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
(EXECUTIVE SUMMARY)

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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.

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
BPD	Borderline personality disorder
CALD	Culturally and Linguistically Diverse[1]
CPD	Continuing Professional Development
CSA	Child sexual abuse[1]
FAE	Fundamental attribution error
GU	Griffith University

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

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INTRODUCTION

Overview

A multi-year project beginning April 2018 on child sexual abuse (CSA) and culturally and linguistically diverse (CALD) communities in Australia is being partly funded by Griffith University (GU). The project is comprised of three intended stages: (1) to develop and evaluate an education program for service providers about CALD client victims/survivors of child sexual abuse, for whether their cultural competency increased; (2) to develop and evaluate an education program for CALD community members, for whether their awareness of child sexual abuse increased; and (3) to develop and evaluate recommendations for how schools can adapt their current child sexual abuse prevention programs to include factors relevant for CALD children, families, and communities, for whether their culturally sensitive engagement increased. Technical Report 1 identifies the findings of Stage 1 (Technical Report 2 will be made available later and Technical Report 3 depends on future funding sources).

Background

Child sexual abuse is a universal problem; while there appears to be cross-cultural variations in its prevalence, it is still reported in all groups. Most research about child sexual abuse is on Western populations. This reflects, in large part, the role of the state in their child protection matters. Governments are responsible for child safety, and as such, funding to support evidence-based practice is made available to help guide their work. In many non-Western countries, the role of the state in child protection is either less or less enforced. It does not necessarily reflect a lower value for child safety, but rather a value for the role of extended families in providing this safety. This further aligns with a cultural need to protect the family's name and spare the stigmatic shame that would otherwise be associated with extra-familial disclosure. One effect of the state being less involved in child safety in non-Western countries is that research and media attention becomes comparatively lower. Combined with a cultural taboo to not discuss any matters to do with sex including abuse, child sexual abuse runs the risk of being seen as a 'Western problem' by both Western and non-Western communities; something that does not really happen in CALD communities because it is not highly visible there. Thus, a number of cultural factors can combine to create a high degree of

silence about child sexual abuse in CALD communities, which can transfer after migration into Western countries and extend into established generations.

Significance

In Australia, CALD communities refer to non-mainstream migrants. Thus, they are not Indigenous (First Nation Aboriginals and/or Torres Strait Islanders), and they differ from the Anglo Saxon/Celtic majority in race, language, culture, and/or religion. Not all migrants come from non-Western countries of origin (e.g. from Germany, Ireland, Netherlands, etc.), but those who do incur an increasingly larger burden of racism the more they differ from Australia's white mainstream (such as and especially Muslims). This further silences a victim/survivor of child sexual abuse from a CALD community: they are aware that should they tell, their entire ethnic community faces negative stereotyping. Thus, Western literature cannot be assumed to apply to non-Western migrant communities; although child sexual abuse is a universal problem, barriers to disclosure are experienced differently due to cultural and racial factors.

To be able to address the needs of this group well in the service, community, and school sectors, research needs to be conducted. It prises open the current silence to help reach CALD victims/survivors of child sexual abuse, while acknowledging that power dynamics between the white mainstream and non-white migrants needs careful navigation, in ways that do not further burden or threaten the safety of CALD victims/survivors of child sexual abuse. All stages in this project honour the challenge of protecting an ethnic minority child in a racist society: for them, both child safety and cultural safety are at risk. Sometimes they are at odds with each other, and at other times one only comes with the other. This project is intended for audiences deeply and fundamentally respectful of this challenge. It is not about 'data mining' this population to gain research-based knowledge that could then be used to systematically increase state intervention. It is about developing empathy/compassion for the multiple violations of personal and social injustice bore by the non-white migrant victim/survivor of child sexual abuse and understanding of culturally appropriate support. Importantly, this research is being conducted by a woman from a CALD community, and so is an empowering act of self-determination against intersecting levels of social inequality.

METHOD

Program development

The main aim of Stage 1 was to develop an education program for 'health and well-being' service providers about CALD client victims/survivors of child sexual abuse, and evaluate whether it improved their cultural competency. The design of the program was informed by a systematic literature review conducted on child sexual abuse and ethnic minority communities in 2016.

