual assault (Follow up Survey_38).

[Org name] offers this service and we encourage interpreters to attend where possible (Follow up Survey_34).

Two sessions held on interpreting in domestic violence and sexual violence support settings (Follow up Survey_22).

Yes – I believe our organisation is planning to run the training session, and seeking funding for this (Baseline Survey_47).

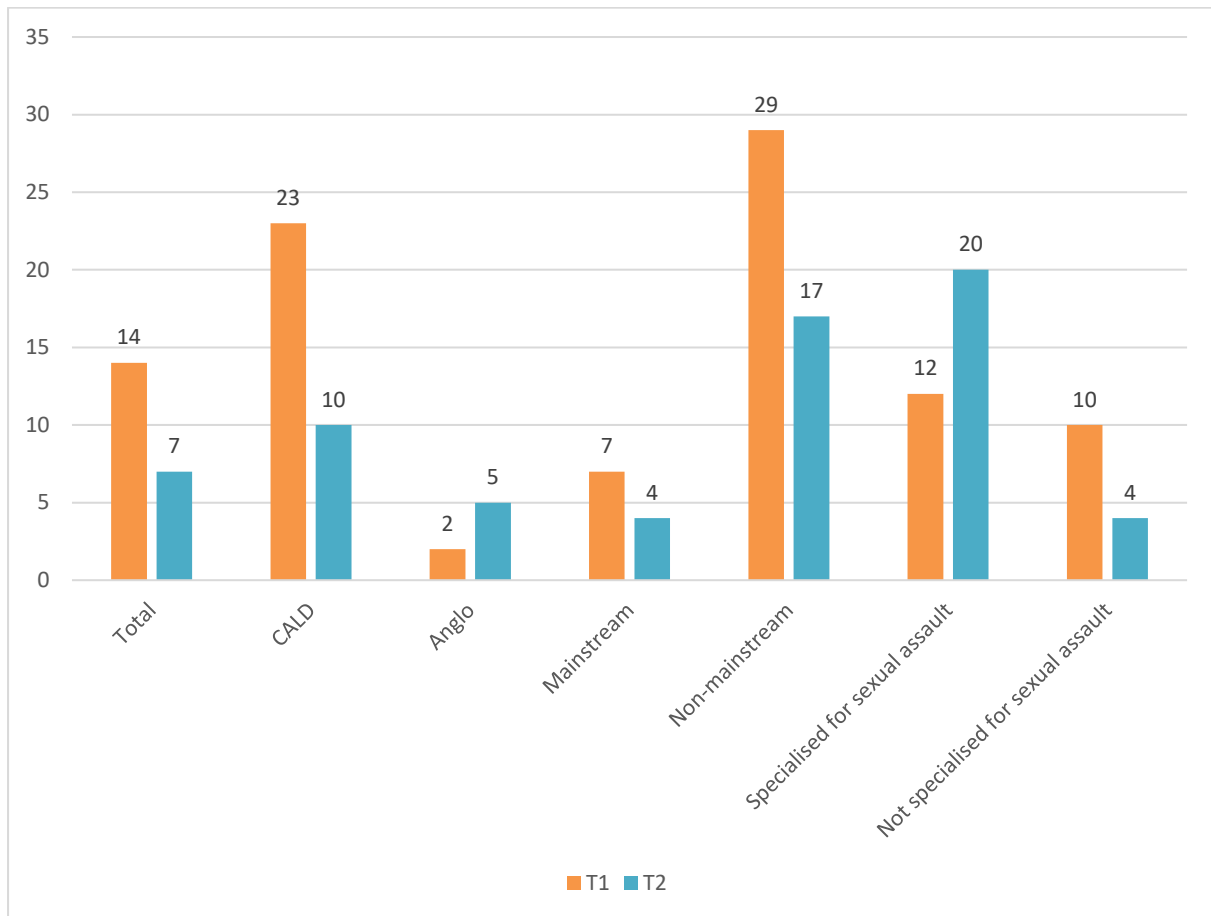
We do not run training sessions for interpreters on matters relating to sexual assault, however we train all staff on how to work effectively and respectfully with interpreters and clients (Follow up Survey_29).

Thus, not including the participants who selected N/A, 14% of the total sample at T1 said they worked at an organisation that runs training sessions for interpreters on matters relating to sexual assault. Surprisingly, this decreased to 7% at T2 suggesting the program was ineffective on this element (see Figure 13).

Descriptively, the data shows that more CALD (T1 23%, T2 10%) than Anglo (T1 2%, T2 5%) service providers, and more service providers in non-mainstream (T1 29%, T2 17%) than mainstream organisations (T1 7%, T2 4%), run training sessions for interpreters on matters relating to sexual assault. There was also little difference on this between service providers who work at organisations specialised for sexual assault (T1 12%, T2 20%) and those who do not (T1 10%, T2 4%) but only at T1, suggesting that the program has been effective on this element among service providers who work in organisations specialised for sexual assault.

Overall, the results show that very few service providers train interpreters on matters relating to sexual assault, that low funding likely constrains this ability, that intentions to do so are afoot within some organisations, and that a desire among service providers for this to occur is present. When it does occur, it is CALD staff, and staff working in organisations designed to support CALD clients, that are more likely to implement this aspect of effective interpreter engagement. Counter-intuitively, the program has not nurtured this trend. There was an observable drop in the number of CALD staff and staff working in non-mainstream organisations that train interpreters on matters relating to sexual assault after the program, and it is not known why.

Figure 13: Percentage distribution on training interpreters on matters relating to sexual assault by cultural background of service provider and types of service organisation (T1 and T2)



Pre-briefing interpreters

At T1, five participants did not answer C.7; eight said ‘Not sure’; 13 said ‘N/A – I do not work at a service organisation’; 32 said ‘No’; and 51 said ‘Yes’. At T2, 10 participants did not answer this question; four said ‘N/A’; 12 said ‘No’; and 18 said ‘Yes’.

Several participants at T1 and T2 also said:

Yes – I would (Baseline Survey_34).

N/A – refer out (Baseline Survey_76).

Yes – whenever possible (Baseline Survey_16).

I’m not sure not my area (Follow up Survey_43).

Yes and no – inconsistent (Baseline Survey_44).

Yes – but does not always happen (Baseline Survey_6).

Not sure – have not dealt with this as yet (Baseline Survey_9).

N/A – According to org policy we should (Baseline Survey_48).

Yes – I would, I believe the others also do (Baseline Survey_46).

I am unaware of the practice in this area (Follow up Survey_20).

No – we've not done this; I've not had need to (Baseline Survey_80).

No – unless it's a factor in the MH presentation (Baseline Survey_35).

It's up to the individual worker to organise this (Follow up Survey_14).

Not sure – do not use interpreters in my program (Baseline Survey_110).

Yes – our specific team but not the agency as a whole (Baseline Survey_95).

Yes – I do as a S/W, but there's no organisational policy (Baseline Survey_104).

Yes – I can only speak to my personal and team practice here (Baseline Survey_99).

I personally do and would however this is not a workplace policy (Follow up Survey_2).

I haven't worked with interpreters and a client regarding sexual assault (Follow up Survey_9).

Not sure, but I have emailed the team to know the answer for the future (Follow up Survey_12).

I haven't had a sexual assault client that needed an interpreter (Follow up Survey_15).

However, TIS will often ask if the appointment relates to violence when allocating interpreters (Follow up Survey_11).

While booking an interpreter, you need to inform the interpreter that it is a domestic violence session (Follow up Survey_40).

Yes – I do, however unsure other workers. This was suggested way to work with interpreter at my work (Baseline Survey_47).

I would like to assume that they do pre-brief as well as confirming the client's comfort with appointed interpreter (Follow up Survey_1).

Struggle to source F2F interpreters. If using F2F then prior debrief is conducted. If using TIS interpreters then no pre-brief (Baseline Survey_32).

That is the reason we are always requesting TIS to provide female interpreters because we are dealing with sensitive issues which is domestic violence (Follow up Survey_42).

It is the practice of the small team that I work in to do so – we brief all interpreters prior to complex meetings with CALD clients. It is not necessarily the practice of my broader department (Follow up Survey_23).

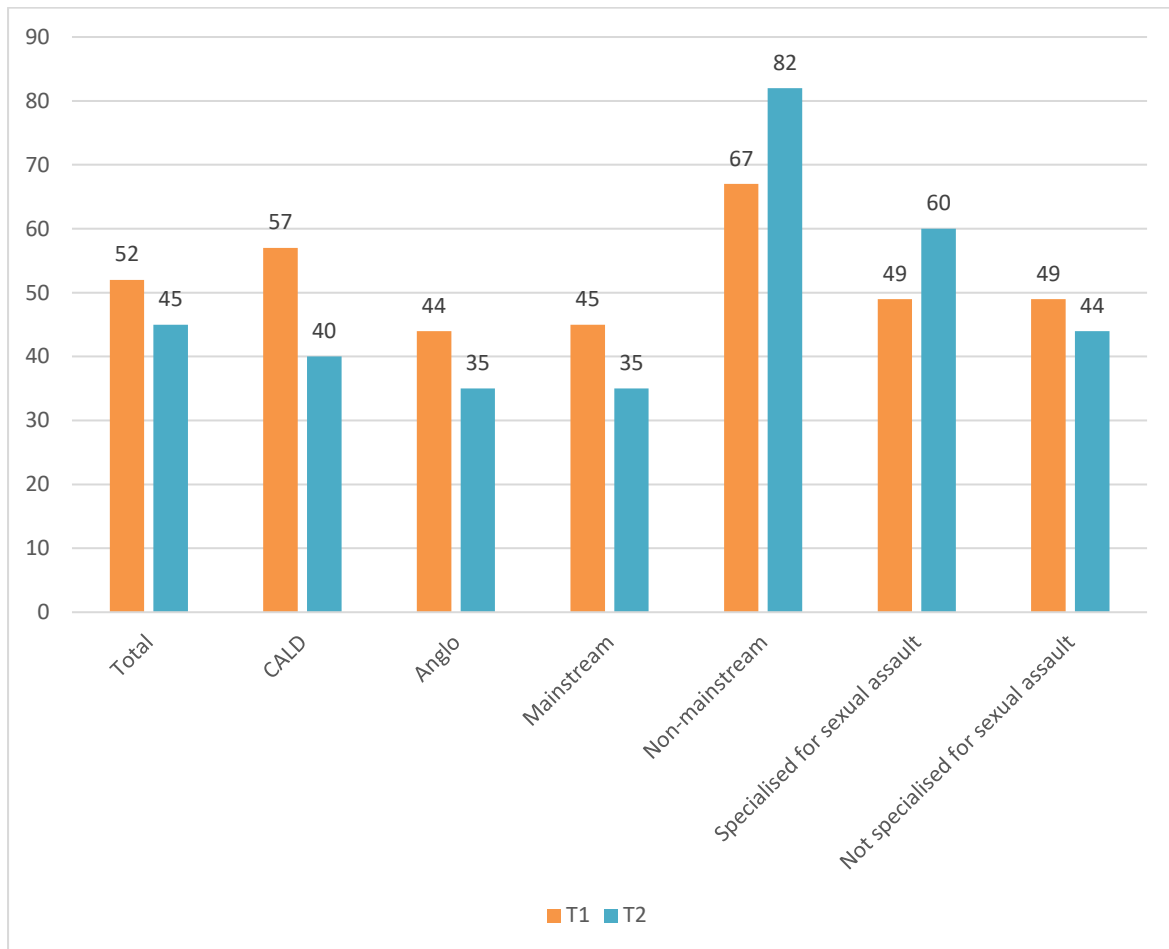
If no pre-brief available, on the request we indicate purpose of the session. However, if the sexual assault matter is brought up at the session, the interpreter can refuse to continue the session. However, our service is well-known as a provider of DV and SA (sexual assault) support services so interpreters can decide in advance if they take the job or not (Follow up Survey_22).

Thus, not including the participants who selected N/A, 52% of the total sample at T1 said they pre-brief interpreters on matters relating to sexual assault. This slightly decreased to 45% at T2, somewhat suggestive of the ineffectiveness of the program on this element (see Figure 14).

Descriptively, the data shows that more CALD (T1 57%, T2 50%) than Anglo (T1 44%, T2 40%) service providers, and more service providers in non-mainstream (T1 67%, T2 82%) than mainstream organisations (T1 45%, T2 35%), pre-brief interpreters on matters relating to sexual assault. In comparison, there is little difference on this between service providers who work at organisations specialised for sexual assault (T1 49%, T2 60%) and those who do not (T1 49%, T2 44%).

Overall, the results show that compared to the number of service providers that only use trained interpreters or train interpreters in matters relating to sexual assault, many more pre-brief interpreters. This may be because in comparison it is easier to do. However, it may not be done consistently, and this in turn may be due to specific client needs, the individual service provider, and/or explicit organisational policies. This practice was also less influenced by the cultural background of the service provider and whether they worked at a mainstream or non-mainstream organisation.

Figure 14: Percentage distribution on pre-briefing interpreters on matters relating to sexual assault by cultural background of service provider and types of service organisation (T1 and T2)



De-briefing interpreters

At T1, six participants did not answer C.8; 13 said ‘Not sure’; 12 said ‘N/A – I do not work at a service organisation’; 44 said ‘No’; and 37 said ‘Yes’. At T2, seven participants did not answer this question; four said ‘N/A’; 17 said ‘No’; and 15 said ‘Yes’.

Participants at T1 and T2 also said:

Yes – I would (Baseline Survey_34).

Yes – I think so (Baseline Survey_59).

Yes – if necessary (Baseline Survey_3).

Yes – where necessary (Baseline Survey_99).

Not sure not my area (Follow up Survey_43).

Yes – whenever possible (Baseline Survey_16).

Yes – but does not always happen (Baseline Survey_6).

Not sure – I would say it is inconsistent (Baseline Survey_44).

N/A – According to org policy we should (Baseline Survey_48).

I am unaware of the practice in this area (Follow up Survey_20).

No – unless it's a factor in the MH presentation (Baseline Survey_35).

Not sure – do not use interpreters in my program (Baseline Survey_110).

Yes – I do and offer only for significantly cases. Not all the time. But this is suggested in my work setting (Baseline Survey_47).

Yes – there is no organisational policy but as a social worker I am concerned about what the interpreter heard and their wellbeing so I do debrief them (Baseline Survey_104).

As required and not all interpreters take up debriefing. However, the majority of the time interpreters have to attend to other interpreting jobs, therefore there is limited time for debriefing. Parking in the area also limits debriefing due to parking restrictions (Follow up Survey_22).

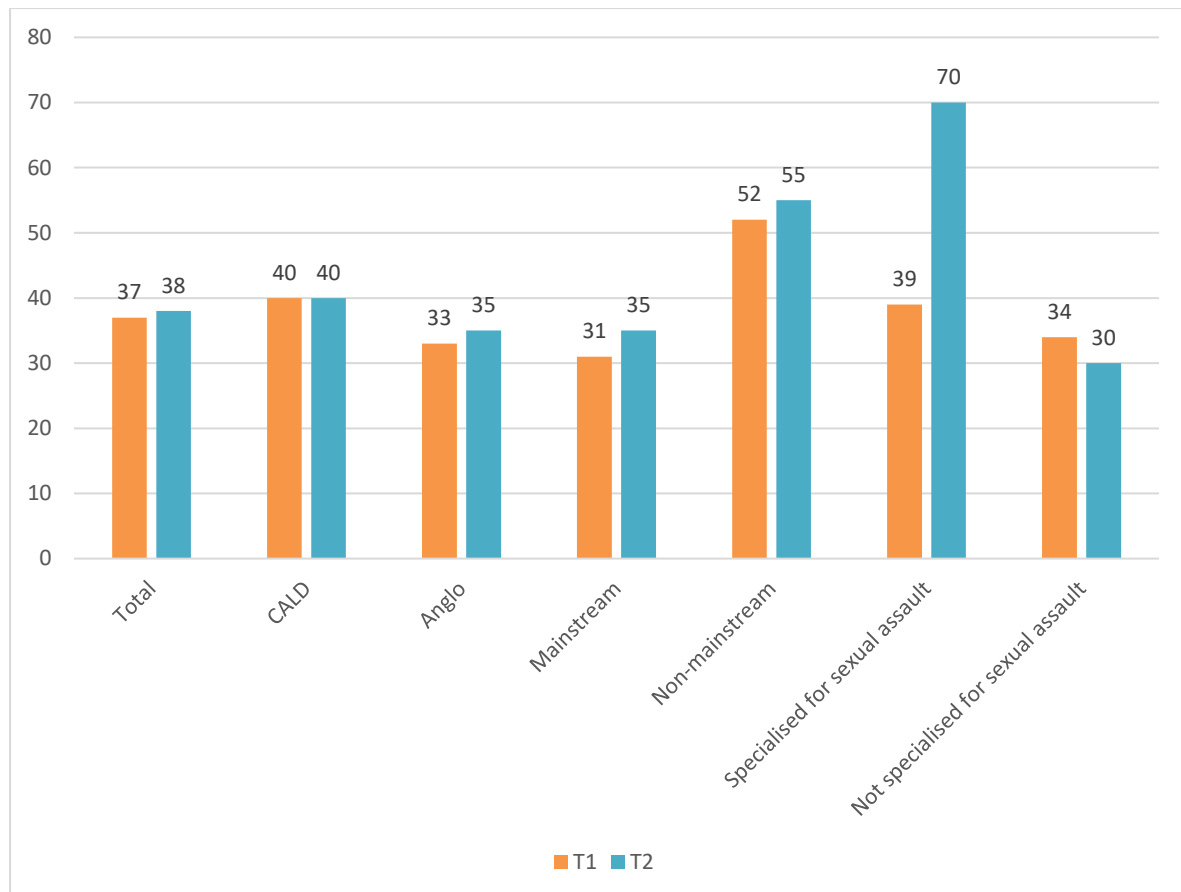
Thus, not including the participants who selected N/A, 37% of the total sample at T1 said they de-brief interpreters on matters relating to sexual assault. This remained consistent at 38% at T2, demonstrating that the program had no effect on this element (see Figure 15).

Descriptively, the data shows that only marginally more CALD (T1 40%, T2 40%) than Anglo (T1 33%, T2 35%) service providers, and more service providers in non-mainstream (T1 52%, T2 55%) than mainstream organisations (T1 31%, T2 35%), de-brief interpreters on matters relating to sexual assault. There was also little difference on this between service providers who work at organisations specialised for sexual assault (T1 39%, T2 70%) and those who do not (T1 34%, T2 30%) at T1 only, suggesting that the program has been effective on this element among service providers who work in organisations specialised for sexual assault.

Overall, the results show that de-briefing occurs more often than the sole use of trained interpreters or training interpreters, but less often than pre-briefing, and appears to depend significantly on the individual case. This practice also appears to be more influenced by

whether the service provider worked at a mainstream or non-mainstream organisation, and less by the cultural background of the service provider.

