



# Children with FASD-related Disabilities Receiving Services from Child Welfare Agencies in Manitoba<sup>1</sup>

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Fetal Alcohol Spectrum Disorder (FASD) is a serious social and health problem for the child welfare, health and education systems in North America. The term FASD describes a wide range of disorders caused by women drinking alcohol during pregnancy. These include Fetal Alcohol Syndrome (FAS), Partial FAS, Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorder (ARND) and Alcohol-Related Birth Defects (ARBD). Characteristics of FASD include growth deficiency, evidence of central nervous system neurodevelopmental abnormalities that result in intellectual and developmental delay, and facial dysmorphism (changes in the shape of the face). Children with alcohol-related disorders often have cognitive and behavioural difficulties that cause them to have problems in school and society.<sup>2</sup>

Although U.S. studies suggest that FASD may be more prevalent in disadvantaged or impoverished populations,<sup>3</sup> little is known about the prevalence of FAS-related disorders in Canadian child welfare systems, or how the unique needs of children with this disability are being met when they are in care.

Fuchs et al.<sup>4</sup> investigated the characteristics of 1,869 children with disabilities who were receiving child welfare services in Manitoba on September 1, 2004. Since some of these children were described as having FASD, this study provided a unique opportunity to report the characteristics of children with FASD within the population of children with disabilities in the provincial child welfare system.

A definition for “children with disabilities” was developed in accordance with the World

Health Organization’s perspective on disability, which highlights both personal and environmental factors. In this study, children with disabilities are those whose ability to participate in age-appropriate activities of daily living was compromised by limitations in one or more areas of functioning. These children, according to the definition developed, also require supports to meet their unique needs. Included were children with congenital conditions, complex medical needs, chronic psychological or mental health concerns, and/or learning difficulties, as well as those with FASD. Six main types of disabilities were examined: intellectual, mental health, medical, physical, sensory, and learning. FASD is usually considered to be an intellectual disability, but is also described as developmental delay in children, or as cognitive impairment.

The most frequently reported types of disabilities identified in the study were intellectual and mental health disabilities. Thirty-three percent of Manitoba’s children in care had a disability and, of this group, 75% had an intellectual disability, and 56% were diagnosed with, or suspected to have, a mental health related disability. Multiple disabilities were common, with the most frequently co-occurring types being intellectual and mental health disabilities.

## **What is the occurrence of FASD-related disabilities in Manitoba’s child welfare system?**

FASD was diagnosed in approximately 34% of children in care with disabilities, or 11% of all children in care in Manitoba. Of the 1,403 children in care with an intellectual disability, 46% had diagnosed FASD.

## What is the profile of children with FASD-related disabilities in Manitoba's child welfare system?

The proportion of boys to girls among those diagnosed with FASD (61% boys and 39% girls) was very close to the 60:40 male:female ratio found in the general disability population of children in care in Manitoba. It is also consistent with the overrepresentation of males within the intellectual disability population.

The average age of the children with FASD was 10.08 years. They were, as a group, slightly younger than the general disability population of children in care, who had an average age of 10.75 years.

The gender distribution of the children in care with FASD and that of the children in care with non-FASD disabilities was similar. However, the age distributions of the two groups were quite different, as shown in Figure 1. The number of children in care with FASD, in both genders, reaches a peak at an earlier age than those with non-FASD disabilities.

The overwhelming majority of children with FASD (89%) were in the permanent care of a child welfare agency. In comparison, 61% of the general population of children with disabilities in care were in permanent care. The use of Voluntary Parental Agreements also differed sharply between these groups: 3% of the FASD group coming into care had Voluntary Parental Agreements, compared to 18% of the general group of children with disabilities in care. A high percentage of the children with FASD (86.9%) came into care as permanent wards.

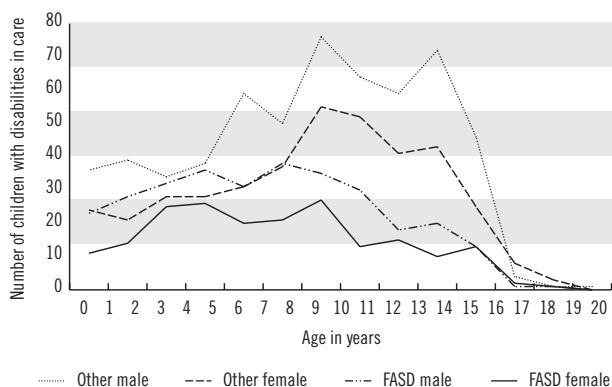
The reasons for children with FASD coming into care were predominately related to a difficult parental situation (62% of children came into care because of the conduct of the parents or the incapacity of the parents to fulfill their parental role). Only 6% of the children with FASD came into care because of reasons that were related to the child's condition or the child's conduct. By comparison, in the non-FASD population, 54% of children were in care for reasons related to parental care and 18% were in care for reasons related to child's conduct or conditions.