In this project, cultural competency in the services sector was seen to be comprised of three overlapping 'circles' of knowledge: knowledge about child sexual abuse, knowledge about CALD communities, and knowledge about good service provision. 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/or being a racial minority. Good service provision requires knowledge about similarities and differences between CALD and other victims/survivors, as well as knowledge about their needs in the clinical setting. To this end, cultural competency was seen to entail:

- 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 sex with 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
        - 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.)

Program delivery, satisfaction, and evaluation

To examine whether and how cultural competency was affected by attending the education program, a primarily quantitative longitudinal evaluation study was conducted; triangulating baseline and six month follow-up survey data with any open-ended qualitative responses provided at both times. The study also assessed service providers' satisfaction with the program at the end of delivery.

All relevant service providers were invited via email to attend the education program, being delivered in one of four culturally diverse cities – Brisbane, Sydney, Adelaide, and Melbourne. In total, 120 service providers (social workers, counselors, psychologists, program trainers, and other relevant professionals) representing 53 different service organisations attended, and were highly satisfied with the program overall ($M = 4.2$ out of 5, $SD = 0.7$, $n = 99$). Most service providers completed the baseline survey ($n = 112$). Of these, 39.3% completed the online six month follow-up survey ($n = 44$).

The evaluation instruments were designed to capture data relevant to the eight research questions (RQs) of the study. These questions merged the aforementioned knowledge elements of cultural competency in ways that made their relevance to CALD communities clear and for the purposes of good service provision.

RESULTS

Knowledge about child sexual abuse and CALD communities

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

Sense of efficacy is a component of cultural competency carried by frontline service providers; operationalised here as being comprised of cultural knowledge, cultural confidence, and cultural sensitivity/respect. It was seen to be a fundamental outcome of the education program.

Six months post program attendance, CALD and Anglo service providers improved on their self-rated general knowledge about CALD groups, and confidence to work with CALD client victims/survivors of child sexual abuse, but not to the same degree on sensitivity to ethnic diversity in daily work practice. These findings support the effectiveness of the program, but also indicate that service providers already have strong social justice values. Gains in knowledge about individualism/collectivism and family reputation were particularly noted, as was the affirmation of the need for cultural sensitivity and competency. Some of the associations between knowledge, confidence, and sensitivity/respect also strengthened as a result of the program. Generally, opportunity to work with this client group is low due to the many barriers to formal service uptake. However, these results are promising for a more 'ready' workforce as a result of engaging with the program.

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

As more research on child sexual abuse is conducted in Western populations, it could be falsely seen as a 'Western problem'. When rigorous international comparative research has been conducted (Finkelhor, 1994; Pereda, Guilera, Forns, & Gomez-Benito, 2009), it has

been found that some samples (e.g. China) consistently report lower prevalence than others (e.g. South Africa). However, there is difficulty interpreting this data for a number of reasons. In addition to differences in the way child sexual abuse is defined across countries and issues relating to the recall of traumatic experiences, there are a wide array of barriers to disclosing the abuse leading to high under-reporting (Sawrikar & Katz, 2017). In CALD communities, utmost importance for protecting family reputation valued in collectivist cultures, prohibitive social norms on discussing any matters to do with sex including abuse, and protecting one's entire ethnic community from racist stereotyping unique to minority populations, all exacerbate this under-reporting. It thus becomes reasonable to err on the side of caution and assume that prevalence is higher than the research data suggests in *all* countries and cultures, and that therefore all children are equally worth protecting regardless of their cultural background.

Six months post program attendance, the proportion of CALD service providers who thought that the prevalence of child sexual abuse in some cultural groups is negligible observably decreased, however very few thought this to begin with too. Also, the proportion of CALD and Anglo service providers who thought that cross-cultural prevalence data is close to accurate decreased. These findings support the effectiveness of the program in challenging service providers' trust of quantitative data about cross-cultural prevalence of child sexual abuse. Generally, it appears there is 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 prevalence is essentially equal; the program appears to have effectively challenged the former.

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?

One myth about child sexual abuse is that perpetrators are usually unknown to the victim (Australian Bureau of Statistics [ABS], 2016, 2006; Collings, 1997). Since matters to do with sex including abuse are not openly discussed, it may make child sexual abuse even less visible in CALD communities and more difficult to challenge/debunk the myth. There is also normative reliance on extended family and community for child-rearing in collectivist cultures (Nesci, 2006), so parents/guardians may unknowingly expose their children to risk of sexual harm if they leave them in the care of those who are also perpetrators (e.g. fathers, uncles, siblings, cousins, family friends, neighbours, etc.). Together, these trends may cause

parents/guardians in CALD communities to be utterly shocked at and disbelieving of their child's disclosure; in other words, more believing of this myth.

