Taking culture seriously: Can we improve the developmental health and well-being of Australian Aboriginal children in out-of-home care?

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Abstract
Background: Children in out-of-home care have well-documented health and developmental needs. Research suggests that Aboriginal children in care have unmet health and intervention needs. In metropolitan Sydney, Kari Aboriginal Resources Inc. (KARI), an Aboriginal organization, provides support to indigenous children in care, including clinical assessment and intervention. We wanted to determine the health and developmental needs of a subset of children in out-of-home care with KARI, who had been in stable care for at least a year. We wanted to identify child, carer, and intervention characteristics that contributed to children doing well. We also wanted to identify enablers and barriers to providing culturally competent intervention.

Methods: We used mixed methods. From the KARI clinic database over the past 3 years, we identified children who had been in stable care with KARI for >12 months. We compared clinical measures and outcomes for these children with results from previous audits. We carried out a group discussion and key informant interviews with therapists and caseworkers to identify risk and resilience factors for each child, as well as enablers and barriers to culturally competent intervention.

Results: The health and developmental profile of the 26 children identified as being in stable care was similar to that of previous audits. Most (88%) were getting speech pathology intervention; one third were getting occupational therapy and psychological intervention; most children and their carers attended cultural programmes. The majority of children (25/26) improved in their developmental health. Caseworkers and therapists identified risk and resilience factors related to child, carer, and home characteristics. They also identified elements of good practice; systemic issues prevented some interventions from being carried out.

Conclusions: There are challenges delivering a trauma-informed, culturally respectful service to Aboriginal children in out-of-home care in an urban setting, but it can be done if attention is paid to culture and the enablers and barriers are identified.

KEYWORDS
child maltreatment, culture, developmental health and well-being, looked-after children, quality improvement

1 BACKGROUND

The number of children living in out-of-home care or alternative care due to maltreatment has increased significantly over the past decade in Australia. According to recent statistics, approximately 43,000 children were identified as being in out-of-home care in Australia, of which more than 18,000 were in New South Wales (NSW), the largest state (Australian Institute of Health and Welfare, 2015). The number of children in care has increased by 20% from June 2010 to June 2014. Children in out-of-home care have been acknowledged to be among the most vulnerable in society, with significant effects on health, development, and well-being. There is now a wealth of national and
international literature documenting the health and developmental needs of these children (Committee on Early Childhood, Adoption, and Dependent Care, 2000; Jee, Tonniges, & Szilagyi, 2008; Nathanson & Tzioumi, 2007; Simms, Dubowitz, & Szilagyi, 2000; Woods, Farineau, & McWey, 2013). Children and young people in care also face a range of barriers to access to health, education, and welfare services and are less likely to access preventive health services such as immunization compared with the general population (Horwitz, Owens, & Simms, 2000; Risley-Curtiss & Stites, 2007; Williams et al., 2001). In Australia, indigenous or Aboriginal children are over-represented in child welfare, with the rate of indigenous children in care almost 10 times the rate for nonindigenous children, with Aboriginal children constituting over one third of all children placed in out-of-home care in 2013–2014 (Australian Institute of Health and Welfare, 2015).

The poor health and developmental status of Aboriginal children in Australia is well documented and a source of national shame (Australian Institute of Health and Welfare, 2011; Freemantle et al., 2006; Priest, Mackean, Davis, Briggs, & Waters, 2009). A history of colonization, dislocation, and poverty compounds the problems for this vulnerable population. Previous reports and studies had concentrated largely on remote and rural populations; more recent studies have identified that urban Aboriginal children have developmental problems starting in early life, although there is a paucity of good quality data on developmental disability (DiGiacomo et al., 2013; McDonald, Comino, Knight, & Webster, 2012). We have previously determined that urban Aboriginal children in out-of-home care had similar health, development, and service needs as those identified in other studies (Raman, Reynolds, & Khan, 2011). However, we found that older school-going children had greater needs overall than younger children and that access to appropriate intervention and preventive health care was a major barrier.