Figure 15: Percentage distribution on de-briefing interpreters on matters relating to sexual assault by cultural background of service provider and types of service organisation (T1 and T2)



Qualitative data

Much of the Q&A discussions at the end of each workshop and open-ended comments on the Follow-up Survey centred on interpreter engagement, demonstrating that it is a central issue in the service space and warrants substantial further research. All quotes obtained from these as well as the Baseline and Participant Satisfaction Surveys are identified below. Overall, the comments highlight the difficulties of working effectively with interpreters, as well as the program’s affirmation of the importance of the four elements investigated (if not effectiveness in improving practice on them):

Good food for thought especially on what is our policy around interpreters (Baseline Survey_104).

I will make time to meet with new interpreter's before session starts with client (Satisfaction Survey_99).

We use a telephone interpreter, but it doesn't make your job easier, it makes your job harder (Q&A Forum_Adel).

Working with interpreters who understand work with clinical issues is complex and difficult (Satisfaction Survey_45).

Interpreter availability on [area name] is extremely low. This provides a problem when supporting clients from CALD backgrounds (Baseline Survey_32).

(Any other comments?) The importance of debriefing before and after with an interpreter if exploring sexual abuse with clients (Satisfaction Survey_25).

Some people ask for, say if they were Iraqi Arabic speaking, they would ask for a Lebanese interpreter, for that issue of confidentiality (Q&A Forum_Melb).

I think it's equally important to offer [interpreter] choices to someone of a particular faith. I think a lot of the time, culture and faith get conflated (Q&A Forum_Syd).

The interpreter speaks Arabic and can be from Lebanon, but the client's from a part of Africa, and that's been really good, it's worked really well (Q&A Forum_Adel).

I find that most interpreters say, 'oh hang on a sec, we don't have a word for that, I'm just trying to explain that to them'. Then I feel 'ok that's fine' (Q&A Forum_Melb).

The interpreter will be from their community, and they say to me [later], the interpreter approached them in church, and said, 'oh how you going?' (Q&A Forum_Adel).

Can I just be devil's advocate here, it's really important we don't use interpreters as cultural brokers, because they come with their own understanding too (Q&A Forum_Adel).

Answers from questions C.7 and C.8 are based on what I would do, as the use of interpreters is not a lot at [org name]. We have it available, but we don't use as often (Baseline Survey_46).

The education around privacy and confidentiality, but also supervision for interpreters who are involved in or going into counselling, trauma or torture cases (Q&A Forum_Melb).

I'm an interpreter. You absolutely cannot divulge information you come across. It threatens our accreditation, and we could be taken to court for breaching confidentiality (Q&A Forum_Melb).

Our organisation is currently undergoing a restructure, but when things stabilise, I anticipate our CALD focus group will reform and the question of briefing interpreters can be raised (Follow up Survey_14).

My observation is that most interpreters are male, but most clients from CALD communities are female, and that is problematic. The need for training interpreters on self-care is another observation (Q&A Forum_Adel).

[Speaking with interpreters after] they're some of the best conversations I've had in learning about culture, and because interpreters move around so many different services that's really valuable too (Q&A Forum_Adel).

I think the challenge of working with interpreters and social workers is a real challenge. The concept of privacy, the concept of working in a clinical relationship with three people, there are conflicts (Q&A Forum_Syd).

As this is a government agency the views appear to be diverse, however most of our client officers are of non-CALD backgrounds and do not speak any languages other than English to provide that assistance (Baseline Survey_65).

The questions with "not sure" are because I have never had personal experience with using an interpreter. My ticked/marked answers were based on my knowledge of the organisation's level of professionalism and accountability (Baseline Survey_50).

Our organisation usually refers clients to appropriate services for CALD clients, when we don't have staff speaking the same language. We also use phone interpreter services for walk-in clients. Majority of our staff are volunteers/students (Baseline Survey_64).

[In the Department of Child Protection] we use telephone interpreters, and we go one step further, and say, 'this interpreter's from a different state, and we won't be using your name'. Some communities are so small that even across states they know each other (Q&A Forum_Adel).

I think your section where you talk about 'use this as an opportunity to teach feminist language, or understand power and control in relationships, or patriarchy' is so important to do. It's so important to have an interpreter that can find those words, so that they can be used well (Q&A Forum_Adel).

I've had lots of experiences where I said something and the interpreter was taking forever. Just the other day, I was explaining what domestic violence was and the interpreter just went on and on and on and on and on. It's hard. You know when you've got a good interpreter (Q&A Forum_Melb).

Something that I think is missing in practice, that I've seen over the years, we don't use interpreters to help us after a visit. We sign off and say bye. Interpreters can be a resource for non-verbal cues. With child sexual abuse, and even physical abuse, there's so much trauma that you need to pick up body language in order to have good clinical engagement (Q&A Forum_Adel).

It is difficult to provide a definitive response to [the] questions in relation to pre-brief and debrief interpreters. There are guidelines about working with interpreters we are [to] comply with. Pre and de brief require prior knowledge that child sexual assault is the focus of the therapeutic work, and the client has consented for the information to be shared in a therapeutic context (Follow up Survey_29).

I went to a mediation and was sitting with my client, and we had a male interpreter, and during the conversation – because I speak the same language but I had no say – the interpreter was saying 'just go back home, at the end of the day he is your everything'. After the whole mediation, I said 'look, this interpreter is not doing his job because he's telling my client to go back to the perpetrator' (Q&A Forum_Melb).

Many interpreters are self-employed or engage in contract work and so my responses would have been too inconsistent. However, I would like to note that all interpreters are working under NAATI's COE (Code of Ethics), and that NAATI as an organisation does engage frequently with CALD communities and approve PD courses on DV, CSA, and so on. We also work with CALD communities every day (Baseline Survey_111).

We are trained to always direct the client back to the professional, but sometimes (there are) things that just do not exist in that culture or country. Bulk-billing (for example) doesn't exist in Japan. It needs a whole paragraph to explain what that is and how it works, so sometimes they might be talking for such a long time. We need to be accurate. We're also required to have knowledge of Australian legal systems, medical systems, healthcare systems, if we don't we can't be an interpreter. But, I'm part of a small group of interpreters that are born here, western interpreters (Q&A Forum_Melb).

I think something to remember as well is that if we're trying to explain systems and government bodies and statutory obligations to a newly arrived client, and then the

interpreter themselves doesn't quite have that knowledge, or hasn't been in the country for very long themselves, for them to understand the concepts, we have to be very mindful of using basic language, which also the interpreter can find a word for in their language. So the idea around training is so important, but no one has the time or resources to do it. What we think is basic information, is not basic to them, so there's an extra barrier with the interpreter because they don't understand the system (Q&A Forum_Adel).

CALD staff and choice regarding matching

Representation of CALD staff

At T1, participants within an organisation provided the same responses to each other to C.10, so the unit of analysis could be the organisation rather than the service provider. Participants from five organisations selected 'N/A' because they worked at a university, were a student on field placement, or did not work in frontline services, and one participant did not answer this question because they were in private practice. Of the remaining 45 organisations, 38 (84.4%) said that CALD staff were employed there. This is a positive finding. However, that 15.6% of organisations do not have any CALD representation is still problematic and in need of address. It indicates that a sizeable number of service organisations are wholly white, and therefore do not have the diversity of knowledge that both colleagues and clients require or benefit from while working in a multicultural society.

At T2, two participants from one organisation provided different responses to each other to C.10. However, of the remaining 26 service organisations represented in the follow up data set, 25 (96.2%) said that CALD staff were employed there, and one private practitioner was of CALD background. This suggests that service organisations with diversity in their staff profile were most interested in the program than those without.

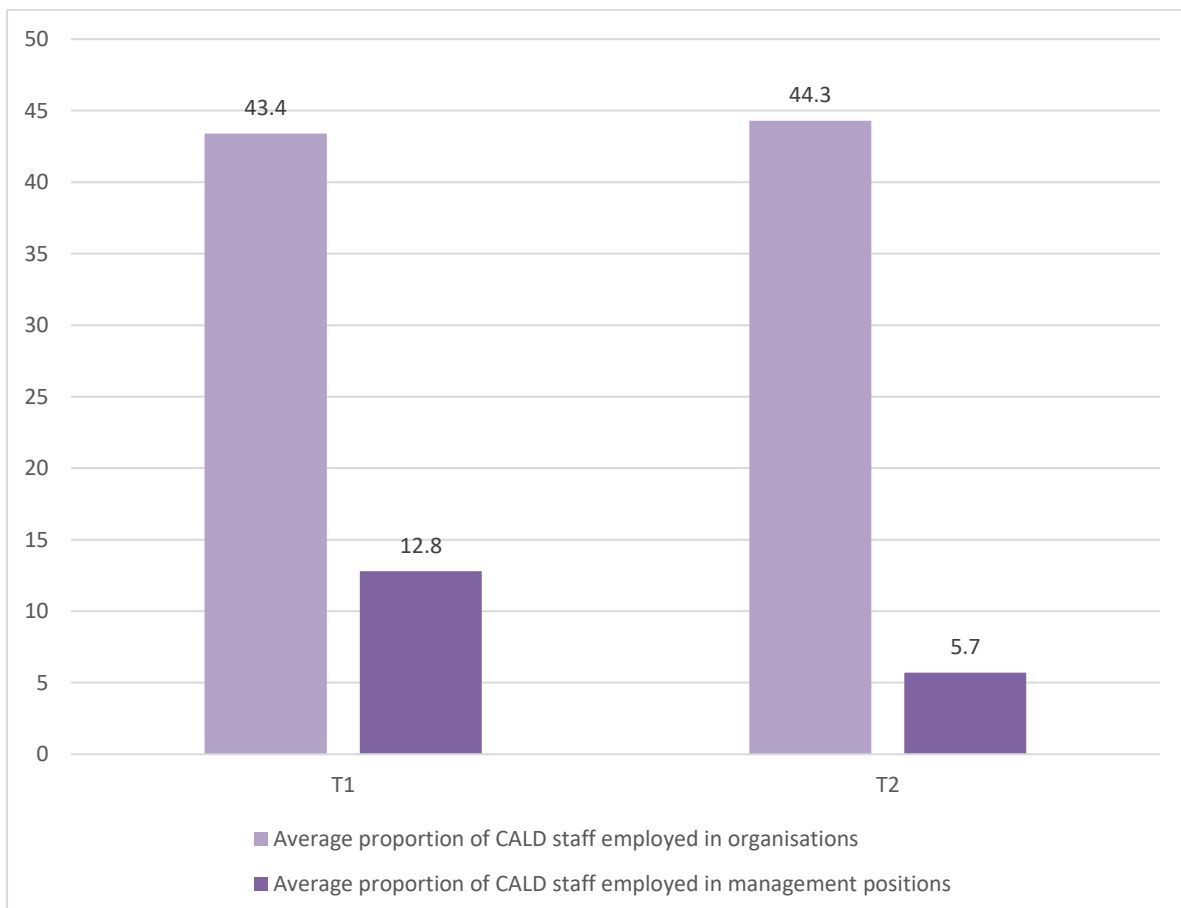
C.11 was designed to explore what proportion of staff are CALD and how many are in management positions, however the data that was collected needs to be treated with caution: 34 participants at T1 and 16 at T2 did not answer a, b, or c; 19 at T1 said they were 'Not sure' about a, b, or c; six at T1 and six at T2 did not provide logically consistent answers, with number of CALD staff either exceeding total staff size or equalling it but additionally identifying CALD staff in management positions; at both T1 and T2 responses from participants within organisations varied from one another; and at T1 and T2 approximations were often offered rather than exact numbers. For all these reasons, the data cannot be seen as trustworthy. Instead, the remaining usable data represents an initial tentative signal.

Regarding proportion of CALD staff, there was usable data for 31 organisations at T1 and 18 at T2. At both times, the average was taken among participants from the same organisation.

Based on this, the proportion of CALD staff was stated to range from 8–100% (M = 43.4%) at T1 and from 8–100% (M = 44.3%) at T2. However, the trends at T1 show (not reported here) that the higher numbers were obtained among non-mainstream organisations that formally support CALD clients (as expected), pushing the average up.

Regarding proportion of CALD staff in management positions, one participant said *N/A – Our organisation is a feminist collective flat structure (Baseline Survey_1)*. There was usable data for 29 organisations at T1 and 18 at T2, and again the average was taken among participants from the same organisation at each time. Based on this, the proportion of CALD staff in management positions was stated to range from 0–100% (M = 12.8%) at T1 and from 0–20% (M = 5.7%) at T2, with the higher numbers at T1 among non-mainstream organisations (not reported here). These low proportions are problematic because they reflect systemic racial bias (i.e. ‘white privilege’), else they would be proportionate to the representation of CALD people in Australia’s population (approximately 33%, ABS 2016). Indeed, almost all participants at T2 worked at organisations with ethnically diverse staff profiles (96.2%) but very few were in management positions (5.7%). The data is summarised in Figure 16.

Figure 16: Average proportion of CALD staff employed in service organisations and in management positions for total sample (T1 and T2)



Qualitative data

Some participants provided qualifying information regarding CALD staff representation within their organisation. Overall, they indicate that CALD staff may not be represented in their team but are in the wider organisation, that some organisations have intentions to grow their CALD staff representation, that there is recognition of low representation of CALD staff in management positions, and that there are institutionally racist barriers:

It's very rare that CALD group will achieve a manager position in this organisation (Follow up Survey_4).

(Any other comments?) The importance of having CALD staff in management and power (Satisfaction Survey_25).

No CALD background employees in small SV team – CALD workers in broader DVAC team (Baseline Survey_22).

We are a small private practice with 2 GP's and 2 psychologists all from CALD backgrounds (Follow up Survey_41).

We have a number of different programs and CALD practitioners are spread based on their skills (Baseline Survey_39).

The org as a whole I cannot totally speak for but I have not noticed a wide prevalence of CALD leadership positions (Satisfaction Survey_88).

Have followed up with some of these teams for more information/clarification, have distributed information to colleagues (from training), (but) the size of the organisation (small) poses challenges for staff that reflect client diversity (Follow up Survey_12).

I know that when I was employed, my manager was hoping to employ someone from CALD background but didn't find anyone suitable. I also know we are trying to be more CALD inclusive – attending networking meetings in CALD services etc. (Baseline Survey_109).

We have CALD practitioners and staff from many varied ethnic communities. To name a few, these include South Sudanese, West African, Iran, Iraq, China, Malaysia, India, Afghanistan, Brazil, and Lithuania. We also have Aboriginal and Torres Strait Islander practitioners and program managers, as well as from other Australian states and territories (Baseline Survey_102).

Client choice regarding ethnic matching

At T1, 19 participants did not answer C.12; three said 'Not sure'; five said 'N/A – We have no CALD clients'; 30 said 'No'; and 55 said 'Yes'. At T2, 10 participants did not answer this question; two said 'N/A'; 12 said 'No'; and 20 said 'Yes'.

Some participants at T1 also said:

Yes – if available (Baseline Survey_39).

No – not explicitly (Baseline Survey_18).

N/A – from memory, no (Baseline Survey_56).

No – we have no CALD staff (Baseline Survey_109).

Yes – always discuss preferences (Baseline Survey_76).

Yes – where we can or refer for all matters (Baseline Survey_59).

Yes – we offer freedom of choice for counselors (Baseline Survey_46).

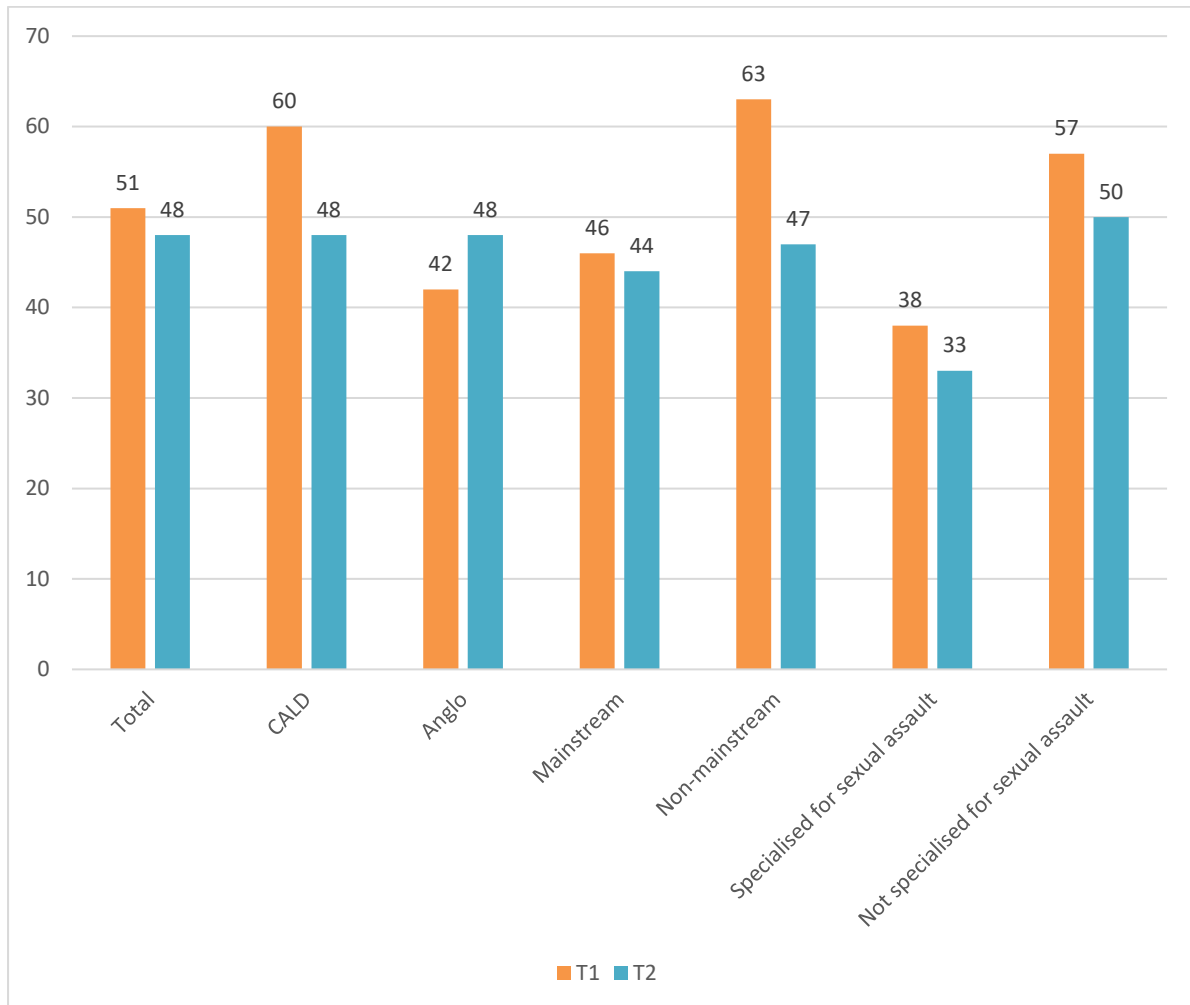
Yes – Indig families but not necessarily other groups (Baseline Survey_20).