However, it may not be possible to determine whether there *are* cross-cultural differences in beliefs of myths about child sexual abuse, for the same reason that quantitative cross-cultural prevalence data is challenging to interpret with confidence: in all cultural groups, there are too many barriers to disclosure and therefore much silence. Thus, the aim of exploring this particular myth in-depth was not to find empirical evidence for the possibility, but to imbue service providers with an appreciation that there *may* be cross-cultural differences in belief of the myth that most perpetrators are unknown with cultural knowledge about why.

Six months post program attendance, the proportion of CALD and Anglo service providers who thought that belief of this myth is cross-culturally equivalent decreased. This change over time suggests that as a result of the program, service providers are deeply engaging with cross-cultural differences in the psychosocial experience of child sexual abuse, and thus less likely to universalise the experience as if it were essentially the same for all victims/survivors.

The results also show that 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.

Trends in the data also suggest that due to tacit cultural knowledge, CALD service providers can sometimes be more judgmental of CALD client families. That is, 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. The program seemed to have imbued CALD service providers with an easing of this 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. Furthermore, protective parenting within CALD communities may be occurring in an unspoken way, and such further research 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?

There are several myths about child sexual abuse. For example, two items from the seminal scale developed by Collings (1997) are 'Adolescent girls who wear very revealing clothing are asking to be sexually abused' and 'Children who do not report ongoing sexual abuse must want the sexual contact to continue'. One effect of such myths is that they can shift culpability (i.e. blameworthiness) from the perpetrator to the victim, who may then carry a fear of not being believed. If, after disclosure, this fear is affirmed with non-supportive and protective responses from parents/guardians it can increase the chances of self-blame, which in turn is associated with poorer mental health outcomes. These processes *could* potentially be heightened in collectivist CALD communities if they prioritise family goals (e.g. protecting family reputation and community standing) over individual goals (e.g. preventing re-victimisation or accessing formal mental health services).

Again, the aim 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 due to the immense number and gravity of barriers to disclosure. Instead, the aim was to imbue service providers with an appreciation that there *may* be such cross-cultural differences with cultural knowledge about why (including barriers to formal service uptake).

Six months post program attendance, the proportion of CALD and Anglo service providers who thought that belief of myths about child sexual abuse that shift culpability to the victim is cross-culturally equivalent decreased. There were also increases in the proportion of service providers who thought that belief of these myths were more or significantly more likely in CALD than Anglo communities. These changes across time suggest that as a result of the program, service providers are deeply engaging with cross-cultural differences in the psychosocial experience of child sexual abuse rather than universalising it.

However, as before, it appears that Anglo service providers do know that there are cross-cultural differences, but out of fear err toward universality/cross-cultural equality to appear 'colour blind'; the program seemed to give them 'permission' to acknowledge it. Troublingly for CALD service providers, there appears 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.

Knowledge about service provision for CALD victims/survivors of child sexual abuse

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

If service providers 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), then it would reflect the fundamental attribution error (FAE; Ross, 1977). This occurs when causal reasoning for behaviour is ascribed to the person despite clear environmental contributors; 'the behaviour of CALD groups can almost completely be explained by who *they* are'. It minimises the role of social factors such as racism in explaining their behaviours.

If Anglo Australian service providers are not racially self-aware and so do not understand that they contribute to their client's observed behaviour in the dyadic clinical space, then there is a risk they may not take responsibility for their racial power. This can add to abuses of power already incurred by the victim, even if unintended, and risk good clinical outcomes. Responsible use of racial power is seen to require service providers being aware of their own culture and how it may be entwined with the psychosocial experience of child sexual abuse, where their culture may be different to those of CALD backgrounds, and acknowledgement of racial differences in power in broader society to help identify how these affect the psychosocial experience of child sexual abuse for ethnic minorities in white-majority countries.

The onus also occurs because CALD clients may not necessarily want an ethnically-matched service provider, for fear of them breaching confidentiality and private family information 'leaking' into the community, thereby leading to a need for the whole workforce to be trained in cultural competency and not just leave 'CALD matters' to CALD workers. Indeed, some CALD workers could abuse their racial power by using tacit cultural knowledge in ways that increase risk of harm to victims/survivors and their families.