Kari Aboriginal Resources Inc. (KARI) is a community-controlled Aboriginal organization operating out of metropolitan Sydney, in NSW, with a focus on providing culturally competent support services to Aboriginal children in out-of-home care. One of the innovative services provided is the KARI multidisciplinary clinic model to assess and manage vulnerable children in care. Building on findings from the previous audit of children in KARI care (Raman et al., 2011), the service expanded to provide individual assessment and therapy, group therapy through play groups, and school readiness programmes, as well as carer education and training. The KARI clinic model follows the out-of-home care health pathway currently operating in NSW, but with additional features including trauma-informed practice, a focus on cultural connectedness, and community capacity building.

The child and youth population of South Western Sydney is the largest in NSW, and there are many subgroups at increased social risk including newly arriving refugees and migrants and a small but significantly disadvantaged Aboriginal population (Fisher et al., 2013). Although the long-established KARI clinic situated in South Western Sydney provides multidisciplinary—therefore resource-intensive—clinical assessment and intervention services to Aboriginal children in out-of-home care, the health outcomes for children who have been in stable care with KARI clinic support have not been documented. We aimed therefore to examine the health and developmental needs of a subset of children, who had been in stable care with KARI for at least a year. We wanted to identify child, carer, and intervention characteristics that contribute to improved health or development outcomes in children and to identify enablers and barriers to providing culturally competent intervention.

2 METHODS

We used a mixed methods approach for this quality improvement study. We identified children who had been in stable care with KARI for at least one year and who had attended the KARI clinic over the past 3 years. Demographic and clinical outcome data were entered into an Excel spreadsheet; simple descriptive analysis and cross-tabulation was done. We compared clinical measures and outcomes for these children using results from audits undertaken in 2009 (Raman et al., 2011) and 2013 (Ruston, Short, & Ralph, 2014). Standardized assessment tools used were the same across the three audits; they included Preschool Language Scales fifth edition, Diagnostic Evaluation of Articulation and Phonology, Bruininks-Oseretsky Test of Motor Proficiency, Griffiths Mental Development Scales Revised (for those with a global developmental delay), and Child Behaviour Checklist. Children were classified as having improved developmental skills, if their scores had improved on standardized assessments and clinicians felt that they had improved functionally.

We carried out a group discussion supplemented by individual key informant interviews with KARI clinicians (doctors, allied health therapists, and child and family health nurse), caseworkers, and managers. All participants had been informed of the study, and the caseworkers had in-depth knowledge of each child and their family situation. Using a structured topic guide, the discussion covered risk and resilience factors in child, home and family, and intervention and service system for each child. The discussion also identified enablers and barriers to culturally competent intervention. Handwritten notes were transcribed as soon as possible following the discussion and interviews by S.R.
and S.I. and cross-checked. Our theoretical framework was built upon a shared understanding of resilience in indigenous young people (Fleming & Ledogar, 2008; Werner, 2005). We used a “framework approach” to analyse the qualitative data, indexing, charting, and interpretation (Pope, Ziebland, & Mays, 2000; Srivastava & Thomson, 2009).

We then triangulated the findings of the quantitative and qualitative data and examined the KARI clinic model against guidelines for culturally competent care (Bainbridge, McCalman, Clifford, & Tsey, 2015; National Health and Medical Research Council, 2005) and trauma-informed practice (Ko et al., 2008). Specifically, we looked at elements of service delivery that had documented partnership between the health care organization with the Aboriginal community, training of health workers in indigenous-specific culturally competent care, and opportunities for self-reflective practice.

Institutional ethics approval was obtained from the health service prior to proceeding with data collection.

3 | RESULTS

3.1 | Quantitative

We identified 26 children who fitted the criteria for stable care for at least one year. Table 1 lists demographic characteristics of these children, mean age was 5 years, and 14 were male. Most were in foster care, and 10 children were in single-carer households.

Table 2 compares health and developmental issues identified on entry into KARI care, compared to previous audits. Other health problems identified at initial assessment included enuresis, encopresis, asthma, sleep disorders, investigation for seizures, foetal alcohol spectrum disorder, congenital conditions, haematological issues, and risk for hepatitis C. Specialist referrals were to ophthalmology, clinical genetics, otolaryngology, cardiology, and neurology. Therapeutic intervention was provided to the children who were assessed to have concerns in developmental and/or behavioural issues. Most (25/26) children received speech pathology, 16 children received occupational therapy, and six received psychological intervention. The majority of children (20/26) along with their foster families attended cultural programmes.