Sometimes – depending on availability and client preference (Baseline Survey_29).

No – the offer of services is limited to CALD service availability (Baseline Survey_75).

Thus, not including the participants who selected N/A, 51% of the total sample at T1 said their service organisation offer CALD clients choice about whether they would like an ethnically-matched service provider. This decreased to 48% at T2, somewhat suggestive of the ineffectiveness of the program on this element (see Figure 17 and Data Table G.8).

Figure 17: Percentage distribution on client choice regarding ethnic matching by cultural background of service provider and types of service organisation (T1 and T2)



Participants from the same organisation provided different responses to each other, so the unit of analysis became the service provider rather than their organisation. Descriptively, the data shows that at T1 more CALD (T1 60%, T2 48%) than Anglo (T1 42%, T2 48%) service providers, more service providers in non-mainstream (T1 63%, T2 47%) than mainstream organisations (T1 46%, T2 44%), and more service providers in organisations not specialised for sexual assault (T1 57%, T2 50%) than those that are (T1 38%, T2 33%), offer CALD clients choice about whether they would like an ethnically-matched service provider, but that these numbers mostly evened out at T2.

Overall, the results show that client choice regarding ethnic matching occurs inconsistently at approximately half the time, and that CALD service providers, and service providers working in non-mainstream organisations, are generally more likely to do it. Interestingly, the results also show that service providers working in organisations not specialised for sexual assault

are more likely to offer ethnic matching. This suggests that in organisations specialised for sexual assault meeting cultural needs is seen as less important than meeting the needs of victims/survivors of sexual assault, thereby failing to take an intersectional lens.

Qualitative data

One participant provided qualitative data regarding ethnic matching. They said:

[Org name] is not a case management or crisis support service and has little face to face interaction with CALD clients. Client service roles are phone-based and it is not always possible to identify CALD clients. [Org name] relies on bilingual staff to assist with translating when language barriers are present. Client services have a dedicated Aboriginal Contact Officer to assist with clients who identify as Aboriginal and/or Torres Strait Islander. CALD clients are given the opportunity to nominate a counselor based on their language preferences (Baseline Survey_53).

Training

For total sample

At T1, two participants did not answer C.9; 11 said ‘N/A – I do not work at a service organisation’; 77 said ‘No’; and 22 said ‘Yes’. At T2, three participants did not answer this question; two said ‘N/A’; 15 said ‘No’; five said ‘Yes’ (but named this program); and 19 said ‘Yes’.

Thus, not including the participants who selected N/A or this program, 21.8% of the total sample at T1 said they had received training on culturally appropriate service provision for CALD victims/survivors of child sexual abuse while working at their service organisation. This had increased at T2 (51.4%) but likely reflects the current program without it being explicitly named by participants. Thus, it could not be claimed that the program has effectively heightened general awareness of this issue in the field.

Some participants identified their source of training, and they included local mainstream or multicultural organisations as well as internal staff. One participant also said, *Yes (a trainer within the organisation. It was a very short/general training though (Baseline Survey_56).* Another said: *We have received training from [org name] on CALD clients experience of trauma, and separately we have received training from [org name] on sexual violence. Workers can opt to seek out specific training as part of their professional development, so some workers may have received more specialised training, e.g. our CNP program where workers speak to victims of sexual assault (Follow up Survey_11).* Overall, the results indicate that training in this area is nascent.

Qualitative data

Several participants offered qualitative feedback that does not explicitly identify the need for training, but does highlight a desire for in-depth knowledge, appreciation of the content within the current program, or ideas for future work, all of which indirectly support the usefulness of training:

(Liked best?) Barriers to seeking help (Satisfaction Survey_1).

(Liked best?) Three things to take home (Satisfaction Survey_2).

(Liked best?) Barriers and how to address (Satisfaction Survey_77).

The topic needs to be taken more in consideration (Satisfaction Survey_56).

(Liked best?) The discussion of the service delivery model (Satisfaction Survey_23).

(Liked best?) How services can better support CALD people (Satisfaction Survey_54).

(Liked best?) Info how to respond when a child wants to disclose (Satisfaction Survey_3).

More knowledge of diverse cultures where child abuse happens? (Satisfaction Survey_94).

(Anything redundant?) Opportunity and role of community leaders (Satisfaction Survey_45).

Never thought of 'being secondary victim'. Have to explore more, thank you (Satisfaction Survey_3).

(Liked best?) Shedding light on barriers we may overlook but need to address (Satisfaction Survey_46).

Highlighting that we should be doing more to support "CALD" people to access our service (Satisfaction Survey_54).

I love how you presented a model with principles underpinned by research and literature (Satisfaction Survey_21).

The reasons for non-disclosure – comparison between Western and non-Western based samples (Satisfaction Survey_95).

The explanations for barriers to services in CALD communities was very helpful and interesting (Satisfaction Survey_99).

Key messages in addressing/understanding CALD communities responses to childhood sexual assault (Satisfaction Survey_96).

(Liked best?) Ideas of cultural competency at organisational level – good to easily apply to be more inclusive (Satisfaction Survey_99).

(Liked best?) The basic linkage and understanding for individuals to work and support CALD communities (Satisfaction Survey_79).

So important to consider CALD backgrounds but to keep your job focused on the client themselves is paramount (Satisfaction Survey_80).

(Liked best?) The barriers women/children from CALD communities experience in accessing support. Thank you very much (Satisfaction Survey_70).

(Liked best?) Acknowledging the many different factors, specifically cultural and acculturative, that pose as barriers to disclosure (Satisfaction Survey_92).

(Any other comments?) Have left today with a clearer understanding of barriers/challenges faced by CALD victims/survivors (Satisfaction Survey_39).

My organisation provides services for all women no matter your background. I'll suggest that this program conduct this session across community levels (Baseline Survey_52).

(Liked best?) Ideas on providing “culturally competent” service provision and particularly your service delivery model -> I'm going to use (try!!) this in my work (Satisfaction Survey_52).

I have learnt more about the difference in the CALD and Western differences. I understand the importance of understanding CALD clients around CSA and the extreme barriers (Satisfaction Survey_37).

Potential leadership and drive to influence and change community attitudes within/for CALD communities – increase awareness of government and organisations and community responsibility (Satisfaction Survey_47).

(Any other comments?) When someone discloses, you might get one shot to put them on the right direction or help them. We, as a community, have to be knowledgeable, educated to support others (Satisfaction Survey_3).

(Any other comments?) Something that stuck out was to acknowledge difference in culture but don't make them feel different. Also not focusing on politeness to the point where victim's trauma is underplayed (Satisfaction Survey_46).

Excellent! Although there was a lot of content I was familiar with, the challenges you raised by your questions has given me a lot to think about in how I provide service to CALD clients – how to make it easier for CALD clients to access service (Satisfaction Survey_34).

It was really interesting, I would have liked to go a bit deeper into possible ways to move forward with issues/barriers for victims for collectivist cultures, how to challenge the negative outcomes of communities punishing victims, whilst remaining cultural respectful (Satisfaction Survey_68).

Many CALD women are unaware and/or have little confidence that they are equal in the eyes of the law – they have rights which are protected by law. Many believe Police and institutions operate in the same way as their home country. Many CALD women are financially abused and coerced. Work at the client's pace (Satisfaction Survey_9).

At times it was difficult to follow if you were speaking about the child victim or adult survivor of sexual abuse. Adults won't present to organisations (DHS etc.) therefore I feel training individuals (as your training is presumably designed to do) is essential – the organisation is only as good as its frontline workers but many do not work as part of organisations (Satisfaction Survey_16).

Just a mindfulness that I think most people in the room were not mandatory reporters to Child Safety (social workers, counselors, human service practitioners etc.) and there is a lot of fear among workers regarding reporting to Child Safety when developing trust (especially with CALD communities) and would be good to touch on navigating this (Satisfaction Survey_65).

In my mind, there is a long journey ahead for child protection agencies across the country to come up to speed in terms of cultural competency with CALD clients in most regards, unfortunately. Progress will be noted when cultural responsiveness is embedded as strongly for CALD families as it is for Aboriginal families and I say this with no disrespect to Aboriginal communities. We all know why Aboriginal practice approaches are so needed due to our past horrific practices. I would, however, like to see the word “culture” be associated with ALL cultures and an equal worth be placed on working effectively with CALD families (Follow up Survey_23).

Multicultural framework

Table 18 contains descriptive data on service providers' ratings of their organisation's respect for ethnic diversity in principle and in practice. This is for the total sample, by the cultural background of the service provider, whether the service provider works at a mainstream or non-mainstream organisation, and whether the service provider works at an organisation specialised for sexual assault or not.

The results show that for the total sample at both T1 and T2, ratings are higher for 'in principle' (T1 M = 4.1, T2 M = 4.4) than 'in practice' (T1 M = 3.7, T2 M = 4.0), but that both are still high. This suggests relatively good convergence between the rhetoric and implementation of a multicultural framework within service organisations. The results also show that ratings increased from T1 to T2, suggesting that the education program was effective in enhancing this component of cultural competency at the organisational level. However, as one participant importantly pointed out, *Re C.3 and C.4 – But we are always learning (Baseline Survey_48)*.

The results also show that ratings are higher among service providers who work in non-mainstream organisations (T1 M = 4.5, T2 M = 4.7; T1 M = 4.2, T2 = 4.7) than those who work in mainstream organisations (T1 M = 4.0, T2 M = 4.3; T1 M = 3.6, T2 = 3.7), at both T1 and T2. This finding is consistent with expectations that CALD-specialised organisations would be better in using a multicultural framework in both word and deed. However, the difference was considerable at T2 and suggests that mainstream organisations have sizeable room for improvement.

Finally, there were no or little differences at T1 between CALD and Anglo service providers, nor between service providers who work at organisations specialised for sexual assault and those who do not. However, there was an observable increase among Anglo service providers (T1 M = 4.1, T2 M = 4.6) for 'in principle' ratings. This may suggest that support from their organisation to attend this program and obtain professional development was particularly positively regarded.

Qualitative data

One participant appreciated that the organisational responsibility was included in the program, not just the responsibility of frontline workers. Importantly, she highlights that the implementation of a multicultural framework is challenging and far from being realised:

I liked the part about cultural awareness of individuals and organisations. I've seen child-centric cultures in so many organisations, but it's really occurred to us it's just ticking a box for the government, it's really Western, not taking others into consideration (Q&A Forum_Adel).

Table 18: Descriptive data on use of multicultural framework by cultural background of service provider and types of service organisation (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
How respectful of ethnic diversity service organisation is in principle (C.3)										
Total	4.1	0.9	111	2	5	4.4	0.7	42	3	5
CALD	4.1	0.9	59	2	5	4.2	0.8	21	3	5
Anglo	4.1	0.8	52	2	5	4.6	0.6	21	3	5
Mainstream	4.0	0.9	74	2	5	4.3	0.8	28	3	5
Non-mainstream	4.5	0.9	30	2	5	4.7	0.6	13	3	5
Specialised for sexual assault	4.0	0.8	34	2	5	4.2	0.8	9	3	5
Not specialised for sexual assault	4.2	0.9	70	2	5	4.5	0.7	32	3	5
How respectful of ethnic diversity service organisation is in practice (C.4)										
Total	3.7	0.9	111	1	5	4.0	0.9	42	2	5
CALD	3.8	1.0	59	1	5	4.0	1.0	21	2	5
Anglo	3.7	0.8	52	2	5	3.9	0.8	21	2	5
Mainstream	3.6	0.8	74	1	5	3.7	0.9	28	2	5
Non-mainstream	4.2	0.8	30	2	5	4.7	0.7	13	3	5
Specialised for sexual assault	3.8	0.7	34	2	5	4.0	0.8	9	3	5
Not specialised for sexual assault	3.8	1.0	70	1	5	3.9	0.9	32	2	5

Data collection

At T1, one participant said 'Not sure' to C.1; seven said 'N/A – I do not work at a service organisation'; 20 said 'No'; and 84 (80%; not including N/A) said 'Yes'. At T2, seven did not answer this question; two said 'No'; and 35 (79.5%) said 'Yes'.

Participants at T1 also said:

Yes – but not very well! (Baseline Survey_99).

Yes – only some programs collect CALD data (Baseline Survey_94).

Within my program there is no data – until recently when I have requested to collect specific data for CALD and a SW student to do research (Baseline Survey_88).

At both T1 and T2, some participants from the same organisation provided different responses to each other. To depict the best possible scenario, data was used from participants who said 'Yes' rather than 'No' and who ticked the highest number of variables. Of the 45 organisations for which there is data at T1, one said 'Not sure'; four said 'No'; and 40 (88.9%) said 'Yes'. Of the 31 organisations for which there is data at T2, six said 'No' or did not respond; and 27 (87.1%) said 'Yes'.

The change over time was small, indicating that the program was not effective in ensuring organisations collect ethnicity-related data. *Prima facie*, it appears that this aspect of organisational cultural competency is already being done well which is why improvements are not being observed, however selecting the most favourable data also somewhat inflates the proportion of organisations collecting this data. More precise, accurate research is required in the future.

As can be seen from Figure 18 (and Data Table G.9), the most common variables that organisations collect data on are languages spoken at home, need for interpreter, and country of birth. All those who provided a qualitative response under 'Other' said:

Diet (Follow up Survey_31).

Ethnicity (Follow up Survey_47).

Ethnic group (Baseline Survey_47).

COB of parents (Baseline Survey_89).

Cultural identity (Baseline Survey_35).

Indigenous Status (Follow up Survey_29).

Preferred language (Baseline Survey_46).

Identified cultural group (Baseline Survey_81).

Minority/ethnicity status (Follow up Survey_34).

Sexual identity/orientation (Baseline Survey_77).

Year of arrival if a migrant (Baseline Survey_51).

What culture they identify with (Baseline Survey_29).

Ethnicity – if majority/minority (Baseline Survey_58).

Cultural group that they identify with (Baseline Survey_16).

If the individual identifies belonging to a culture (Baseline Survey_66).

Year of arrival in Australia (Baseline Survey_19, Follow up Survey_22).

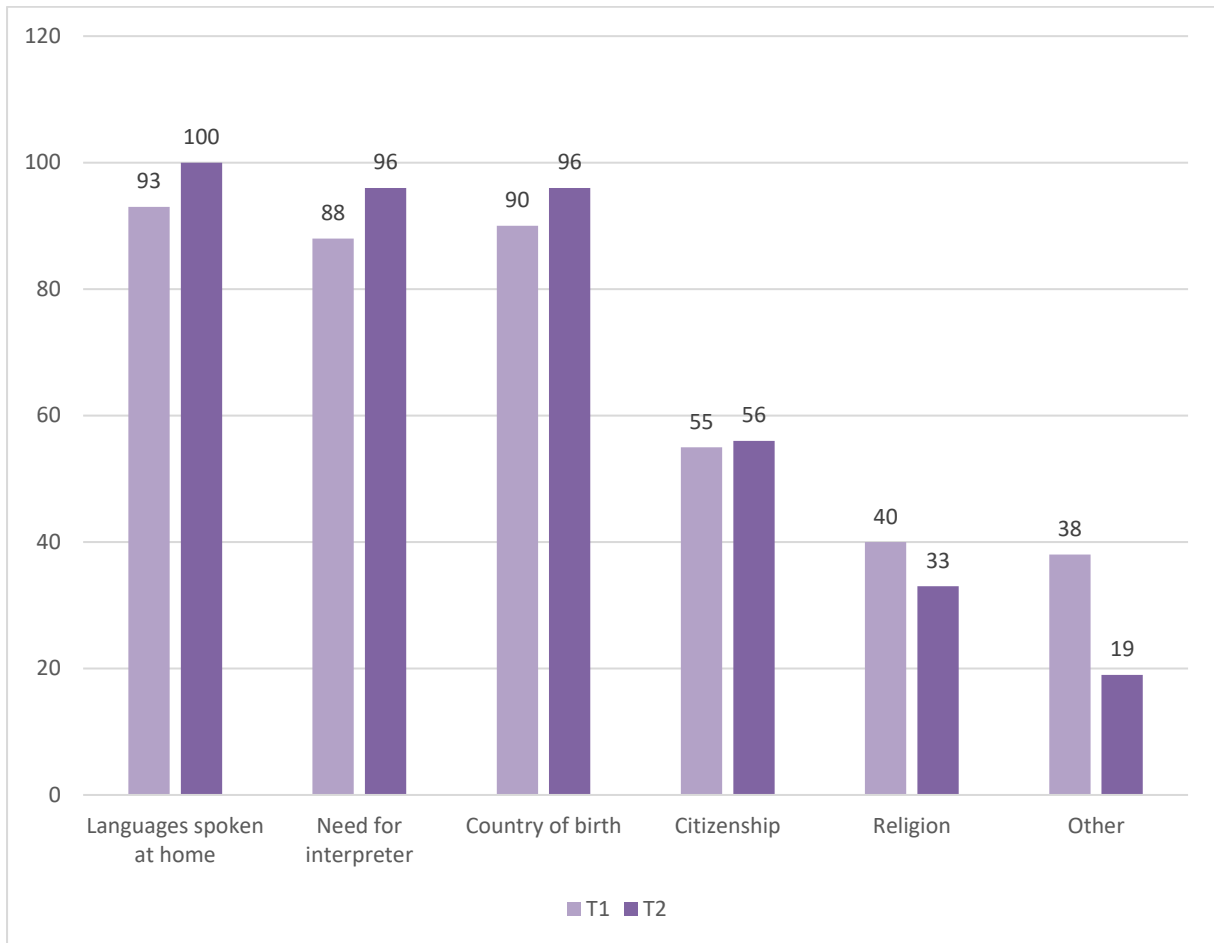
Relevance of culture etc. relating to presenting need (Baseline Survey_101).

Cultures within cultures e.g. Dinka in South Sudanese context (Baseline Survey_34).