Six months post program attendance, the proportion of service providers who had heard of the phrase 'white privilege' had not increased, but this was because most had already heard of it prior to the program. On the other hand, a change may have been observed among medical practitioners such as GPs and psychiatrists had they attended. The qualitative data showed that participants appreciated discussions on white privilege, terminology for describing the client group, acknowledging the role of skin colour, and intersectionality as useful for framing how best to understand and engage with CALD communities. The need to differentiate 'white feminism' from 'brown feminism' was also highlighted.

Additionally, cultural self-awareness was found to be high among both CALD and Anglo service providers which is why there was no observed change over time. However, further research is required to examine what exactly constitutes as *cultural* self-awareness for each of them, including the extent to which it reflects *racial* self-awareness. Overall, racial self-awareness – being critically reflective of 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.

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?

In CALD collectivist and hierarchical communities, mental illness is seen as shameful because it threatens family name and therefore community standing (Sawrikar, 2005). As such, it becomes 'safer' to somatise the symptoms of emotional distress (Ferrari et al., 2015) or obtain medication from respected authoritative doctors for psychiatric symptoms, than to engage with counselling services and share how they are feeling. Labels such as 'post-traumatic stress disorder' also legitimate their psychological difficulties as a result of the childhood sexual abuse. However, a primarily medical approach to mental illness places responsibility for resolving the trauma within the victim, who also risks being labelled 'crazy' or 'mad' (Reavey et al., 2006). Lack of awareness about a sociological approach to the treatment of mental illness allows unequal distributions in power across gender – sexism as a result of patriarchal societal structures – to remain unnamed, minimised, or overlooked. A sociological approach 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.

It may be that a primarily medicalised approach is in the best interest of a specific individual CALD client; it may be too difficult for her to engage with a sociological approach to treatment, given that traditional gender roles are overt in collectivist cultures and family reputation and cohesion are utmost in need of protection. That is, getting some help in ways that are culturally acceptable may be better than getting no help. However, if practitioners focus on physical or mental ill-health (such as treating sexually transmitted diseases or bipolar disorder exclusively) without an awareness of the problems of a myopic medical approach and the benefits of a macro sociological one, then good clinical outcomes could be compromised. To help mitigate unintended irresponsible use of gendered power, the education program did not see the use of a sociological approach as essential for good practice but rather awareness of it.

Six months post program attendance, the proportion of service providers who believed that a sociological approach to the treatment of mental illness resulting from child sexual abuse is useful or effective increased, but was also already high to begin with. This finding supports the effectiveness of the program in further increasing the responsibility for gendered power that social workers, counselors, psychologists, program trainers, and other relevant professionals take within their practice. The results also speak of a journey among CALD service providers in becoming a feminist against highly valued traditional gender roles in collectivist cultures, and of not judging highly patriarchal societies and therefore demonstrating respect for difference among Anglo service providers.

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

Professional omnipotence by service providers also threatens good outcomes for the client. For example, service providers may believe that formal services are the only way that 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 borderline personality disorder (BPD). Service providers may believe that the clinical setting is more effective than self-help strategies (e.g. reading relevant books or online resources, engaging in music, art, or narrative therapy, etc.) and therefore do not suggest these to the client in conjunction with the formal services. 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 non-offending family members and other victims/survivors of child sexual abuse.

Six months post program attendance, the proportion of service providers who do not believe that all mental illnesses can be treated with formal services did not really change over time (approximately 75%), suggesting it is a strongly held view. The high proportion also indicates that most service providers already use their professional power responsibly, and the belief was somewhat related to age and work experience.

Service providers who do believe that all mental illnesses can be treated with formal services appear to view this belief 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 could be challenging if not impossible.

The 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 good practice to CALD victims/survivors of child sexual abuse?

Good service provision does not all belong to frontline service providers. Their work needs to be supported structurally by their service organisation to help maximise outcomes for the client (Sawrikar, 2017). The following organisational support is seen as essential: using interpreters trained in matters to do with sexual assault and providing such training to them; having an ethnically diverse workforce including in management positions; providing regular 'cultural competency' training to service provider staff; using a 'multicultural framework'; and mandatorily collecting data on ethnicity-related variables. Ideally, all promotional

materials (e.g. pamphlets, website, etc.) contain images of a target client group that is ethnically diverse, and the organisation has strong links with local CALD community members and organisations.