Follow-up assessments of children in the current cohort revealed that the majority (25/26) had improved in their developmental scores and from clinician assessment; the majority of carers (22/26) were actively engaged with KARI therapeutic services.

3.2 | Qualitative

Risk and protective factors operating under the following categories were identified in the group discussion and the interviews; see Table 3 for a summary.

3.2.1 | Child characteristics: “She is cute as…”

Clinicians and case managers identified a range of risk and protective factors at the individual level for the children in stable care. Coming into stable care early in life was identified as one of the most protective factors; being bright, affectionate, and socially engaging was another. Having positive connections to family was seen as a strength, but inconsistent contact with birth family was felt to be worse than having no contact.

3.2.2 | Home and family characteristics: “They don’t bend the rules just because they are family”

Being in kinship care placement and placed with siblings could be protective for some children, whereas for others, family placements actually exacerbated behavioural problems. Caseworkers and managers stressed the contextual nature of family placements. Kinship carers in particular, who played by the rules and did not try to bend them, were seen to be positive. Carers, who were strongly culturally connected,
were seen as being a positive role model for children. Respondents from the group discussion acknowledged that high standards for assessing the appropriateness of carers were sometimes not maintained. Family size was a major logistic issue; many Aboriginal children belong to large sibships, and maintaining them in a placement with biological siblings was difficult.

### 3.2.3 Therapeutic intervention: “Some carers just get it”

The major strength was that foster carers who engaged with intervention acknowledged the role of trauma. Conversely, there were some carers who ("never mind how many courses they attend") just were not able to engage therapeutically. The importance of culturally embedded therapy services was seen as very positive.

### 3.2.4 Service and organizational characteristics: "Everyone is aunty and uncle"

The major strength of KARI as an organization was that children and families accessing KARI felt at home; everyone was part of an extended family. The major difficulty in the urban setting was appropriately placing children culturally, working out where they belonged.

### 3.3 Assessing strengths of service delivery

The KARI clinic model performed well against criteria for culturally competent care and trauma-informed practice. Specifically, there is a clear Memorandum of Understanding outlining the role of partner organizations (health and welfare); all clinicians have completed training in Aboriginal cultural understanding, and the clinical team engages in quarterly peer review and reflection. Caseworkers are present in all assessments to provide both cultural and social support to the carers and children. Recommendations and responsibilities are clearly documented at the end of each assessment with a clear review plan added. All therapists have been trained in trauma-informed practice, have regular supervision sessions, and attend regular updates.

### 4 DISCUSSION

Several national and international studies, including our own previous audit of children in KARI care, have documented the significant health and developmental concerns that children in out-of-home care present with (Hansen, Mawjee, Barton, Metcalf, & Joye, 2004; Nathanson & Tzioumi, 2007; Raman et al., 2011; Simms et al., 2000). This in-depth study of Aboriginal children in stable care is the first to unpack the different elements of the service and support system needed to improve children’s developmental well-being in urban Australia. We found that despite having a similar burden of health and developmental concerns on entry into care, most children improved in stable care, this finding being similar to what Horwitz, Balezstracci, and Simms (2001) reported from their Connecticut sample. The elements that helped support children’s positive trajectory in our study were multidisciplinary and cross-agency services that worked collaboratively in a trauma-informed manner, strong cultural engagement by children and their families, and the lead agency becoming the surrogate extended family to create a culturally understood sense of “belonging.”

Children in this cohort were assessed on entry into care as having significant health and developmental concerns (see Table 2); arguably, they had greater developmental vulnerability than previous cohorts, in that the majority of them were identified with speech and developmental concerns. We know that urban Aboriginal children experience stressful life events (Askew, Schluter, Spurling, Bond, & Brown, 2013); children in this cohort were certainly exposed to very high levels of stress. Demographic and home characteristics of this cohort (see Table 1) also suggest risk factors. The Horwitz et al. (2001) study found that children in foster care who were older and female were more likely to improve; those with greater needs were