*Cultural background and means of connection (people, organisations, events)
(Baseline Survey_80).*

*We ask individual to advise us whether there are cultural issues we should be aware
of (Baseline Survey_102).*

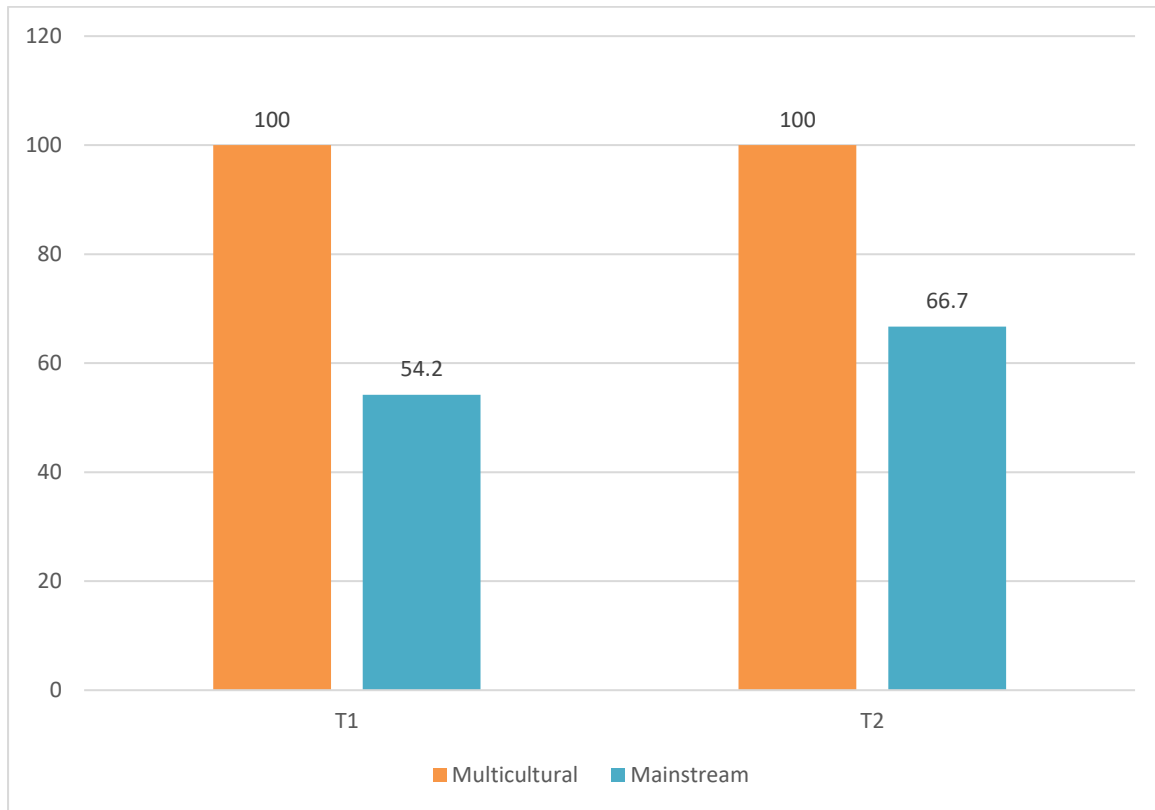
Figure 18: Percentage distribution on organisations collecting ethnicity-related data (T1 and T2)



Promotional inclusiveness

Within the month prior to the programs being delivered (i.e. between 25 Feb–25 Mar 2019), the homepage and each main tab on the websites of the 61 organisations that registered were explored for their visual inclusiveness (Yes or No). For the purposes of this study, images of only Indigenous Australians did not constitute as ethnically diverse/visually inclusive. However, not all registrants attended the programs on the day, or completed or named their organisation on the Baseline Survey, so only data for the 46 organisations named on the Baseline Surveys have been analysed here. Visual inclusiveness was explored again six months later (25 Sep 2019), and findings are summarised in Figure 19.

Figure 19: Percentage distribution on visual inclusiveness of website by type of service organisation (T1 and T2)



At baseline, three organisations were universities rather than service organisations, and so were not included in further analyses. Of the remaining 43 organisations, three (7%) had no website, one (2.3%) did not use any images, and four (9.3%) used inanimate images not of people (e.g. flowers); likely to be intentional as part of branding and/or informed by costs. Excluding these, 24 were mainstream organisations and 13 (54.2%) had websites deemed visually inclusive. Three of the mainstream organisations that did not have images of people from CALD communities did however provide different language options, thereby addressing linguistic accessibility. All 11 multicultural organisations were visually inclusive.

At follow up, 16 of 24 (66.7%) mainstream organisations were deemed visually inclusive. Of the three additional organisations, one was national and two were state-based. The only small increase in the proportion of mainstream organisations implementing this aspect of cultural competency may not necessarily indicate the program’s ineffectiveness about this, but rather that organisations may not have sufficient funds or other resources to prioritise and implement it.

Links with local CALD organisations

There appeared to be a small amount of confusion with the question regarding links with other local CALD community organisations or members within such organisations. Most answered it based on what they currently do (as the question intended to ascertain), but a small number of participants seemed to base it on what they would do (indicative of a future intention should a CALD victim/survivor present to their service). Thus, the validity of this data appears slightly compromised, and in turn should be treated with some caution.

Table 19: Descriptive data on links with CALD community organisations by cultural background of service provider and types of service organisation (T1 and T2)

	T1					T2				
	M	SD	N	Min	Max	M	SD	N	Min	Max
Total	2.4	0.9	107	1	4	2.7	1.0	43	1	4
CALD	2.5	1.0	56	1	4	3.0	0.8	23	1	4
Anglo	2.3	0.8	51	1	4	2.7	1.1	21	1	4
Mainstream	2.1	0.8	73	1	4	2.1	0.7	27	1	3
Non-mainstream	3.1	0.9	28	1	4	3.7	0.5	15	3	4
Specialised for sexual assault	2.1	0.8	34	1	4	2.6	0.9	9	1	4
Not specialised for sexual assault	2.6	0.9	67	1	4	2.7	1.0	32	1	4

Table 19 contains the descriptive data for the total sample, by the cultural background of the service provider, and by types of service organisation. (See also Data Table G.10 for frequency data). As expected, it shows that non-mainstream organisations have stronger links (T1 M = 3.1, T2 M = 3.7) than mainstream organisations (T1 M = 2.1, T2 M = 2.1) at both T1 and T2.

However, it also shows that organisations not specialised for sexual assault have stronger links (T1 M = 2.6, T2 M = 2.7) than organisations specialised for sexual assault (T1 M = 2.1, T2 M = 2.6) at T1. This seems to suggest that the intensity of clinical work involved with sexual assault victims/survivors, in a resource-poor climate, limits the ability of organisations specialised for sexual assault to take an intersectional approach for its CALD clients. However, after the program the difference closed suggesting that the program may have had an impact on promoting intersectionality.

Overall, there was an increase in ratings of links with CALD organisations from T1 to T2 for the total sample (T1 M = 2.4, T2 M = 2.7), and among CALD (T1 M = 2.5, T2 M = 3.0) and

Anglo (T1 M = 2.3, T2 M = 2.7) service providers. This is suggestive of the effectiveness of the program on this element of organisational cultural competency.

Qualitative data

Two participants provided qualitative data regarding links with local community organisations:

Re C.13: My team yes, broadly no (Satisfaction Survey_44).

C.13 to my knowledge leaves all responsibility for connections to the Multicultural Services team within DCP – which is possibly 4–5 staff members who assist/provide advice across 19 offices and program areas (Baseline Survey_85).

Summary

- The onus for cultural competency does not all belong to frontline service providers; structural support from their service organisation/institution is equally required.
- The following forms of organisational/institutional support were seen as mandatory:
 - using interpreters trained in matters to do with sexual assault, and service organisations providing such training to interpreters
 - having an ethnically diverse workforce, including in management positions
 - providing regular ‘cultural competency’ training, to address staff turnover and respond to new and emerging communities
 - using ‘a multicultural framework’, and thus fundamentally valuing cultural differences
 - mandatorily collecting data on all ethnicity-related variables
- Two forms of organisational/institutional support were seen as ideal:
 - using visual images of an ethnically diverse target client group in promotional materials
 - having strong links with local CALD community members and organisations
- The results show that CALD staff, and staff working in CALD-specialised (i.e. non-mainstream) organisations, are more likely to only use interpreters trained in matters relating to sexual assault. By corollary, the results also show that the program was most effective in increasing the number of Anglo service providers, service providers from mainstream organisations, and service providers from organisations not specialised for sexual assault, that use trained interpreters. Overall, it appears that many service providers are unable to only use trained interpreters due to resource constraints, lack of awareness of organisational policies, and policies about which interpreters can be used.
- Prior to the program, CALD staff, and staff working in CALD-specialised organisations, were more likely to train interpreters on matters relating to sexual assault, but this decreased substantially after the program and it is not known why. It did however increase among service providers working in organisations specialised for sexual assault, suggestive of the program’s effectiveness for this group. Overall, there is a desire and intention among service organisations to train interpreters, but low funding appears to constrain this ability.
- CALD staff, and staff working in CALD-specialised organisations, are more likely to pre- and de-brief interpreters on matters relating to sexual assault. The program appeared mostly ineffective in changing these, except for service providers working in organisations specialised for sexual assault for whom there is an observable increase. Compared to the number of service providers that used trained, or train, interpreters, more pre- and de-brief interpreters, perhaps because they are easier in comparison to

implement. Pre-briefing was also more common than de-briefing. However, pre- and de-briefing may not be done consistently, due to specific client needs, the individual service provider, or whether there are such explicit organisational policies.

- The difficulties of working effectively with interpreters requires substantial further research.
- Positively, most service organisations employed CALD staff. However, they were more often employed in CALD-specialised rather than in mainstream organisations. Moreover, approximately 15% of service organisations do not have any CALD staff, which is problematic and in need of address because it indicates that a sizeable number of service organisations are wholly white. They therefore do not have the diversity of knowledge that both colleagues and clients require and benefit from while working in a multicultural society.
- It is not known with confidence how many CALD employees are in management positions, but it appears that it is very low (approximately 6–13%), and that those who are work in CALD-specialised rather than mainstream organisations. This trend reflects white privilege; the systemic racial favouring of opportunities to white Australians.
- Overall, there is some recognition by service organisations of the need to address the low representation of CALD staff including in management positions.
- Although it occurs inconsistently, CALD staff, and staff working in CALD-specialised organisations, are more likely to offer CALD clients choice about whether they would like an ethnically-matched service provider. Overall, the program was ineffective in changing the number of service providers that offer choice about ethnic-matching to CALD clients. Interestingly, service providers working in organisations not specialised for sexual assault are more likely to offer ethnic matching, suggesting that organisations specialised for sexual assault do not or are unable to take an intersectional lens; de-prioritising meeting cultural needs to the needs of victims/survivors of sexual assault.
- The proportion of service providers who reported having received training on culturally appropriate service provision for CALD victims/survivors of child sexual abuse while working at their service organisation had increased over time, but this does not necessarily indicate that the program was effective in heightening general awareness of this issue in the field as their response may be about the current program. When training other than this program had been received, it was by local mainstream or multicultural organisations as well as internal staff but was seen as short or general. Overall, there is desire for in-depth knowledge, appreciation of the content within the current program, and ideas for future work, which all support the usefulness of further continued training.

- The use of a multicultural framework – operationalised as respect for ethnic diversity – was rated as higher ‘in principle’ than ‘in practice’, and higher among CALD-specialised organisations. Ratings also increased over time, demonstrating the effectiveness of the program. Support from organisations to attend professional development opportunities such as this education program are highly regarded by staff and perceived as their organisation implementing a multicultural framework.
- The proportion of service organisations collecting data on ethnicity-related variables did not increase over time, indicating that the program was not effective in improving this aspect of cultural competency. However, this may be because it is already being done well. The most common variables on which data is collected include languages spoken at home, need for interpreter, and country of birth. Less frequently, organisations also collect data on citizenship, religion, ethnicity, year of arrival, and diet.
- All CALD-specialised organisations had visually inclusive websites; just over half of the mainstream organisations had visually inclusive websites; and a small number of mainstream organisations were not visually inclusive, but their website offered different language options. These proportions did not change substantially over time, indicating that the program was not really effective in addressing it. However, resource constraints may have an impact on being able to prioritise or implement it.
- As expected, CALD-specialised organisations have stronger links with local CALD community organisations. However, unexpectedly, organisations not specialised for sexual assault have stronger links than those specialised for sexual assault. This again suggests that the intensity of clinical work involved with sexual assault victims/survivors, in a resource-poor climate, limits the ability of such organisations to take an intersectional approach for its CALD clients. However, ratings of links did improve over time, suggesting that the program was effective in promoting intersectionality and this element of organisational cultural competency.

DISCUSSION

Summary of key findings

As a result of collectivist values and pressures, CALD victims/survivors of child sexual abuse may interpret the abuse differently. Specifically, they may not recognise that a crime has been committed and/or that it is serious. Alternatively, they may recognise that a crime has occurred, but due to fear of shaming the family name and fear of reprisals for doing so (most commonly social exclusion and isolation from their community, but sometimes even death; Sawrikar & Katz, 2017a), seeking help for the psychological impacts of the abuse can become ‘out of the question’. These cultural factors can be exacerbated by social factors such as fear and mistrust of statutory authorities resulting from experiences in their home countries or during migration, as well as difficulty accessing culturally appropriate services due to their low availability (Sawrikar, 2017).

Leaving victims with few outlets outside of the family, for a crime they are likely to be blamed for, can have the effect of worsening the already severe impact on the victim/survivor’s mental wellbeing; delays in disclosing and seeking help can ‘make things worse’ (Sawrikar & Katz, 2018, 2017b). Thus, treatment systems that can effectively address the trauma of child sexual abuse are critical. However, treatment must be delivered with the understanding that their client is an ethnic minority, so while collectivism and patriarchy may have contributed to the severity of their symptoms, victims from minority groups will not want to be judged for these things. Such judgment is likely to be perceived as an affront to their ethnic identity, and it can perpetuate fear of lack of (personal and cultural) safety.

To put it all another way, effective treatment requires a non-judgemental approach from mainstream service providers combined with self-determined action from ‘within’ (the purpose of Stage 2 of this study). Indeed, mainstream and non-mainstream organisations have different types of ‘power’. Mainstream organisations are often seen by ethnic minorities as better resourced (Babacan, 2006) and non-mainstream organisations can act as advocates for human rights and social justice, to help give CALD victims the strength to break free from the collectivist and patriarchal pressure to ‘suffer alone in silence’. The health care system should play to these strengths to ensure the best possible outcomes for victims/survivors of child sexual abuse from CALD communities.

To this end, Stage 1 of this study was designed to improve the cultural competency of practitioners within existing service organisations across Australia (for which they also received CPD certification). Eight research questions were explored and examined.

Together, the results tell a complex story about culturally appropriate service delivery. They firstly show that low uptake of formal services by CALD communities leaves service providers with some practice wisdom, but that the program worked to mostly affirm this knowledge and boost confidence to work with CALD victims/survivors of child sexual abuse.

There also appears to be a slight false assumption among CALD service providers that the prevalence of child sexual abuse is different across cultures, and a slight false assumption among Anglo service providers that the prevalence is essentially equal. The former reflects a trend in the broader CALD community of deflected attention and therefore misperceptions of child sexual abuse being a ‘Western problem’. The latter reflects presumptions of universality in the psychosocial experience of child sexual abuse and/or a need to appear ‘colour blind’ as a way of using white privilege responsibly.

For CALD service providers, there appears to be deep internal conflict. On the one hand they may feel disappointed with and judgmental of their culture, while simultaneously understanding the barriers their cultural group face in being able to take loud/vocal community-level responsibility for child sexual abuse. Indeed, protective parenting may be occurring but only in an unspoken way, which makes such cultural strengths less visible and therefore impactful in risk of harm and strengths and needs assessments.

Service providers appreciate being able to have open discussions about racism, white privilege, terminology, skin colour, cultural and racial self-awareness, and critical reflection, and see these as useful for framing how best to understand and engage with this client group. However, solidarity from white feminists may not occur due to not relating to the experience of racism and brown feminists may still fear harmful cultural beliefs or patriarchal norms, additionally highlighting the necessity of an intersectional approach between the two systems of oppression that women of colour navigate – racism and sexism.

Service providers begin and maintain strong social work/social justice values across their careers; striving to use racial, gendered, and professional power responsibly. For example, they will only gently, and with respect, challenge strong traditional gender roles in collectivist cultures. They will also understand that a sociological approach to the treatment of mental illness is useful and effective and that not all mental illnesses can be treated with formal services, thereby implementing empowering trauma-informed practice. Indeed, family and group therapy were regarded with caution, reflecting the wisdom of practitioners about what might increase risk of psychological harm to victims/survivors, but in comparison more readily encouraged self-help strategies. They also often work in organisations that collect

data on ethnicity-related variables, thereby enhancing their ability to monitor the profile and respond to the needs of their client base.

Still, organisational barriers can constrain the work of frontline service providers. For example, poor resourcing to address the difficulties of working effectively with interpreters was particularly highlighted. That there is under-representation of CALD staff in management positions perpetuates and reflects white privilege, and therefore institutionally systemic practice that is white-centric. Only half of the mainstream organisations had visually inclusive websites with images of an ethnically diverse target client base, and CALD-specialised organisations had stronger links with local CALD community organisations.

In a climate where Australia's multicultural milieu is expanding, and CALD communities have utmost fear of service organisations due to mandatory reporting laws, drawing possible statutory attention, and breaches of confidentiality that could mar family reputation, the whole Australian mental health and sexual assault workforce needs to be appropriately trained. Such an effort implements a multicultural framework beyond mere rhetoric, so that 'CALD matters' are not just left to CALD workers. Indeed, support from organisations to attend this professional development opportunity was highly regarded by staff.

Methodological strengths and weaknesses

The main strength of the study was that the program's content was informed by a recently conducted systematic literature review, thereby being embedded in scholarly findings. It was also new and innovative as no such other in-depth program currently exists, and which adapted international research to Australia's particular needs and context. To enhance nationwide accessibility, the program will be converted to online mode, be accredited by AASW, and be eligible for CPD certification. The methodological approach was also ethical and rigorous, triangulating quantitative and qualitative data in a longitudinal design. Nevertheless, there are some methodological weaknesses that need to be acknowledged.

The first is that this study has grouped several different races, cultures, languages, and religions together, falsely homogenising their needs and experiences. Unfortunately, this is a risk with all research that has to do with CALD communities. Fontes (1993) calls this 'ethnic lumping'. It is usually unavoidable and/or justified on the grounds that small sample sizes in research for each CALD group warrants combining them, to be able to say something more representative of the larger category.

There is some merit in this. By virtue of being a minority, these various groups do have something in common, making results for one group reasonably generalisable to another. It

also has merit at a broad cultural level; many CALD groups are collectivistic, so these cultural trends are also likely to generalise from one group to another. Where it has limitations is at the more nuanced level. Traditions, beliefs, norms, and values about child sexual abuse within one group, including how to conceptualise it, speak about it, and address it, will not necessarily transfer to another. These limitations must be acknowledged, and addressed where possible, as part of ethical conduct in research.