Six months post program attendance, little had changed with respect to interpreter engagement. This seems to speak less of the ineffectiveness of the program, and more of the difficulties of working effectively with interpreters which was particularly noted by service providers. At both baseline and follow up, it was found that more service providers pre- and de-brief interpreters compared to those that used trained, or train, interpreters, reflecting organisational policies about which interpreters can be used, resource constraints despite organisational desire and intent to improve practice with interpreters, and inconsistent practice among individual service providers further influenced by specific client needs.

Positively, most service organisations employed CALD staff. However, they were more often employed in CALD-specialised rather than in mainstream organisations, and 15% of organisations at baseline did not have any CALD staff which is problematic because it indicates that a sizeable number 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.

There is some recognition by service organisations of the low representation of CALD staff in management positions. In this study, it was very low (between 6–13% at baseline and follow-up), and were mostly in CALD-specialised rather than in mainstream organisations. This reflects white privilege; the systemic racial favouring of opportunities to white Australians.

Client choice regarding ethnic matching occurs approximately half the time, and CALD service providers and service providers in CALD-specialised organisations are generally more likely to do it. The program was ineffective in increasing this. The results also show that service providers 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 awareness of this issue in the field, as their inexplicit 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' within mission statements, philosophy, practice frameworks, etc. – operationalised in the study 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. However, this may be because it appears as 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 collect data on citizenship, religion, ethnic background, year of arrival, and diet.

All CALD-specialised organisations had visually inclusive websites; just over half of the mainstream organisations had visually inclusive websites, which marginally improved over time; and a small number of mainstream organisations were not visually inclusive, but their website offered different language options. Resource constraints may have an impact on organisations being able to prioritise or implement this aspect of cultural competency at the organisational/institutional level.

Finally, CALD-specialised organisations have stronger links with local CALD community organisations as expected, however so did organisations not specialised for sexual assault which was not expected. It 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 with local CALD community organisations did improve over time, suggesting that the program has been effective in promoting intersectionality.

DISCUSSION

Summary of key findings

Stage 1 of this study evaluated an education program designed to improve the cultural competency of practitioners within existing service organisations across Australia. Eight research questions were explored to examine whether this aim was supported. Appendix A contains a summary of the results.

Together, the findings tell a complex story about culturally appropriate service delivery. They show that low uptake of formal services by CALD communities leaves service providers with some practice wisdom, which the program's contents mostly affirmed, in turn boosting 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 patriatrchal 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.

Nevertheless, 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 other in-depth such program currently exists, and which adapted international research to Australia's particular needs and context. To enhance nation-wide accessibility, the program will be converted to online mode, be accredited by the Australian Association of Social Workers (AASW), and be eligible for Continuing Professional Development (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.

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. 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 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: 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.	✓
	2. Service providers will improve on their self-rated confidence to work with CALD victims/survivors of child sexual abuse.	✓
	3. Service providers will improve on their self-rated sensitivity to ethnic diversity in daily work practice.	✗
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.	✗
	5. The proportion of service providers who believe that cross-cultural prevalence data is accurate or close to accurate will decrease.	✓
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.	✓

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.	✓
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. 9. The proportion of service providers who have heard of 'white privilege' will increase.	× ×
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.	✓
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.	✓
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. 13. The proportion of service organisations that train their interpreters on matters relating to sexual assault will increase. 14. The proportion of service organisations that pre-brief their interpreters before meeting a client with a matter relating to sexual assault will increase. 15. The proportion of service organisations that de-brief their interpreters after meeting a client with a matter relating to sexual assault will increase. 16. The proportion of service provider staff from a CALD background employed by a service organisation will increase.	✓ × × × ×

17. The proportion of service provider staff from a CALD background employed in a management position by a service organisation will increase.	✗
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.	✗
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.	✓
20. Service providers will increase their rating of their service organisation's value for a 'multicultural framework' within mission statements, philosophy, practice frameworks, etc.	✓
21. Service providers will increase their rating of their service organisation's implementation of a 'multicultural framework' within daily practice work.	✓
22. The proportion of service organisations that collect data on ethnicity-related variables will increase.	✗
23. Service providers will increase their rating of their service organisations' links with local CALD community organisations and/or members.	✓
24. The proportion of service organisations that contain images of a target client group that is ethnically diverse on its website will increase.	✓