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**TABLE 3** Risk and protective factors identified at child, family, and organizational levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Protective factors</th>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>Good health, Good looking, socially engaging</td>
<td>High medical needs, Developmental delay</td>
</tr>
<tr>
<td></td>
<td>Healthy attachment with carers</td>
<td>Inconsistent contact with birth family</td>
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<tr>
<td></td>
<td>Young age at entry</td>
<td>Being placed with a large sibship</td>
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<tr>
<td></td>
<td>Eager to connect to culture</td>
<td>Siblings with disruptive behaviour</td>
</tr>
<tr>
<td>Carers/home</td>
<td>Carer understands needs of child</td>
<td>Carers who do not deal with trauma</td>
</tr>
<tr>
<td></td>
<td>Carers working hard to keep siblings together or maintain contact</td>
<td>Kinship carers with family pathology, bearing burden of guilt</td>
</tr>
<tr>
<td></td>
<td>Family with structure and routines</td>
<td>Carers uncomfortable with parenting</td>
</tr>
<tr>
<td></td>
<td>Two-parent situation</td>
<td>Large family size</td>
</tr>
<tr>
<td></td>
<td>Kinship carers that “do not bend rules”</td>
<td>Overbearing, overprotective</td>
</tr>
<tr>
<td></td>
<td>Family well supported</td>
<td>Carers who do not accept intervention</td>
</tr>
<tr>
<td></td>
<td>Family culturally connected</td>
<td></td>
</tr>
<tr>
<td>Intervention</td>
<td>Reparative parenting course</td>
<td>Carers who do not respond to therapy</td>
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<tr>
<td></td>
<td>Good early education support, especially Aboriginal specific</td>
<td>Carers who struggle to carry through with therapeutic advice at home</td>
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<tr>
<td></td>
<td>Culturally embedded therapy</td>
<td></td>
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<tr>
<td>Service/organization</td>
<td>KARI seen as extended family</td>
<td>Connecting with kinship carers</td>
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<td></td>
<td>Rapport between workers and carers</td>
<td>Hazy lines of responsibility</td>
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<tr>
<td></td>
<td>KARI seen as culturally “safe” place</td>
<td>Difficulty with placing children, knowing where they belonged</td>
</tr>
<tr>
<td></td>
<td>Working relationship with mainstream health and welfare</td>
<td>Carers transitioning from another non-Aboriginal agency</td>
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less likely to improve. The only child who did not improve in our study had a severe chronic health condition. Clinicians and caseworkers worked together to balance risk and protective factors that they identified (Table 3). The therapeutic and support team theorized that improvements were seen in children whose carers had an understanding of developmental trauma, were responsive to the child's needs, and participated and invested in the therapeutic experience. Clearly from a trauma-informed perspective (Conradi et al., 2011), a child who feels safe and stable in their placement is more responsive to cognitive- and developmental-based therapies and more likely to learn. We postulate that there was a trauma-informed therapeutic alliance between carers, caseworkers, and clinicians, which encouraged holistic management. As Conradi et al. (2011) suggest, building on from relationship-based case planning and case management, cross-system partnerships and system collaboration were crucial elements of trauma-informed practice for foster care placement stability.

Our main objective in this study was to achieve a more nuanced understanding of Aboriginal children's well-being, not to merely document their health and developmental status. Caseworkers and the clinical team knew that children enter care developmentally vulnerable. Resilience factors identified at child level reflected the literature (Cabaj, McDonald, & Tough, 2014; Slack et al., 2011; Zolkoski & Bullock, 2012), in that children who were socially competent, young at entry, had good health, and good attachment to primary caregivers did well. Research suggests that child level correlates account for the highest proportion of variance in outcomes (Bell, Romano, & Flynn, 2013). At the home and family level, having a two-carer family (40% of our sample were in single-carer families), carers who were well supported and worked hard to understand their children were seen to be better. Bell et al. (2013) found that the family level contributed to a considerable proportion of the explained variance in child outcomes in their Ontario out-of-home care study, particularly for younger children. From the intervention and service perspective, connecting children to good quality early childhood education and having good interagency relations and relationship with family, all delivered within a culturally congruent framework, was key. Importantly, our study exemplifies what Ungar (2013) calls for specifically to build resilience in maltreated children, based on best evidence. He suggests that social supports and formal services be made more accessible; programmes need to be flexible; and interventions need to be tailored to children who have experienced maltreatment rather than generic interventions.