Another limitation of the study was the low sample size and power, being half of what was anticipated. Although the sample was nationally representative, interest in the area had been overestimated especially among medical professionals (GPs and psychiatrists). Replication studies with larger sample sizes and all target audiences represented would be required in the future, to verify the tentative findings reported here. Such studies would also need to link the data sets across time to be able to conduct repeated measures statistical analyses, and therefore test for significant changes over time and empirically establish the effectiveness of the program.

Unfortunately, a more in-depth component collating narratives that represent the needs and experiences of all key stakeholders was out of budget in this study, including and especially the voices of CALD victims/survivors of child sexual abuse themselves. Indeed, one participant did say, *Allow CSA survivors to voice their concerns, allowing open discussion and potential solutions (Baseline Survey_27)*. Thus, further qualitative research is required. At the very least, it is hoped that the results of this study provide the beginning of a more sophisticated national knowledge base that can be used to discuss the complexities of how best to engage with CALD victims/survivors of child sexual abuse and their families, and help promote good population-level health outcomes for them.

Implications for practice and suggestions for future research

The literature on psychosocial differences in the needs and experiences of victims/survivors of child sexual abuse across cultural groups is scant, largely reflecting that culture, race, and migration are seen as marginal issues. Arguably, multiculturalism ‘forces’ researchers in countries like Australia to reflect on assumptions they may otherwise take for granted, and that deep level of reflection requires a great amount of work. In this vein, it is perhaps not surprising that these factors are only slowly beginning to be addressed in the national and international literature base. Political sensitivities also make publishing and funding in this area difficult, leaving practitioners to learn about this client group by themselves without a broader theoretical framework to help contextualise their acquired practice wisdom.

There are several areas this work can continue to expand into. Arguably, four immediate areas are on improving practice with interpreters, investigating unspoken protective parenting in CALD communities, improving data collection systems, and employing CALD staff in management positions in mainstream organisations. Such changes would need to be rigorously evaluated to document if, how much by, and why improvements in the implementation of a multicultural framework within organisations had positive flow-on effects for their CALD clients.

Importantly, any such work that is conducted by CALD feminist researchers would be powerful acts of self-determination, using strengths-based and empowerment-based approaches, regarding the identification of risk and protective factors within collectivist cultures. However, due to white privilege and patriarchy, the credibility or validity of their findings could be questioned with scrutiny sufficient to silence it, not be taken seriously, or failed to be implemented, all leading to an unethical exercise in ‘data mining’ highly vulnerable populations for no real effect. Indeed, the program was regarded overall with high satisfaction, but that its structure still generated disproportionate criticism reveals the depth of the lack of awareness of threat to cultural safety among white practitioners when brown scholars finally speak.

Conclusion

Effectively meeting the clinical needs of victims/survivors of child sexual abuse from CALD communities is critical. This is because patriarchal and collectivist norms can prohibit disclosure and help-seeking, and thus become serious risk factors to victims’ mental health; they will suffer the same psychological impacts as their white counterparts, but seem to be at risk of suffering them at higher intensities including greater suicidality.

This requires that treatment services to be delivered with cultural competency. That is, regardless of the number and types of cultural barriers that could be encountered in the service context, organisations still carry a responsibility to deliver services in ways that appropriately and effectively meet the needs of CALD victims/survivors. Indeed, Thiara, Roy and Ng (2015) found in their study of service responses in the UK to black and minority ethnic (BME) women and girls experiencing sexual violence, that “many organisations perceived barriers to access to be ‘internal’ to women and their communities, citing issues such as cultural taboos, stigma, and language. (Only) a small number acknowledged ‘external’ barriers of racism, inaccessible or lack of services, and inadequate knowledge among services and staff” (p. 4).

Overall, the results suggest that any progress toward meeting the therapeutic treatment, advocacy, and support needs of CALD victims/survivors could be a slow and difficult process. It may take several generations to effect change, especially since patriarchal norms that lead to gendered abuses of power, stigma for seeking help for mental illnesses, and fear of disclosure for the shame it can bring to a family, occur in all cultural groups including the mainstream and so are widespread and long-standing issues of concern that cut across all groups in society. That is, patriarchy and collectivism are pertinent to CALD groups in quantity more than in quality.

Knowledge of these relevant issues and challenges seem best used to design interventions that have realistic expectations about their effectiveness. As Boakye (2009) says, “although some beliefs and practices may be difficult to change in the short-term, they nonetheless can be changed if consistently challenged through constructive engagement” (p. 954). Arguably, evaluative research examining the effectiveness of such intervention programs may find that simply and genuinely engaging with communities to try and better meet their needs (‘process’) is more effective than actual improvements in community awareness, prevention, disclosure, and treatment of child sexual abuse (‘outcomes’).

Fundamentally, a feminist framework is essential. Encouraging CALD communities to reflect on how elements of collectivist and patriarchal culture may be acting as a risk factor to the personal safety of (especially female) children is a necessary and valuable endeavour (the purpose of Stage 2 of the project). However, it is also critical that such discussions protect ‘cultural safety’ – where non-mainstream cultures are safe to reflect on themselves, have the right to be protected and preserved, and where the structural barriers of racism, discrimination, and unequal distribution of power are both properly acknowledged and never forgotten.

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APPENDIX A: List of organisations invited via email to attend education program

To identify which organisations to invite to the education program, the search terms “sexual assault services QLD, NSW, SA, and VIC” and “refugee or multicultural services QLD, NSW, SA, and VIC” were used in Google. State child protection departments and legal organisations that were identified using these searches were not excluded, as they may still provide informal counseling support to CALD victims/survivors of child sexual abuse. The list of organisations contacted in this project is not an exhaustive list of organisations addressing sexual assault in Australia.

The organisations that were invited in this study are listed below, and have been categorised as either mainstream, multicultural, or ethno-specific. Mainstream organisations are open to CALD clients but not exclusively; multicultural organisations cater to CALD clients from any ethnic background; and ethno-specific organisations cater to CALD clients from specific ethnic backgrounds. All these organisations are either specialised for sexual assault; not specialised for sexual assault but may have client victims/survivors who disclose to them; or do not provide any support services but rather information or training about sexual or other forms of violence or child maltreatment. National services are represented in the four states of this study.

In early January 2019, each organisation received an initial contact email that directed potential participants to Cvent (the registration management system). This site contained the following introductory blurb³⁵:

The Royal Commission into Institutional Responses to Child Sexual Abuse (2013–2017) identified Culturally and Linguistically Diverse (CALD) communities as a sub-group of Australia’s population that we know very little about. To help heed the call on building knowledge and capacity in the services sector, a cultural competency education program has been developed by Dr Pooja Sawrikar at Griffith University (p.sawrikar@griffith.edu.au).

She will deliver the program in four cities:

- Brisbane: Monday 25 March 2019, 8.30-1pm, [The Ship Inn at Southbank](#)
- Sydney: Wednesday 27 March 2019, 8.30-1pm, [Waldorf Parramatta Apartment Hotel](#)
- Adelaide: Friday 29 March 2019, 8.30-1pm, [Sage Hotel](#)
- Melbourne: Wednesday 3 April 2019, 8.30-1pm, [Melbourne Metropole Central](#)

Please register by Friday 22 March 2019. The cost is \$65 p.p. and coffee/tea on arrival, morning tea, and lunch will be provided. The program is primarily designed for service providers in sexual assault and domestic violence organisations (such as counselors, social workers, and psychologists), however GPs,

³⁵ This was amended slightly in mid-Feb 2019 to include Melbourne, which was added as a study site later.

psychiatrists, and relevant program trainers, researchers, and policy-makers are also invited to attend as the content is relevant to their work.

CALD victims/survivors of child sexual abuse may not necessarily want a service provider who is of the same cultural background as themselves. Thus, all service providers need to be ready with knowledge about how best to understand and meet their needs, if and when they present at a service organisation. We look forward to meeting you as you take up this professional development opportunity.

Note: This program has been CPD endorsed by Australian Association of Social Workers (AASW), and will be listed on the Events websites of AASW, Australian Psychological Society (APS), and Australian Medical Association (AMA). As it is newly developed, attendees will be invited to complete a short voluntary survey that aims to evaluate it (GU HREC approval no. 2018/953). Funding support has been provided by the School of Human Services and Social Work. Please distribute this invitation widely through your networks.

To help boost recruitment, the ensuing follow-up email was sent mid-February 2019. This, along with the addition of a fourth site (Melbourne)³⁶, successfully increased the number of registrants from approximately 80 to 100. It also prompted six potential participants to indicate that they were unable to attend but wished to remain informed; indicative of interest in the area and intent to gain further knowledge and information:

Dear all,

Thank you to everyone who has already registered for this program – I look forward to meeting you, and engaging in this important and complex conversation.

If you are interested in attending but have not yet registered, please note that the closing date is Friday 8 March 2019 (brought forward for catering purposes). The link to register is below. Please also note that due to interest, the program will additionally be delivered in Melbourne (unfortunately due to funding constraints, it is not possible to travel to other cities).

If you are unable to attend, but would like to remain updated about the project (including access to the program slides and a program evaluation report), please do let me know.

To clarify, the program is primarily for service providers, however even if you do not directly work with victims/survivors of child sexual abuse, it will still be useful to know of the program's scope and content (for example, should a CALD victim/survivor disclose to staff within your organisation; to be aware of current research findings and knowledge in the field; etc.).

Thank you for your time, and kind regards,

Dr Pooja Sawrikar

³⁶ Melbourne was not originally included in the study because the funding awarded by GU only covered the costs associated with program deliveries in three cities. Due to interest from Victoria, the study scope was expanded and the costs were bore by the researcher.

A second and final follow-up email was sent mid-March 2019, helping to add a small number of registrants to the final total:

Dear all,

This message is a final reminder about the education program on child sexual abuse and CALD communities. Places are still available. The link to register has been extended to Friday 22 March 2019.

Kind regards, Dr Pooja Sawrikar

Finally, academic contacts within universities in QLD, NSW, SA, and VIC were contacted to help recruit relevant researchers. Those who assisted disseminated the invitation through their networks (e.g. via email, Facebook, LinkedIn, etc.).

In summary, the list below contains all 267 invited organisations, who in turn were encouraged to disseminate the email invitation widely through their networks. Thus, the final list of 53 organisations represented at the education program is not exclusive to those on this list. The final list has not been included in this Report to help protect their anonymity. However, they are listed on the [Project Website](#)³⁷ under “Accredited service providers” in an unmarked way (i.e. they are included with organisations that have also completed the online program).

³⁷ <http://www.nomoresilence.info/accredited-service-providers>

Mainstream organisations (National)

1. 1800 Respect
2. Act for Kids
3. Association of Children's Welfare Agencies (ACWA)
4. Australian and New Zealand Association for the Treatment of Sexual Abuse (ANZATSA)
5. Australian Childhood Foundation
6. Australia's National Research Organisation for Women's Safety Ltd. (ANROWS)
7. Australian Women Against Violence Alliance (AWAVA)
8. Blue Knot Foundation (formerly Adults Surviving Child Abuse)
9. beyondblue
10. Bravehearts
11. Centre for Community Welfare Training (CCWT)
12. Child Wise
13. Children and Young People with Disability Australia
14. CREATE Foundation
15. Headspace
16. Kids Helpline
17. Lifeline
18. Living Well
19. National Association for Prevention of Child Abuse and Neglect (NAPCAN)
20. No to Violence
21. On the Line Australia Inc.
22. People with Disability Australia
23. Phoenix Australia Centre for Posttraumatic Mental Health
24. QLife
25. Rape and Domestic Violence Services Australia
26. Relationships Australia
27. Survivors and Mates Support Network (SAMSN)
28. Victims Access Line

Mainstream organisations (QLD)

29. Anglicare Southern Queensland
30. Brisbane Domestic Violence Service (BDVS)
31. Brisbane Rape and Incest Survivors Support Centre (BRISSC)
32. Caboolture Regional Domestic Violence Service
33. Cairns Domestic Violence Service
34. Cairns Sexual Assault Service
35. Centre Against Sexual Violence Logan, Beenleigh and Beaudesert
36. Court Network
37. Domestic Violence Action Centre
38. Domestic Violence Prevention Centre

39. Domestic Violence Resource Service Mackay and Region
40. Domestic Violence Service of Central Queensland
41. DV Connect
42. Gladstone Region Sexual Assault Service
43. Gold Coast Centre Against Sexual Violence Inc.
44. North Queensland Domestic Violence Resource Service
45. North Queensland Women's Legal Service
46. Queensland Council of Social Services (QCOSS)
47. Sandbag Community Centres and Services
48. South Burnett Women's Service
49. Suncoast Cooloola Outreach Prevention and Education (SCOPE)
50. The Women's Centre Townsville
51. Wide Bay Sexual Assault Services
52. Women's Infolink
53. Women's Legal Service Qld
54. Working Against Violence Support Service (WAVSS)
55. WWILD Sexual Violence Prevention Service Association Inc.
56. Zig Zag

Mainstream organisations (NSW)

57. Bankstown Women's Health Centre
58. Blacktown Women's and Girls' Health Centre Inc.
59. Blue Mountains Women's Health and Resource Centre
60. Catholic Care
61. Central West Women's Health Centre
62. Cumberland Women's Health Centre Inc.
63. Domestic Violence Legal Service
64. Education Centre Against Violence
65. Good Shepherd
66. Heartfelt House Alstonville, Northern Rivers region
67. Illawarra Women's Health Centre
68. Interrelate Family Centres
69. Liverpool Women's Health Centre
70. Macarthur Diversity Service
71. NSW Council of Social Service (NCOSS)
72. NSW Rape Crisis Centre – Central Coast, Leichhardt, Lismore, Albury-Wodonga
73. Northern Rivers Community Gateway
74. Redfern Legal Centre International Student Service
75. Rosebank Child Sexual Abuse Service Inc.
76. Rosie's Place
77. Wash House

78. WILMA Women's Health Centre

79. Women's Cottage

Mainstream organisations (SA)

80. Ballarat Health Services

81. Centacare Adelaide

82. Centre for Treatment of Anxiety and Depression, University of Adelaide

83. Elliston Community Health Services

84. Government of South Australia Health

85. Hope Counseling and Therapy

86. Junction Australia

87. Legal Services Commission of South Australia

88. Mallee Sexual Assault Unit and Domestic Violence Services

89. Quorn Health Services

90. Shelter SA

91. Shine SA

92. Soothing Minds

93. South Western Centre Against Sexual Assault

94. Southern Adelaide Domestic Violence Service Inc.

95. Therapy Services

96. Uniting Care Wesley County South Australia

97. Uniting Communities

98. Victim Support Service South Australia

99. Wimmera Health Care Group

100. Women's Health Service

101. Women's Information Service

102. Women's Legal Service South Australia

103. Yarrow Place

Mainstream organisations (VIC)

104. Australian Childhood Trauma Group

105. Australian Institute of Family Studies (AIFS)

106. Bethany Community Support

107. Centre Against Sexual Assault (CASA) Forum

108. Central Highlands Family and Domestic Violence Service Berry Street

109. Central Highlands Integrated Family Violence Committee

110. Centre Against Violence

111. Centre for Non-Violence

112. Child & Family Services Ballarat

113. Community Legal Centres

114. Court Network

115. Domestic Violence Resource Centre Victoria (DVRCV)

116. Domestic Violence Victoria
117. Drummond St Services Inc.
118. Eastern Domestic Violence Service Inc. (EDVOS)
119. Eastern Metropolitan Region Regional Family Violence Partnership
120. Emerge Women and Children's Support Network
121. Gippsland Women's Health
122. Grampians Community Health
123. Kara House
124. Kildonan Uniting Care
125. Latrobe Community Health Service
126. Northern Family and Domestic Violence Service (NFDVS) Berry Street
127. Northern Integrated Family Violence Services (NIFVS)
128. Peninsula Health (Community Health)
129. Quantum Support Services
130. Safe Steps Family Violence Response Centre
131. Safe Futures Foundation
132. Salvation Army Crossroads Family Violence Service
133. SalvoConnect
134. Sexual Assault Crisis Line
135. Star Health
136. The Sexual Assault & Family Violence Centre (The SAFV Centre)
137. UnitingCare Gippsland
138. Victoria Legal Aid (VLA)
139. WAYSS Ltd
140. Western Integrated Family Violence Service
141. Women with Disabilities Victoria (WDV)
142. Women's Health Goulburn North East
143. Women's Health in the North
144. Women's Health in the South East
145. Women's Health West
146. Women's Homelessness Prevention Project
147. Women's Housing Ltd
148. Women's Information Referral Exchange (WIRE)
149. Women's Information Support & Housing in the North
150. Women's Legal Service
151. Women's Liberation Halfway House
152. WRISC Family Violence Support

Multicultural organisations (National)

153. AMES Australia
154. Australian Multicultural Foundation

- 155. Australian National Committee On Refugee Women (ANCORW)
- 156. Australian Refugee Association
- 157. Federation of Ethnic Communities' Councils of Australia (FECCA)
- 158. Forum of Australian Services for Survivors of Torture and Trauma (FASSTT)
- 159. Multicultural Mental Health Australia
- 160. Refugee Council of Australia
- 161. Refugee Health Network of Australia
- 162. Settlement Council of Australia
- 163. St Vincent de Paul, Asylum Seeker Program

Multicultural organisations (QLD)

- 164. Access Community Services Inc.
- 165. Asylum Circle
- 166. Asylum Seeker Resource Centre (QLD and NSW)
- 167. Brisbane Refugee and Asylum Seeker Support Network
- 168. Bundaberg and District Neighbourhood Centre, Multicultural Action Group
- 169. Caboolture Neighbourhood Centre, Community Action for a Multicultural Society (CAMS) Program
- 170. Centacare Far North Queensland (FNQ), Multicultural Services
- 171. Culture in Mind
- 172. Ethnic Communities Council (ECC, QLD and NSW)
- 173. Harmony Place
- 174. Immigrant Women's Support Service
- 175. Mater Refugee Complex Care Clinic
- 176. Mercy Community, Community Action for a Multicultural Society (CAMS) Program
- 177. Multicultural Communities Council Gold Coast Inc.
- 178. Multicultural Community Centre
- 179. Multicultural Development Australia (MDA), Brisbane Multicultural Centre
- 180. Multicultural Families Organisation
- 181. Multicultural Youth Advocacy Network (MYAN, QLD and NSW)
- 182. MultiLink
- 183. PHN Darling Downs and West Moreton
- 184. Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT)
- 185. Queensland TransCultural Mental Health Centre
- 186. Red Cross, Migration Support Programs
- 187. Refugee Connect
- 188. Romero Centre
- 189. The Oasis Centre
- 190. Toowoomba Refugee and Migrant Service
- 191. World Wellness Group

Multicultural organisations (NSW)