## Multiple disabilities, especially ADHD, common in FASD-affected children in care

Many children with FASD had co-occurring disabilities. Mental health disabilities occurred in 46%, while 20% had a medical condition, 17% had physical impairments, 3% had a learning disability, and 2% had a sensory disability. In total, 88% of children with FASD had co-occurring disabilities.

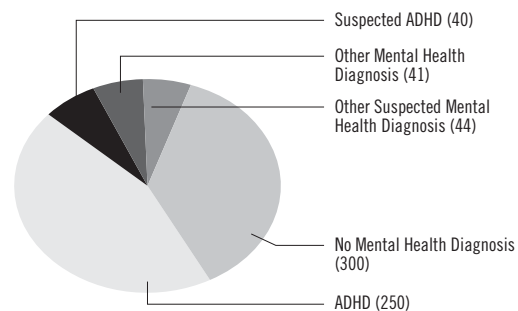
As previously noted, intellectual disabilities often coincided with mental health disabilities. The most commonly occurring combination of cognitive and mental health disabilities was FASD and Attention Deficit Hyperactivity Disorder (ADHD). As shown in Figure 2, of the 640 children with diagnosed FASD, 46% had no mental health disorder, 39% had a diagnosis of ADHD, and 6% were suspected as having ADHD. An additional 6% of children had a different mental health diagnosis, and 7% were suspected to have a different mental health disorder.<sup>5</sup>

**Figure 1: A comparison of the age by gender distribution profiles of children diagnosed with FASD and children in care with non-FASD disabilities**



Source: Fuchs, D., Burnside, L., Marchenski, S. & Mudry, A. (2005).

**Figure 2: Number of children in care with FASD and mental health disorders**



Source: Fuchs, D., Burnside, L., Marchenski, S. & Mudry, A. (2005).

## Aboriginal children with FASD overrepresented in care

This study found that 81% of the children with FASD in care in Manitoba were First Nations (Treaty Indian). The cultural origins of the remainder of the children in care with FASD were Métis (9%), non-Aboriginal (5%), non-status Aboriginal (4%), or not known (1%).

The general overrepresentation of Aboriginal children in the Canadian child welfare system has been well documented, and is thought to be related to the disconnections from language, culture, and family that have been experienced by Aboriginal people as a result of colonization, the interventions of residential schools, and the mainstream child welfare system.<sup>6</sup> Coping with these disconnections has been challenging, to say the least, and many Aboriginal people and communities struggle with the poverty that is so often related to other social problems such as substance misuse, family violence, and child neglect.

The rate of disabilities for Aboriginal people has been reported to be twice as high as that of the non-Aboriginal population in Canada, and the rate of FASD in some Aboriginal communities may be significantly higher as well.<sup>7</sup> It is possible that First Nations families who live on reserves may be disadvantaged in receiving services for their children with disabilities, since reserves fall under federal jurisdiction and social services are typically provided by provinces and territories. For these reasons, there may be an increased risk of Aboriginal children with disabilities coming into care.

### What are the policy implications?

In summary, Fetal Alcohol Spectrum Disorder is an area of significant concern in Manitoba's child welfare system, with 11% of all children in care having FASD. More than one third of the children in care with disabilities have been diagnosed with FASD. This is an entirely preventable condition, as it results from women drinking alcohol while pregnant. Its prevalence in the population of Aboriginal children with disabilities, especially First Nations children, indicates a strong need for establishing and expanding programs that emphasize the importance of not drinking any alcohol if a pregnancy is being planned, or, especially, during pregnancy. There is a strong need for such programs to be accessible and culturally appropriate.

- 1 This information sheet is based on the report: Fuchs, D., Burnside, L., Marchenski, S. & Mudry, A. (2005). *Children with disabilities receiving services from child welfare agencies in Manitoba*. Toronto, ON: Centre of Excellence for Child Welfare.
- 2 Koren, G. & Nulman, I. (2002). *The motherisk guide to diagnosing Fetal Alcohol Spectrum Disorder*. Toronto, ON: The Hospital for Sick Children.
- 3 Jacobson, S.W., Jacobson, J.L., Sokol, R.J., Chioldo, L.M. & Corobana, R. (2004). Maternal age, alcohol abuse history, and quality of parenting as moderators of the effects of prenatal alcohol exposure on 7.5 year intellectual function. *Alcoholism: Clinical and Experimental Research*, 28(11), 1732–1745.
- 4 Fuchs, D., Burnside, L., Marchenski, S. & Mudry, A. (2005). *Children with disabilities receiving services from child welfare agencies in Manitoba*. Toronto, ON: Centre of Excellence for Child Welfare.
- 5 Percentages add up to more than 100 since some children had, or were suspected to have, co-occurring disabilities, and were therefore counted twice.
- 6 Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to overrepresentation of aboriginal children in Canada's child welfare system. *Social Services Review*, 78(4), 577–601.
- 7 Standing Committee on Human Resources Development and the Status of Persons with Disabilities. (2003). *Building a brighter future for urban Aboriginal children*. Ottawa, ON: House of Commons. Retrieved October 23, 2005 from <http://www.parl.gc.ca/InfoComDoc/37/2/HUMA/Studies/Reports/humarp04/05-hon-e.htm>

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