Risk factors for poor development at child, family, and service system levels were identified; these were mostly unavoidable. The benefit of getting input from caseworkers, managers, and clinicians was that we could contextualize and situate each child uniquely; it was clear that "one size did not fit all" children. For example, the role of the family (i.e., presence of siblings and contact with birth parents) could be strongly positive in one context and potentially harmful in another. Similarly, kinship care could be positive for some children; for others, especially those families with psychopathology, kinship care was not necessarily positive. Kinship care has been linked with mixed outcomes (Sakai, Lin, & Flores, 2011), although the Campbell comprehensive review found that on the whole children in kinship care had less behavioural problems and had more placement stability (Winokur, Holtan, & Valentine, 2009). From their Danish study, Andersen and Fallesen (2015) found that only when the kin caregiver is particularly empathic and dutiful does this type of care prove more stable than other types of out-of-home care. Thus, although the facilitators to providing quality care to children in KARI care were about promoting protective factors, the barriers were largely beyond the control of individual clinicians, welfare workers, or even the organization. Examples include large family size or large sibships, the quality and past experiences of kinship carers, and the difficulty of finding appropriate family and cultural placement.

At every level of inquiry, the child, the family, the intervention, and the service system, cultural factors were positively identified. As an organization, KARI was seen as "culturally safe"; their staff, in particular the clinicians and therapists, engaged in culturally embedded practice. Foster families who were strongly culturally connected did better, and children who showed an eagerness to connect to culture fared better, according to our key informants. Priest et al. (2012), in their exploration of urban Aboriginal child health and well-being, identified critical elements that make up strong culture, strong child, and strong environment. As identified by their urban informants, elements of an Aboriginal perspective on culture were "identity, being proud and strong, kinship and family connection, respect for Elders, connection to Country, connection to family, connection to community, ceremony, art and artefacts" (Priest et al., 2012, p. 189). KARI's clinical team—with the caseworkers creating a therapeutic alliance—attempts to address all of these critical elements to connect children to their culture, even while workers acknowledge the difficulties of placing some of the children in the appropriate cultural context. We know that cultural competence is more than cultural awareness—it is the set of behaviours, attitudes, and policies that come together to enable a system, agency, or professionals to work effectively in cross-cultural situations (Cross et al., 1989). Assessing the KARI clinic and therapeutic service against cultural competency criteria (Bainbridge et al., 2015), we found that it performed well. Specifically, this multidisciplinary clinical service was set up within an indigenous organization, after extensive consultation with local Aboriginal communities, with service delivery tailored to the needs and preferences of the local community and with clinicians extensively trained in cultural perspectives.

The major limitation of this study was the small number of children identified to be in "stable care." Despite having a culturally congruent agency strongly connected to the local community working as advocates for the children, only a small number of children remain in stable placements. Our bar for stable care placement was anything over 12 months. Sadly, this is the real life, lived experience of most children in care; they are buffeted about by family, service, and system factors, well outside their control. Our objective however was not to have a large sample size in order to measure the health and service needs of children in out-of-home care; as mentioned before, this has already been well established. We wanted to get an in-depth understanding of the elements that contribute to children's positive trajectory; we feel we achieved that. We did not interview carers and were only able to gauge carer perspectives through caseworkers. We might have gotten richer data for analysis from carer's views and perhaps different perspectives on risk and resilience.
5 | CONCLUSIONS

We echo the sentiments of the authors of the recent Lancet commission on “Culture and Health” that the “systematic neglect of culture in health is the single biggest barrier to advancement of the highest attainable standard of health” (Napier et al., 2014, p. 1640). In our assessment of Aboriginal children in out-of-home care in an urban setting, we found that when children are in stable care, most improve. Cultural engagement appeared to be a major factor in children’s health, well-being, and personal development. We identified risk and resilience factors related to child, carer, therapy, and service levels; some were not amenable to change. However, the therapeutic alliance of the family, caseworkers, and clinicians delivering trauma-informed services within a culturally embedded framework meant that protective factors could be boosted and risks ameliorated. Milroy (2013) suggests that a culturally secure, trauma-informed model of care moves beyond security, towards sanctuary. We have shown that there are challenges to delivering a trauma-informed, culturally embedded programme in a large metropolitan region, but it can be done if careful attention is paid to risk and resilience factors, contextualized and individualized for each child.

REFERENCES