- 192. Asylum Seekers Centre
- 193. House of Welcome
- 194. Immigrant Women’s Speakout Association
- 195. Jesuit Refugee Service Australia
- 196. Multicultural Disability Advocacy Association
- 197. Multicultural NSW
- 198. NSW Refugee Health Service
- 199. Refugee Advocacy and Casework Service
- 200. Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS)
- 201. Settlement Services International (SSI)
- 202. Sydney Multicultural Community Services
- 203. SydWest Multicultural Services
- 204. TransCultural Mental Health Centre
- 205. Western Sydney Migrant Resource Centre (MRC)

Multicultural organisations (SA)

- 206. Migrant Resource Centre (MRC)
- 207. Migrant Women’s Support Program
- 208. Multicultural Communities Council of South Australia
- 209. Multicultural Youth SA Inc.
- 210. Refugee Advocacy Service of South Australia
- 211. Supporting Survivors of Torture and Trauma (STTARS)
- 212. Women’s and Children’s Hospital SA, Child and Adolescent Mental Health Services (CAMHS)
Multicultural Services

Multicultural organisations (VIC)

- 213. Action on Disability within Ethnic Communities (ADEC)
- 214. Australian Intercultural Society
- 215. Australian Multicultural Community Services Inc.
- 216. Australian Multicultural Foundation
- 217. Centre for Multicultural Youth (CMY)
- 218. Centre for Culture, Ethnicity, and Health
- 219. Core Community Services
- 220. Cultural Infusion
- 221. Darebin Ethnic Communities Council (DECC)
- 222. Ethnic Communities Council of Victoria (ECCV)
- 223. FKA Children’s Services Inc.
- 224. Gippsland Multicultural Services
- 225. inTouch Multicultural Centre Against Family Violence
- 226. ISHAR
- 227. Loddon Campaspe Multiculturalism Services
- 228. Migrant Information Centre (Eastern Melbourne) (MIC)

- 229. Migrant Resource Centre North West Region
- 230. Migrant Resource Centre Westgate Region (MRCW)
- 231. Multicultural Centre for Women’s Health (MCWH)
- 232. Multicultural Futures
- 233. National Ethnic Disability Alliance (NEDA)
- 234. New Hope Foundation
- 235. North East Multicultural Association (NEMA)
- 236. Southern Migrant and Refugee Centre
- 237. Victorian Refugee Health Network
- 238. Youth Activating Youth

Ethno-specific organisations (National, QLD, and VIC)

- 239. African-Australian Multicultural Employment and Youth Services (AAMEYS)
- 240. Australian Catholic Migrant & Refugee Office
- 241. Australian Muslim Women’s Centre for Human Rights
- 242. Catholic Migrant Centre
- 243. Islamic Women’s Association of Australia
- 244. MyCentre Multicultural Youth Centre
- 245. Sudanese Australian Integrated Learning (SAIL) Program
- 246. Spectrum
- 247. Tzedek

Universities (QLD)

- 248. Bond University
- 249. Central Queensland University
- 250. James Cook University
- 251. Queensland University of Technology
- 252. University of Queensland
- 253. University of Southern Queensland
- 254. University of the Sunshine Coast

Universities (NSW)

- 255. Australian Catholic University
- 256. Macquarie University
- 257. Southern Cross University
- 258. University of New England
- 259. University of New South Wales
- 260. University of Sydney
- 261. Western Sydney University

Universities (SA)

- 262. University of South Australia
-

Universities (VIC)

- 263. Deakin University
 - 264. La Trobe University
 - 265. Monash University
 - 266. Royal Melbourne Institute of Technology (RMIT University)
 - 267. The University of Melbourne
-

APPENDIX B: Ethics Information Statement



ETHICS INFORMATION STATEMENT

Project title: ‘Addressing child sexual abuse (CSA) in culturally and linguistically diverse (CALD) communities in Australia’ (HREC Approval No: 2018/953)

What is this project about?

In 2018, Griffith University (GU) contributed funding to a study on child sexual abuse (CSA) and culturally and linguistically diverse (CALD) communities in Australia. The project has been designed with three stages, engaging with: (a) organisations that provide services or information to victims/survivors of child sexual abuse, (b) parents/guardians from CALD communities, and (c) culturally diverse schools. Stage 1 has received ethics approval from GU’s Human Research Ethics Committee (HREC); Stage 2 will be conducted in mid-2019; and Stage 3 will be conducted if further funding is secured. In Stage 1, an education program has been developed, based on findings from a recent systematic literature review conducted in the area. Research is being conducted to evaluate if the program is effective.

What is involved if I choose to take part in the evaluation?

The evaluation of the Stage 1 education program is comprised of a short paper-based anonymous survey pertaining to topics that will be covered in the education program (approx. 15–20 mins to complete). In six months, participants will be invited via email to complete the same survey questions, online and anonymously. Tracking change over time assists with obtaining an understanding of the effect of the program, if at all, on service delivery. Your consent to take part in the baseline and follow-up surveys will be implied if you complete and return them.

What are my rights as a possible research participant?

You do not need to take part in the evaluation of this program if you do not wish to. Your participation is completely voluntary. In any publication arising from this project (e.g. reports, journal articles, conference presentations, etc.), only deidentified group data will be reported. All publications will be available from the project’s website (yet to be established). Please check this site regularly to obtain up-to-date information on the project findings. Consistent with ethics protocol, research data will be kept for seven years. It will only be available to the Chief Investigator (CI: Dr Pooja Sawrikar), thereby protecting your right to confidentiality.

Are there any risks if I take part?

If you are a victim/survivor of child sexual abuse and/or from a CALD background, the content in this education program may be distressing. If you experience distress, you are free to leave at any time without explanation or prejudice. If you experience distress but would like to continue participation in the education program, please inform the CI (Dr Pooja Sawrikar) privately at the end of the program, so that appropriate

counselling can be arranged with you in ways that best meet your needs. For example, you may opt to call Lifeline (13 11 14), choose to speak with a manager within your service organisation, or make contact with a different service organisation.

Are there any benefits for taking part?

By attending today's education program, you have the opportunity to build knowledge and capacity about service provision for CALD client victims/survivors of child sexual abuse. Through the open discussion 'Q&A' forum at the end, you also have the opportunity to contribute to a final version of this program (to be freely available to all service providers online across Australia later). In taking part in the evaluation of the education program, you have the opportunity to provide feedback on what you see to be its strengths and weaknesses. You can also contribute to the evidence required to demonstrate its possible effectiveness.

What if I am not happy about something?

If you have any concerns about the ethical conduct of this project you can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on (ph) 3735 4375 or (email) research-ethics@griffith.edu.au. All information is confidential and will be handled as soon as possible.

Where can I get more information?

If you would like to make further inquiries about the education program and/or evaluation study, please contact Dr Pooja Sawrikar (p.sawrikar@griffith.edu.au).

Summary

- If I complete and return the anonymous survey, this indicates that I have agreed to take part in the Griffith University research project specified above.
- I understand the information about my participation in the research project, which has been provided to me by the researcher.
- I understand I will be asked to provide permission to allow the program to be audio-taped (this is to assist with accuracy in transcription).
- I understand that my participation is voluntary and that I can cease my participation at any time.
- I understand that my participation in this research will be treated with confidentiality.
- I understand that any information that may identify me will be de-identified at the time of analysis of any data.
- I understand that no identifying information will be disclosed or published.
- I understand that all information gathered in this research will be kept confidentially for seven years at the University.
- I am aware that I can contact the researchers at any time with any queries. Their contact details are provided to me.
- I understand that this research project has been approved by the GU Human Research Ethics Committee.

THIS INFORMATION SHEET IS FOR YOU TO KEEP

APPENDIX C: Program evaluation survey



Baseline and follow-up evaluation survey

(THIS SURVEY IS ANONYMOUS)

Introductory blurb (baseline)

As this education program is newly developed and being rolled out across four states (QLD, NSW, SA and VIC), it is important that we collect information about who attended and how their practice may have changed over time. This survey is completely anonymous. There are no right or wrong answers, so please respond honestly. You do not need to answer any question you do not wish to. Please ask for assistance if you need help with any question. Each person is to complete the survey by themselves. As the project is not interested in individuals but rather all people who attend the education program, data will be pooled and analysed together as a group. Your consent to take part in the baseline evaluation of this education program is implied by completing and returning this survey.

Introductory blurb (follow-up)

Six months ago, you took part in an education program about child sexual abuse and CALD communities. We collected information that day, and would now like to ask the same questions again to see if there has been any change since attending the program. This survey is completely anonymous. There are no right or wrong answers, so please respond honestly. You do not need to answer any question you do not wish to. As the project is not interested in individuals but rather all people who attended the education program, data will be pooled and analysed together as a group. Your consent to take part in the follow-up evaluation of this education program is implied by completing this survey.

SECTION A – Demographics about you and your service organisation

1. Gender:

- Female
- Male
- Another response is applicable (e.g. prefer not to say, non-binary/gender conforming, etc.)

2. Age: _____ (in years)
3. Country of birth: _____
4. Language/s other than English spoken at home: _____
_____ [OR circle here if N/A]

5. Cultural background: (Please tick one)

- Indigenous (Aboriginal and/or Torres Strait Islander)
- Anglo (Saxon and/or Celtic)
- CALD ('Culturally and Linguistically Diverse'; people neither Indigenous nor Anglo)
- Mixed _____

6. I describe my cultural identity as: (Write anything that is true for you, e.g. 'I am ...' Australian, Italian, Sudanese, Irish, Australian-Korean, Nepalese-Australian, etc.) _____

7. How would you describe your professional role? (Please tick one)

Service provider

- Counsellor
- Social worker
- Psychologist
- General practitioner
- Psychiatrist

Other relevant professional

- Other (e.g. researcher/academic, policy development, program trainer, etc.) _____

8. How long have you been working as a service provider or other relevant professional? (This includes all current and previous work history) _____ (in years)

9. What is the name of the organisation you currently work at? _____

10. What state or territory is your local office situated in?

- | | | | |
|------------------------------|------------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> ACT | <input type="checkbox"/> NSW | <input type="checkbox"/> NT | <input type="checkbox"/> QLD |
| <input type="checkbox"/> SA | <input type="checkbox"/> TAS | <input type="checkbox"/> VIC | <input type="checkbox"/> WA |

11. What suburb is your local office situated in? _____

12. Is the organisation you currently work at: (Please tick one)

- Specialised for CALD groups (i.e. the service formally supports clients from CALD backgrounds)
- Not specialised for CALD groups (i.e. the service is for clients from any background)
- N/A (I do not work at a service organisation)

13. Is the organisation you currently work at: (Please tick one)

- Specialised for sexual assault (i.e. the service is for clients presenting with sexual assault/violence)
- Not specialised for sexual assault (i.e. the service is for clients presenting with any issue)
- N/A (I do not work at a service organisation)

SECTION B – Your current self-rated ‘cultural competency’

1. How knowledgeable do you think you are about CALD groups generally?

Not at all					Completely
1	2	3	4	5	

2. How confident do you feel to work with CALD victims/survivors of child sexual abuse?

Not at all					Completely
1	2	3	4	5	

3. How self-aware of your own cultural background do you feel you are?

Not at all					Completely
1	2	3	4	5	

4. How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel you are in your daily work?

Not at all

Completely

1

2

3

4

5

5. Have you ever heard of the phrase ‘white privilege’? (Please tick one)

Yes

No

6. How different do you think cultural groups are on prevalence of child sexual abuse?

1 – Not at all (the prevalence of child sexual abuse is essentially the same in all cultural groups)

2 – A little bit (some cultural groups have higher prevalence of child sexual abuse than others but not by a substantial amount)

3 – A lot (some cultural groups have higher prevalence of child sexual abuse than others by a substantial amount)

4 – Completely (some cultural groups have very high prevalence of child sexual abuse and in other groups the prevalence is essentially absent/negligible)

7. How difficult do you think it is to interpret cross-cultural prevalence data of child sexual abuse?

1 – Not at all (if the research was conducted rigorously, then the numbers are accurate)

2 – A little bit (if the research was conducted rigorously, then the numbers are close enough to being accurate)

3 – A lot (even if the research was conducted rigorously, the numbers will still be substantially difficult to interpret)

4 – Completely (even if the research was conducted rigorously, the numbers will still be impossible to interpret)

8. One myth about child sexual abuse is that perpetrators are usually strangers. However, the research shows that most perpetrators are known to the victim (e.g. fathers, uncles, siblings, cousins, family friends, neighbours, teachers, priests, etc.). Compared to Western populations (e.g. Anglo Australians), do you think CALD communities are:

- 1 – Significantly less likely to believe this myth
- 2 – Less likely to believe this myth
- 3 – Equally likely to believe this myth
- 4 – More likely to believe this myth
- 5 – Significantly more likely to believe this myth

9. One effect of myths about child sexual abuse is that they can shift culpability (i.e. blameworthiness) from the perpetrator to the victim. Two examples of such myths are: (i) “Adolescent girls who wear very revealing clothing are asking to be sexually abused”, and (ii) “Children who do not report ongoing sexual abuse must want the sexual contact to continue”. Compared to Western populations (e.g. Anglo Australians), do you think CALD communities are:

- 1 – Significantly less likely to believe myths about child sexual abuse that shift culpability to the victim
- 2 – Less likely to believe myths about child sexual abuse that shift culpability to the victim
- 3 – Equally likely to believe myths about child sexual abuse that shift culpability to the victim
- 4 – More likely to believe myths about child sexual abuse that shift culpability to the victim
- 5 – Significantly more likely to believe myths about child sexual abuse that shift culpability to the victim

10. A ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse acknowledges differences in social power across groups in society (e.g. by race, gender, class, ability, sexuality, etc.). That is, it tries to understand the individual client as a member of broader society. It is also known as a ‘social justice’ approach. Which one of the following is true for you?

- 1 – I believe that a ‘sociological approach’ is useful or effective because trends in society do play a substantial role in understanding an individual

2 – I do not believe that a ‘sociological approach’ is useful or effective because trends in society do not play a substantial role in understanding an individual

3 – I am not sure; I would like to learn more about what a ‘sociological approach’ to the treatment of mental illness that occurs as a result of child sexual abuse entails

11. In addition to the one-on-one service you provide to clients, do you suggest to them ...? (Please tick all that are relevant)

Self-help strategies (e.g. reading relevant books or online resources; engaging in music, art, or narrative therapy; etc.)

Family therapy

Group therapy (with other victims/survivors)

None of the above

N/A (I am not a service provider)

12. Do you think that all mental illnesses can successfully be treated with formal clinical services (e.g. counselors, social workers, psychologists, psychiatrists, etc.)?

Yes

No

SECTION C – Your rating of your service organisation’s current ‘cultural competency’

1. Does your organisation collect data on ethnicity-related variables for its CALD clients? (Please tick one)

Yes (Go to Qn 2)

No (Go to Qn 3)

N/A (We have no CALD clients; Go to Qn 3)

N/A (I do not work at a service organisation; Go to Qn 3)

2. If yes, which ones? (Please tick all that are relevant)

Languages spoken at home

Need for interpreter

Country of birth

Citizenship (e.g. Australian, permanent resident, temporary resident, refugee, asylum seeker, etc.)

Religion

Other _____

3. How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel your organisation is ***in principle*** (e.g. in mission statements, philosophy, practice frameworks, etc.)?

Not at all

Completely

1

2

3

4

5

4. How respectful of ethnic diversity (i.e. race, culture, language, and/or religion) do you feel your organisation is ***in practice*** (i.e. daily work)?

Not at all

Completely

1

2

3

4

5

5. Does your organisation ***only*** use bilingual staff or interpreters trained in matters relating to sexual assault when required for the client? (Please tick one)

Yes

No (We use any CALD staff member or interpreter that is available at the time we need them, whether they are trained in matters relating to sexual assault or not)

N/A (I do not work at a service organisation)

6. Does your organisation run training sessions for interpreters on matters relating to sexual assault? (Please tick one)

Yes

No

N/A (I do not work at a service organisation)

7. Does your organisation pre-brief interpreters before meeting a client with a matter relating to sexual assault?

(Please tick one)

- Yes
- No
- N/A (I do not work at a service organisation)

8. Does your organisation de-brief interpreters after meeting a client with a matter relating to sexual assault?

(Please tick one)

- Yes
- No
- N/A (I do not work at a service organisation)

9. Have you ever received training on culturally appropriate service provision for CALD client victims/survivors of child sexual abuse while working at your organisation? *(Please tick one)*

- Yes *If yes, by whom? (e.g. another staff member, a local community organisation, etc.)*

- No
- N/A (I do not work at a service organisation)

10. Does your organisation have service provider staff from CALD backgrounds (including those of mixed ethnicity)? *(Please tick one)*

- Yes (Go to Qns 11 and 12)
- No (Go to Qn 13)
- N/A (I do not work at a service organisation; Go to Qn 13)

11. If yes:

- (a) how many in total?** _____
- (b) how many of these are in management positions?** _____

(c) what is the total service provider staff size of your local office? _____ (i.e. please do not include administrative staff)

12. If yes, does your service organisation offer CALD client victims/survivors of child sexual abuse choice about whether they would like an ethnically-matched service provider? (Please tick one)

Yes

No

N/A (We have no CALD clients)

13. How strong would you rate the links of your organisation with other local CALD community organisations and/or members within them?

1 – Not at all strong (we have no links with local CALD community organisations or members of such organisations)

2 – Somewhat strong (we have had some contact with local CALD community organisations or members within them but it is not regular)

3 – Quite strong (we have regular contact with local CALD community organisations or members within them)

4 – Very strong (our links with local CALD community organisations or members within them could be described as excellent)

14. (Baseline) If you would like to add information that helps contextualise any of your responses, or make any other general comments, please do so here: _____

14. (Follow up) If you would like to add information that helps contextualise any of your responses, or make any other general comments, please do so here (e.g. information that particularly stood out for you or specific knowledge you feel you have gained having attended the program; parts of your practice that have since changed; enduring discomfoting information or experiences in your knowledge base or work practice, etc.):

THIS IS THE END OF THE SURVEY. THANK YOU FOR YOUR TIME. PLEASE NOW RETURN IT TO THE PROGRAM MODERATOR.

Office use only

Site Location: Brisbane Sydney Adelaide Melbourne

Date: _____ / _____ / _____ *Time start:* _____ *Time finish:* _____

APPENDIX D: Program overview



Education program about child sexual abuse (CSA) and culturally and linguistically diverse (CALD) communities

Program overview

8.30-9.00am: Registration (please sign attendance sheet) / Coffee and tea on arrival

9.00-10.30am: Introduction; Ethics Information Statement about evaluation study explained;
Anonymous baseline survey completed

10.30-11.15am: Education program delivered (Discussion #1)

11.15-11.45am: Morning tea

11.45-1.15pm: Education program delivered (Discussion #2, 3)

1.15-2.00pm: Lunch & 'Open Q&A forum'

(Survey on satisfaction with the program completed and returned into confidential box)

APPENDIX E: Survey on satisfaction with education program



Satisfaction with the education program

This survey is completely anonymous. You do not need to answer any question you do not wish to.

1. Overall, how satisfied are you with today's education program?

Not at all

Completely

1

2

3

4

5

2. If you wish to explain your answer to Q1, please do so here: _____

3. What did you like best about today's education program? _____

4. Was there anything you thought was redundant? _____

5. Why did you choose to attend today's education program? _____

6. Do you have any other comments you would like to make? (e.g. information that particularly stood out for you or specific knowledge you feel you have gained having attended the program; parts of your practice that you think will now change; discomfoting information or experiences*, etc.) _____

THIS IS THE END OF THE SURVEY. THANK YOU FOR YOUR TIME. PLEASE COMPLETE AND RETURN IT INTO THE CONFIDENTIAL BOX BEFORE LEAVING.

Office use only

Site Location: Brisbane Sydney Adelaide Melbourne
Date: _____ / _____ / _____ Time start: _____ Time finish: _____

***Some explanation about terminology and concepts that have been used today...**

We all have different areas of knowledge and expertise, and so become familiar with different terms used in those disciplines. Today, you will have heard terms like 'CALD', ethnic minorities, white/black, the Anglo Australian mainstream, and Western and non-Western (or Eastern) countries and cultures. These terms can be confronting if you are not used to hearing or using them. Please feel free to express this discomfort in your anonymous feedback. This extends to any material that has been covered today, and which you have experienced as discomfoting (e.g. responsible uses of racial, gendered, and professional power, etc.).

APPENDIX F: Email invitation to take part in six month follow-up survey

Initial email

Dear attendee,

Thank you for taking part in the education program on child sexual abuse and Culturally and Linguistically Diverse (CALD) communities six months ago. To explore how the program may have changed your or your service organisation's knowledge and/or practice, if at all, we are inviting you to complete a short 15 minute online follow-up survey. The questions replicate those completed at the time the program was delivered.

Consistent with normal ethical practice in research, it will be assumed that if you complete this survey you have given consent for your responses to be pooled with all participants and analysed together as a group (HREC Approval No. 2018/953).

The survey is completely anonymous. You do not have to take part if you do not wish to. There are no right or wrong answers, so please respond honestly. You do not need to answer any question you do not wish to.

The link to the survey will be open between 2–27 September 2019. A reminder invite will be sent out again on 16 September 2019 to those who have not yet completed it.

Thank you in advance for your time. Your participation is greatly valued, as it assists with obtaining evidence about the in/effectiveness of the education program.

Sincerely,

Dr Pooja Sawrikar

First reminder email

Dear attendee,

Recently we invited you and others to participate in a six-month follow up survey about the education program for service providers on child sexual abuse and CALD communities. We note that you have not yet completed this survey, and wish to remind you that it is still available should you wish to take part. To participate, please click on the link below.

We wish to thank the 20% of participants who so far have completed this survey. A second and final reminder email will be sent on 23 September 2019 to those who have not completed it by that time. The survey closes 27 September 2019.

Sincerely,

Dr Pooja Sawrikar

Final reminder email

Dear attendees,

This is the final email reminder about the survey evaluating ‘Child sexual abuse and CALD communities: An education program for service providers’. The link closes this Friday 27 September 2019 at 5pm, and can be accessed at the bottom of this email.

So far, 30% of participants have completed the survey and we are most appreciative of their time. You do not need to complete this survey if you do not wish to, but if you are still considering it, it would be most appreciated – the higher the response rate, the higher the validity of the data.

Please note: the poor formatting of these emails on the survey platform (LimeSurvey) has given some participants the impression of the link not being trustworthy. My apologies for this, this is not the case. The system is simply including the formatting coding when it sends out the emails (and if I could work out how to rectify it I would!). Please rest assured that there is no issue with the survey link (LimeSurvey is endorsed for use by Griffith University because of its ability to collect data anonymously).

Kind regards,

Pooja Sawrikar

APPENDIX G: Frequency data tables

Data Table G.1: Frequency data on beliefs about cross-cultural prevalence of child sexual abuse by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
Prevalence essentially the same in all cultural groups				
CALD	18	31	10	50
Anglo	12	24	8	38
Total	30	28	18	44
Some cultural groups have higher prevalence but not by a substantial amount				
CALD	18	31	5	25
Anglo	25	49	8	38
Total	43	39	13	32
Some cultural groups have higher prevalence by a substantial amount				
CALD	17	29	2	10
Anglo	13	25	3	14
Total	30	28	5	12
Some cultural groups have very high prevalence and in others the prevalence is essentially absent/negligible^a				
CALD	5	9	3	15
Anglo	1	2	2	10
Total	6	6	5	12

a – χ^2 tests were not performed on these cells because n was < 5 in most of them.

Data Table G.2: Frequency data on beliefs about accuracy of cross-cultural child sexual abuse prevalence data by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
If research was rigorous, data is accurate				
CALD	0	0	2	9
Anglo	1	2	0	0
Total	1	1	2	5
If research was rigorous, data is close enough to accurate				
CALD	13	22	1	5
Anglo	15	28	2	10
Total	28	25	3	7
If research was rigorous, data will still be substantially inaccurate				
CALD	39	67	14	64
Anglo	36	68	14	70
Total	75	68	28	67
If research was rigorous, data is still impossible to interpret				
CALD	6	10	5	23
Anglo	1	2	4	20
Total	7	6	9	21

Data Table G.3: Frequency data on cross-cultural belief of the myth that most perpetrators are unknown by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
CALD communities are significantly less likely to believe the myth that most perpetrators are unknown than Western populations				
CALD	2	3	4	18
Anglo	1	2	1	5
Total	3	3	5	12
CALD communities are less likely to believe the myth that most perpetrators are unknown than Western populations				
CALD	7	12	3	14
Anglo	9	17	4	20
Total	16	14	7	17
CALD communities are equally likely to believe the myth that most perpetrators are unknown to Western populations				
CALD	28	47	6	27
Anglo	36	68	11	55
Total	64	57	17	40
CALD communities are more likely to believe the myth that most perpetrators are unknown than Western populations				
CALD	16	27	6	27
Anglo	7	13	3	15
Total	23	21	9	21
CALD communities are significantly more likely to believe the myth that most perpetrators are unknown than Western populations				
CALD	6	10	3	14
Anglo	0	0	1	5
Total	6	5	4	10

Data Table G.4: Frequency data on cross-cultural belief of myths that shift culpability to the victim by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
CALD communities are significantly less likely to believe myths that shift culpability to the victim than Western populations				
CALD	1	2	1	5
Anglo	1	2	1	5
Total	2	2	2	5
CALD communities are less likely to believe myths that shift culpability to the victim than Western populations				
CALD	4	7	0	0
Anglo	3	6	1	5
Total	7	6	1	2
CALD communities are equally likely to believe myths that shift culpability to the victim to Western populations				
CALD	25	42	7	32
Anglo	30	57	10	48
Total	55	49	17	40
CALD communities are more likely to believe myths that shift culpability to the victim than Western populations				
CALD	21	36	8	36
Anglo	17	32	8	38
Total	38	34	16	37
CALD communities are significantly more likely to believe myths that shift culpability to the victim than Western populations				
CALD	8	14	6	27
Anglo	2	4	1	5
Total	10	9	7	16

Data Table G.5: Frequency data on beliefs about the usefulness of a sociological approach to treatment by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
I believe that a ‘sociological approach’ to the treatment of child sexual abuse is useful or effective				
CALD	34	59	15	71
Anglo	36	68	17	81
Total	70	63	32	76
I do not believe that a ‘sociological approach’ to the treatment of child sexual abuse is useful or effective				
CALD	3	5	0	0
Anglo	1	2	0	0
Total	4	4	0	0
I would like to learn more about what a ‘sociological approach’ to the treatment of child sexual abuse entails				
CALD	21	36	6	29
Anglo	16	30	4	19
Total	37	33	10	24

Data Table G.6: Frequency data on professional omnipotence by cultural background of service provider (T1 and T2)

	T1		T2	
	N	%	N	%
Suggests additional self-help strategies (B.11)				
CALD	46	39	16	33
Anglo	34	34	16	38
Total	80	37	32	35
Suggests additional family therapy (B.11)				
CALD	32	27	14	29
Anglo	26	26	10	24
Total	58	27	24	26
Suggests additional group therapy (B.11)				
CALD	32	27	18	37
Anglo	24	24	12	29
Total	56	26	30	33
None – Does not suggest additional self-help, family, or group therapy (B.11)				
CALD	4	3	0	0
Anglo	6	6	2	5
Total	10	5	2	2
N/A – Not a service provider (B.11)				
CALD	4	3	1	2
Anglo	9	9	2	5
Total	13	6	3	3
Thinks all mental illnesses can be successfully treated with formal clinical services (B.12)				
CALD	9	16	6	29
Anglo	11	21	6	29
Total	20	18	12	29

Data Table G.7: Frequency data on interpreter engagement by cultural background of service provider and types of service organisation (T1 and T2)

	T1		T2	
	N	%	N	%
Only using interpreters trained in matters relating to sexual assault (C.5)				
CALD	19	33	8	38
Anglo	8	17	5	25
Total	27	26	13	32
Mainstream	13	18	8	32
Non-mainstream	12	43	5	42
Specialised for sexual assault	9	27	2	20
Not specialised for sexual assault	16	24	11	41
Training interpreters on matters relating to sexual assault (C.6)				
CALD	13	23	2	10
Anglo	1	2	1	5
Total	14	14	3	7
Mainstream	5	7	1	4
Non-mainstream	8	29	2	17
Specialised for sexual assault	4	12	2	20
Not specialised for sexual assault	7	10	1	4
Pre-briefing interpreters on matters relating to sexual assault (C.7)				
CALD	31	57	10	50
Anglo	20	44	8	40
Total	51	52	18	45
Mainstream	32	45	9	35
Non-mainstream	18	67	9	82
Specialised for sexual assault	16	49	6	60
Not specialised for sexual assault	32	49	12	44
De-briefing interpreters on matters relating to sexual assault (C.8)				
CALD	22	40	8	40
Anglo	15	33	7	35
Total	37	37	15	38
Mainstream	22	31	9	35
Non-mainstream	14	52	6	55
Specialised for sexual assault	13	39	7	70
Not specialised for sexual assault	23	34	8	30

Data Table G.8: Frequency data on client choice regarding ethnic matching by cultural background of service provider and types of service organisation (T1 and T2)

	T1		T2	
	N	%	N	%
Offer CALD clients choice about ethnic matching with service provider (C.12)				
CALD	34	60	10	48
Anglo	21	42	10	48
Total	55	51	20	48
Mainstream	34	46	12	44
Non-mainstream	19	63	7	47
Specialised for sexual assault	13	38	3	33
Not specialised for sexual assault	40	57	16	50

Data Table G.9: Frequency data on organisations collecting data on ethnicity-related variables (T1 and T2)

	T1		T2	
	N	%	N	%
Languages spoken at home	37	93	27	100
Need for interpreter	35	88	26	96
Country of birth	36	90	26	96
Citizenship	22	55	15	56
Religion	16	40	9	33
Other	15	38	5	19

Data Table G.10: Frequency data on links with CALD community organisations by cultural background of service provider and types of service organisation (T1 and T2)

	T1		T2	
	N	%	N	%
Links not at all strong				
CALD	9	16	2	9
Anglo	6	12	3	14
Total	15	14	5	12
Mainstream	13	18	4	15
Non-mainstream	2	7	0	0
Specialised for sexual assault	8	24	1	11
Not specialised for sexual assault	7	10	4	13
Links somewhat strong				
CALD	19	34	7	32
Anglo	28	55	6	29
Total	47	44	13	30
Mainstream	40	55	13	1
Non-mainstream	3	11	0	0
Specialised for sexual assault	14	41	3	33
Not specialised for sexual assault	29	43	10	31
Links quite strong				
CALD	18	32	7	32
Anglo	11	22	6	29
Total	29	27	13	30
Mainstream	17	23	9	35
Non-mainstream	12	43	4	27
Specialised for sexual assault	11	32	4	44
Not specialised for sexual assault	18	27	9	28
Links very strong				
CALD	10	18	6	27
Anglo	6	12	6	29
Total	16	15	12	28
Mainstream	3	4	0	0
Non-mainstream	11	39	11	73
Specialised for sexual assault	1	3	1	11
Not specialised for sexual assault	13	19	9	28

APPENDIX H: Full list of remaining qualitative responses

For brevity, only exemplar quotes were used in the main body of the Report. However, to honour the voices of all participants, the full list of remaining responses is documented below. These come from the Baseline Survey (coded 1–112), Participant Satisfaction Survey (coded 1–100), Q&A Forums (coded by city), Email (coded T1 or T2), or Follow up Survey (coded 1–44).

Program attendance

Professional development

PD (Satisfaction Survey_6, 14).

Improved practice (Satisfaction Survey_31).

I'm open to new info (Satisfaction Survey_98).

For more information (Satisfaction Survey_53).

To further my education (Satisfaction Survey_80).

To build cultural competence (Satisfaction Survey_77).

To increase skills and awareness (Satisfaction Survey_69).

I'm fairly new to the CALD service space (Satisfaction Survey_100).

Increases my understanding of those issues (Satisfaction Survey_11).

For training on 'child' sexual abuse awareness (Satisfaction Survey_56).

To gain more knowledge for my organisational role (Satisfaction Survey_85).

To expand and potentially learn something unknown (Satisfaction Survey_79).

Increase awareness/knowledge on child safety matters (Satisfaction Survey_62).

To address gaps in my knowledge regarding this topic (Satisfaction Survey_74).

To get more information of CSA and to support our clients (Satisfaction Survey_89).

Strong interest in increasing knowledge and practice in this area (Satisfaction Survey_51).

To inform myself on how to work in a CALD sensitive and aware way (Satisfaction Survey_95).

I work with children, and it is good to be more educated about child sex abuse (Satisfaction Survey_3).

Very relevant to my work – wanting to make sure I was being culturally competent (Satisfaction Survey_73).

To update my knowledge in CSA in CALD, which I come across less but have done (Satisfaction Survey_21).

To provide a better service to children and adolescents who've been sexually abused (Satisfaction Survey_15).

To get a better understanding of working with CALD clients and assist with my work (Satisfaction Survey_39).

I wanted to learn more about how I respond to victims/survivors of child sexual abuse (Satisfaction Survey_59).

Relevant training on the importance of creating knowledge on working with CALD survivors (Satisfaction Survey_48).

To increase knowledge and understanding regarding prevalence of CSA in CALD communities (Satisfaction Survey_82).

To widen my knowledge base particularly in regards to providing better sexual assault counselling services (Satisfaction Survey_92).

To understand more about CSA in diverse community. To upgrade new research and studies in diversity (Satisfaction Survey_42).

Working effectively with CALD communities is of high priority to me personally and professionally, as it is for my team (Satisfaction Survey_19).

I work with children with disabilities. I felt it would be good professional development workshop/program (Satisfaction Survey_36).

I wanted to get more knowledge about sexual assault so I can support my clients/people in a more professional manner (Satisfaction Survey_81).

To feel more comfortable if a client was to approach our service in need of assistance with a history of child sexual abuse (Satisfaction Survey_38).

To learn more about principles of working/responding to highly sensitive issues within "CALD" communities and experiences (Satisfaction Survey_84).

Interested in learning more about how I can assist best with victims of child sexual abuse and individuals in CALD communities (Satisfaction Survey_46).

To increase my awareness of other ethnicities, my interest in supporting children who have been affected by sexual abuse, become more culturally competent (Satisfaction Survey_52).

I felt like I needed to know more about how abuse is experienced within CALD communities so I can better identify and support those who have experienced abuse (Satisfaction Survey_35).

I try to attend as much training as possible as I enjoy learning as much as I can to allow/be able to give my clients as much support as I can in all areas that they may need it (Satisfaction Survey_37).

Relevance and/or interest

Interest on the topic (Satisfaction Survey_91, 26).

Relevant to my work (Satisfaction Survey_60, 5).

Very important for my work (Satisfaction Survey_87).

Relevant to my organisation (Satisfaction Survey_20).

Relevant to working with clients (Satisfaction Survey_44).

To be a more effective practitioner (Satisfaction Survey_63).

Running CALD trainings internally (Satisfaction Survey_71).

Interest in my CALD community and topic of CSA (Satisfaction Survey_10).

Opportunistic – prelude to an upcoming conference (Satisfaction Survey_76).

I sit on the Child Safety committee at my organisation (Satisfaction Survey_100).

Because I work with CALD communities and their children (Satisfaction Survey_94).

Relevance to the work I do. The important relevance of the topic (Satisfaction Survey_8).

I work with CALD clients and CSA survivors so today seemed relevant (Satisfaction Survey_23).

I work with CALD individuals and I thought the topic is very relevant to my work (Satisfaction Survey_55).

Due to my ongoing personal and professional interactions with CALD communities (Satisfaction Survey_88).

Due to role – we roll out child safe org info – good fit for working with CALD communities (Satisfaction Survey_57).

I work with childhood sexual assault across the broad spectrum of diversity within Australian society (Satisfaction Survey_97).

I provide service to various non English speaking clients, I believe the training was very relevant to my practice (Satisfaction Survey_2).

Interest and responsive responsibility to working with CALD communities as well as multicultural children and families (Satisfaction Survey_45).

I work as sexual assault counsellor and have a particular interest and work history of working with people from refugee communities (Satisfaction Survey_99).

I work closely with [NGO name] on the [Suburb name] and have produced a DVD on the issue of domestic violence and women in CALD communities, where we briefly look at child sexual abuse (Satisfaction Survey_40).

Program delivery

Format and timeframe

(Liked best?) Q&A (Satisfaction Survey_42).

(Liked best?) The group discussion (Satisfaction Survey_4).

(Liked best?) The (Q&A) discussion over lunch was great (Satisfaction Survey_99).

A few more opportunities to learn what other people do in the room (so we can collaborate and help each other) (Satisfaction Survey_67).

I suggest interspersing content delivery with discussion or application as it is difficult to attend to lectures for extended periods (Satisfaction Survey_50).

More participation throughout the course would of been more productive. Became tired due to listening and not being able to engage with the presenter (but) presenter was good (Satisfaction Survey_6).

The format of delivery was not entirely conducive for absorption of information. Instead of one Q&A at close, providing space for table discussion of key terms at the completion of each module (Satisfaction Survey_88).

While I can understand wanting to deliver content and ask questions at the end, perhaps at the end of each theme (1, 2, and 3), there could have been the chance for discussion, it was a bit long to sit with no comment (Satisfaction Survey_7).

Understand there was a lot of content to get through but a little more interaction (i.e. questions of group discussions) throughout could have helped with processing and concentration. But thank you for delivering such great content and for the time you have put into research in such a difficult topic (Satisfaction Survey_100).

Presentation

Excellent (Satisfaction Survey_18).

Thanks for an inspiring day (T1_Email).

All relevant (Satisfaction Survey_57).

Good presenter (Satisfaction Survey_55).

Very informative (Satisfaction Survey_25).

Clear and concise (Satisfaction Survey_27).

Informative, clear (Satisfaction Survey_28).

Content was good (Satisfaction Survey_73).

Thought provoking (Satisfaction Survey_51).

Content interesting (Satisfaction Survey_30).

It was very informative (Satisfaction Survey_58).

Nothing was redundant (Satisfaction Survey_52).

I enjoyed today's session (Satisfaction Survey_98).

(Anything redundant?) Nil (Satisfaction Survey_9).

(Liked best?) Your energy (Satisfaction Survey_75).

Informative. Presentation style (Satisfaction Survey_2).

(Liked best?) All information (Satisfaction Survey_89).

Thank you for the presentation (Satisfaction Survey_79).

Very well explained, thank you (Satisfaction Survey_26).

Relevant, variety of terms/ideas (Satisfaction Survey_21).

Very solid, substantial material (Satisfaction Survey_84).

(Liked best?) Lots to think about (Satisfaction Survey_34).

The information was well presented (Satisfaction Survey_74).

(Any other comments?) Many things (Satisfaction Survey_3).

(Liked best?) Clear communication (Satisfaction Survey_85).

I like how tailored the program was (Satisfaction Survey_49).

(Liked best?) Relevant case examples (Satisfaction Survey_20).

(Anything redundant?) Not really (Satisfaction Survey_23, 47).

(Liked best?) The engaging presenter (Satisfaction Survey_68).

Extremely well stepped out/articulated (Satisfaction Survey_31).

Cultural awareness was very thorough (Satisfaction Survey_72).

(Anything redundant?) No, all relevant (Satisfaction Survey_36).

(Anything redundant?) Not at all (Satisfaction Survey_8, 72, 72).

(Anything redundant?) No. All relevant (Satisfaction Survey_36).

Excellent research and literature review (Satisfaction Survey_57).

Comprehensive research and information (Satisfaction Survey_46).

Great that you're tackling this taboo issue (Satisfaction Survey_15).

Presenter's fantastic knowledge of the area (Satisfaction Survey_87).

(Liked best?) So much information stood out (Satisfaction Survey_20).

(Liked best?) Dr Sawrikar's ability to present (Satisfaction Survey_38).

(Anything redundant?) No, it was very relevant (Satisfaction Survey_21).

(Liked best?) Complexities were well presented (Satisfaction Survey_76).

Pooja used good metaphors to make her points (Satisfaction Survey_99).

Very informative, good structure of the program (Satisfaction Survey_89).

(Anything redundant?) N/A (Satisfaction Survey_38, 59, 64, 65, 74, 80, 96).

Very interesting conference and in-depth knowledge (Satisfaction Survey_94).

Information provided was clear, relevant, and useful (Satisfaction Survey_80).

Very well presented, very engaging, and informative! (Satisfaction Survey_82).

Comprehensive, well paced, pitched at the right level (Satisfaction Survey_18).

Thank you very much for that excellent educational training in Sydney (T1_Email).

Good presenting – confident, clear and easy-to-follow (Satisfaction Survey_39).

Your presentation skills are excellent. Well done Dr. Pooja (Satisfaction Survey_8).

Great presentation, research, an explanation of the issues (Satisfaction Survey_56).

I felt it was very informative and full of useful information (Satisfaction Survey_60).

Very thorough and informative. Very clear and thoughtful (Satisfaction Survey_35).

(Liked best?) The flow of the slides and content, the examples (Satisfaction Survey_3).

Liked the way the three sections were connected and built on (Satisfaction Survey_84).

(Liked best?) Breakdown of data and presentation of findings (Satisfaction Survey_91).

Thank you Pooja. It was a very interesting and thought provoking presentation (T1_Email).

(Anything redundant?) No, to be honest, it was all very useful (Satisfaction Survey_34).

Information is well presented, not discomfoting, very respectful (Satisfaction Survey_36).

(Liked best?) New material/the mix of conceptual and practical tips (Satisfaction Survey_30).

(Liked best?) Clarity of information and relaxed delivery of content (Satisfaction Survey_51).

The training was delivered in a clear and culturally appropriate way (Satisfaction Survey_59).

Comprehensive and relevant, current information focused on the client (Satisfaction Survey_9).

Informative training, presented very clear, presented new information (Satisfaction Survey_83).

(Liked best?) The depth of research on cultural awareness from Pooja (Satisfaction Survey_47).

(Liked best?) Knowledge, passion, interest to an untapped area of need (Satisfaction Survey_45).

(Any other comments?) Issues were properly identified in the literature (Satisfaction Survey_11).

(Liked best?) Trainer so well-versed in material and clear on direction (Satisfaction Survey_86).

(Liked best?) The clear way issues were explained that left no ambiguity (Satisfaction Survey_19).

(Liked best?) The way it was delivered, respectful, recognising limitations (Satisfaction Survey_83).

(Liked best?) Part 1 – found this very informative and thought provoking (Satisfaction Survey_100).

Great explanations, pitched at the right level, relevant and practical examples (Satisfaction Survey_19).

Excellent presentation of your research!! Great language, very clear articulation (Satisfaction Survey_52).

Great content, great program. Look forward to further exploration, expanded scope (Satisfaction Survey_17).

Presenter was very knowledgeable and had a very approachable way of delivering info (Satisfaction Survey_33).

(Anything redundant?) No (Satisfaction Survey_3, 10, 18, 19, 26, 35, 42, 46, 51, 62, 63, 84, 88, 90, 91, 94, 95, 97).

The overall approach of the project is great – I look forward to seeing how it comes together (Satisfaction Survey_50).

Presenter was engaging and easy to listen to, and clearly knowledgeable on the issue and passionate (Satisfaction Survey_7).

I really enjoyed the day and the discussion it raised. Pooja was very engaging and easy to listen to (Satisfaction Survey_35).

(Liked best?) Well-organised material including PowerPoint. Instructor's calm and clear presentation (Satisfaction Survey_61).

Well researched presentation. However, despite the lack of data, the person is the best 'cultural expert' (Satisfaction Survey_64).

A thorough literature review was demonstrated with a tangible resource for the community provided (Satisfaction Survey_63).

I really enjoyed this program. The facilitator was really good, her respect created lots of safety in the group (Satisfaction Survey_42).

(Liked best?) Exposure to theories and existing research underpinning the program and challenging myths (Satisfaction Survey_96).

(Anything redundant?) No, all new and wonderful information. I am going to share at our next team meeting (Satisfaction Survey_40).

Pooja did a brilliant job of explaining seriously complex topics in a sensitive, passionate, and clear way (Satisfaction Survey_95).

Well presented, informed speaker with great knowledge of CALD. Very interested in the subject and it shows (Satisfaction Survey_24).

Great, thank you. Good to get an understanding of where the actual research is at and subsequent statistics (Satisfaction Survey_97).

Very difficult/sensitive issues raised logically and respectfully, and giving permission to discuss in our services (Satisfaction Survey_69).

I liked how it was explained. The information was clearly explained and presented so it was easy to understand (Satisfaction Survey_81).

I have lots of new refreshing articles to read to update my practice and knowledge to best have these conversations (Satisfaction Survey_21).

Good concrete information to integrate theory and how it can apply to practice and improve better service delivery (Satisfaction Survey_41).

(Liked best?) Seeing the results of previous research done on topic. Look forward to seeing results of current research (Satisfaction Survey_36).

Overall I thought the training was really good and I like how it challenged assumptions relating to this experience (Satisfaction Survey_74).

Thank you so much for the opportunity to attend Pooja, it was very good. The effort you put into the research and presentation were worth it (T1_Email).

(Liked best?) The philosophy -> underpinning of the issues impact CALD communities in the area of CSA so perfectly discussed (Satisfaction Survey_20).

Explained research well and provided practical advice and clear picture on how research can inform practice and service provision (Satisfaction Survey_39).

Topic is very interesting, well researched. It's clear that the presenter bases the training on comprehensive and rigorous research (Satisfaction Survey_50).

(Liked best?) The speaker (her passion) and information about things service provider should be aware of when working with CALD people (Satisfaction Survey_90).

Loved the 'bread crumb' approach to information, the clear and informative information/presentation style and PowerPoint presentation (Satisfaction Survey_20).

(Anything redundant?) No. Because it was relatively new for me, everything was relevant. Possible workshop: how does this fit with both of my fields: FOC and TAFE (Satisfaction Survey_76).

Very engaging presenter, well researched, knowledgeable but also approachable and provides practical examples and analogies to assist understanding, Thank you. (Satisfaction Survey_69).

(Any other comments?) Looking forward to sharing what I have learnt today. Could we please have another session to expand on it the more it is 'out there in the open' the better (Satisfaction Survey_40).

(Explanation for overall satisfaction rating?) The session was relevant, well researched, well presented. The boldness to touch on sensitive words, i.e. "race and white privilege" (Satisfaction Survey_8).

I have attended several trainings focusing on "sexual child abuse in the CALD communities" and none of them explained the following information. (Liked best?) The information and the way it was presented. I found the whole presentation very useful, very engaging, and informative, thank you! (Satisfaction Survey_12).

Pooja, I don't have any questions because as far as I'm concerned everything you presented covered, it was so comprehensive, everything was so factual and so up-to-date, even some very sensitive issues were done so frankly, it really was an outstanding presentation, all my expectations were exceeded (Q&A Forum_Adel).

Presenter was engaging and passionate. Exciting to have this area (CALD) identified as an essential area requiring more research to inform intervention and treatment. I really enjoyed the session and your passion for change in this area. It helped to affirm that what I do in treatment is mostly correct (reminded me to do things I perhaps don't do often enough – such as reinforcing confidentiality and being more sensitive to the value they (clients) place on their culture) (Satisfaction Survey_16).

Other

Disability service provider (Baseline Survey_67).

Few information on service links/providers (Satisfaction Survey_89).

(Any other comments?) Ask me in 6 months! (Satisfaction Survey_76).

(Any other comments?) Where to from here? (Satisfaction Survey_68).

Intercultural competent = culturally responsive? (Satisfaction Survey_45).

Can't yet see what ed package would look like for services (Satisfaction Survey_57).

Second day on the job at organisation, so still understanding how things work (Baseline Survey_79).

Given I am in policy development, I am not completely across front-line practice (Baseline Survey_97).

Amend title of program to "Providing Culturally Competent CSA services to CALD" (Satisfaction Survey_75).

Service does not see clients for crisis or child sexual assault based on previous clients (Baseline Survey_76).

I work in a women's service which employs 5–6 workers including admin and manager (Baseline Survey_60).

Treatment need and focus on slides – Health (JIRT) and interpreter (FaCS) roles? (Satisfaction Survey_47).

Generic CALD service may not be suitable to individual children, young people, or women (Baseline Survey_75).

Even if we're not a mandatory reporter I always talk about the moral responsibility (Q&A Forum_Melb).

(Liked best?) That the program will be rolled out to (CALD) community and schools also (Satisfaction Survey_15).

How to deliver the child sexual abuse awareness/education content to CALD community? (Satisfaction Survey_47).

Very small organisation, with 1 x staff director, wishing to grow and engage diverse communities (Baseline Survey_93).

Absence of attention to Specialist Services that work with clinical practitioner, e.g. Health, JIRT (Satisfaction Survey_45).

Morning break too long – 15 mins adequate as it was half day program and lunch was not far (Satisfaction Survey_16).

Is there research on diversity in the sexualised behaviours of children who have been sexually abused? (Q&A Forum_Bris).

That whole movie ‘10 Things I Hate About You’ is like a textbook example of boys can’t take no for an answer (Q&A Forum_Melb).

We also deal with sexual assault, DV, common assault, home invasions etc. – a wide range of acts of violence (Satisfaction Survey_65).

I have just been appointed to my position so am not fully aware of all practices etc. in the organisation (Baseline Survey_20).

(Cultural background) Mother is Chinese and father is English. Grew up in a cross-cultural environment (Follow up Survey_30).

There is no reference to what CSA services are available through Health, JIRT – which is fundamental to understand service (Baseline Survey_75).

I would like to see the results of the survey and the longitudinal study and like to see if the service delivery model plays out in practice (Satisfaction Survey_23).

I felt there was a greater focus, particularly in latter two sections, on working with adult survivors in lieu of contemporary child victims and their families (T1 _78).

There is an opportunity to link current CSA issues with the Royal Commission and the work through Child Safe organisation governance (Satisfaction Survey_47).

My role is not first for service providers and our services are broad around families and relationships – not sexual assault per se (Baseline Survey_59).

Please when presenting do not soften your voice when saying an important point – can’t hear at the back especially at the end of sentences (Satisfaction Survey_30).

(Anything redundant?) The slides on assessment – seemed as a general assessment guide which would apply to all people we work with? (Satisfaction Survey_40).

Morning tea needs to be a little earlier if lunch is so late and more for morning tea or make lunch earlier and we come back to the course after lunch (Satisfaction Survey_67).

I don't work in any organisation, I have a private practice and am a bilingual psychologist. I provide clinical support to various members of CALD communities (Baseline Survey_84).

I work with service providers in my organisation across the state so I am unsure of specific local process/procedures for service provision (all are different) (Baseline Survey_66).

We are a service that works with clients with moderate-severe MH issues from 0–18 years and their families. We are part of the [org name]. Clients can self-refer (Baseline Survey_87).

Understanding of non-white cultures is very different in my native country/state – California – which is how a minority-majority state (predominantly Latino under 16) (Baseline Survey_83).

Please note that I have been unable to answer some questions (particularly around the interpreter information) as the program I lead does not specifically work in this space (Follow up Survey_26).

I work for [org name]. However, I work specifically for [program name]. The organisation has other programs so my answers only reflect my experience working with [my program] (Baseline Survey_43).

I was wondering about female genital mutilation, because to me that's child sexual abuse. Can you talk a little bit more about that, how come it's not included here in your research? (Q&A Forum_Bris).

I work in private practice with another psychologist and 2 GPs. Clients contact us directly for appointments – usually referred by other GPs (at their request or on the GP's or family/friend's advice) (Baseline Survey_98).

I expect there'll be some really interesting research coming out of the online stuff, in terms of where people may feel more comfortable accessing services, for the safety and anonymity of social media and support chat rooms (Q&A Forum_Syd).

I'm wondering with the internet era, people in western society are communicating more online, or if there's been higher, more people speaking about child sexual abuse, because of their access to the internet all over the world? (Q&A Forum_Syd).

I have been at my current org for less than 1 year and my program's quite separate to case management programs/one on one service delivery, hence difficulty providing definitive answers to some of the above questions (in Section C) (Baseline Survey_110).

I have had a few students presenting in classes who disclose CSA. Given the impact on children's services I would like to be able to "pre-warn" students. FDC (Family Day Care) – Our scheme has had to deal with two CSA disclosures from CALD backgrounds (Baseline Survey_38).

I just want to make a comment on the reporting of sexual abuse in CALD communities, in my experience, men are much more likely to report. There are significant gender differences in that. In my experience, probably 10 to 1 men adult survivors of child sexual abuse (Q&A Forum_Adel).

My main focus in these responses was from the viewpoint of our Family Day Care Service. We have a few CALD Educators and families. There has been a few issues with children disclosing from CALD backgrounds when we have accessed local support organisations (Follow up Survey_18).

I work as a case worker in child maltreatment (Intensive Family Support program). My service also provides a specific CSA program (Sexual Assault Counseling Service). As such, I am not a CSA service provider but do case manage families where CSA (both child victim and child perpetrator) is present (Baseline Survey_51).

I work for a homelessness service that works with people and families from a wide range of culturally and linguistically different backgrounds – but we are an assessment and referral service and would not directly offer support regarding child sexual abuse. We would refer to a different service with the expertise to do so (Baseline Survey_19).

Maybe some understanding of the criminal justice system in that country, only because, even though you may be very clear that every country every culture condemns it (child sexual abuse), it's an absolute no no, it would be interesting to see the socio- social context as to how they respond to it, how the criminal justice system responds to that (Q&A Forum_Adel).

(I describe my cultural identity as:) A Kissi by tribe, born in Sierra Leone and grew up in Guinea Republic due to Civil War in Sierra Leone in 1991 January. I came to Australia as a refugee since 2002. I have never being back home. I believed in my culture and will always continue to practice my culture. I glad that I am in a country that is a Multicultural country that believe in every culture and respect all values (Follow up Survey_42).

You mentioned 'cultural traitors'. Some of the CALD families I've worked with where the children have been brave enough to stand up and make a statement, I think of one 15 year old in particular that was sexually abused by her dad and seeing the whole community turn against the child. She knew she would not have community support – for a child to have to realise that, shows incredible strength. I'd like to think that maybe our education system has something to do with that. She went to school and she's learnt about her rights (Q&A Forum_Adel).

Along with all the taboos you mentioned about talking about sex, disclosure etc. from a community with collectivist approach – I just wanted to raise an even greater taboo than abuse by men (and men with status in community, i.e. cleric, priest, etc.), is abuse by women and in particular by women in the church (i.e. nuns). This is something I have worked with in National Redress work (amongst Aboriginal children in institutions – magnified shame of not being believed. Double TABOO – feeling that no services want to listen, acknowledge that it happens exclusion, etc.) (Satisfaction Survey_34).

Talking about the legal system, the one case where I was really able to get a child to disclose, there were 7 or 8 family members and one sounded protective enough to become the kinship carer. (She) went through the judicial system ... went to the hospital ... has a video-recording ... but the perpetrator got away with it in the end cos of evidence stuff. There was a small discrepancy with her

first statement, (and) was told it wouldn't stand up against cross-examination. It sent an awful message to the community, with the perpetrator still going to community events; there's no justice 'how come I can't tell my story in court'. It sets CALD communities up for failure in so many ways (Q&A Forum_Adel).

From my work experience with diverse clients, it's really hard for most to realise they're getting sexually abused in the first place, because in some cultures it is 'your duty to say yes whenever he is asking me for intercourse'. And you're not going to disclose any sexual abuse if you're thinking 'yeah, that's part of my job, I'm his wife'. It's a really private thing that you will talk about with clients from diverse communities. When you do a risk assessment, most of these CALD clients say 'no, I have not been sexually abused', but when you explore that (later) they don't realise that legally, that it's illegal to sexually abuse (Q&A Forum_Melb) ... And each generation's teaching that to their kids, so hopefully these kids are going to schools that are now incorporating the child protection, Victoria Child Safe standards, teaching kids about saying 'no, stop, speak up if they feel unsafe', because otherwise that's just passed on, especially for girls (Q&A Forum_Melb).