

Children with FASD

Involved with the Manitoba Child Welfare System

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Executive Summary

Meeting the needs of children with disabilities creates significant challenges for child welfare agencies. In Manitoba, it has been shown that one third of children in care fall within a broad definition of disability and 17% of children in care are affected by diagnosed or suspected Fetal Alcohol Spectrum Disorder (FASD) (Fuchs, Burnside, Marchenski, & Mudry, 2005). FASD encompasses a range of conditions that are caused by maternal alcohol consumption during pregnancy. Indicators include physical characteristics and inhibited growth, neurodevelopmental problems, and behavioral and cognitive difficulties that are inconsistent with developmental level. As a result, children with a diagnosis of FASD present agencies with an array of complex and variable needs. Both the significant proportion of children with FASD in care and the nature of their needs make it important to understand the relationship of this population to child welfare agencies. The purpose of this research was to gather information on the legal status and placement histories of children with FASD in care and compare those histories to the histories of children with other disabilities and children with no disabilities.

This research was exploratory and descriptive in design. It examined information gathered through special queries submitted to the Child and Family Services Information System (CFSIS). Random samples of children with FASD, children with a disability that was not FASD and children with no disability were established and grouped according to their legal status on December 1, 2005. Only children who were permanent wards or who were under a Voluntary Placement Agreement (VPA) on that date were included. Six disability by legal status groups were described and their means compared.

The data clearly showed that children with FASD had come into care at a mean age that was at least a year younger than any other group of children. They became permanent wards more quickly. Their mean age at becoming permanent wards was two years younger than children with no disabilities and three years younger than children with other disabilities. Placements followed a similar pattern. Legal status and placement histories confirmed that children with FASD spend a greater proportion of their lives in care of an agency than other children. Although VPAs were frequently used for other groups of children, they were seldom used for children with FASD.

The number of children with FASD and their demonstrated dependence on child welfare agencies emphasizes the importance of strategically addressing their needs. Further, information from the Addictions Foundation of Manitoba that 1200 women of child-bearing age were screened for addictions programs in the 2005-2006 year gives clear indication that there is an ongoing risk of increasing demand for services for children with FASD. The implications for agencies include increasing demands on the expertise of workers, caregivers and service providers and the program supports currently available; and increasing need for comprehensive service plans to support the transition of children with FASD into adulthood. Manitoba social policy must address the need for: capacity building, greater accessibility to diagnostic services and culturally relevant prenatal alcohol use prevention programs. Further research is needed to identify the unique developmental needs of children with FASD who are in care.

1. Introduction

Meeting the needs of children with disabilities creates significant challenges for child welfare agencies in Manitoba. Because of additional risk factors associated with disability, these already vulnerable children have a greater potential than other children for requiring the support or protection of a child welfare agency. In Manitoba, it has been shown that one third of children in care fall within a broad definition of disability (Fuchs, Burnside, Marchenski, & Mudry, 2005). Significantly, 17% of children in care were affected by a particular disability: diagnosed or suspected Fetal Alcohol Spectrum Disorder (FASD) (Fuchs et al.). Children with a diagnosis of FASD present agencies with an array of complex and variable needs that are a result of their compromised neurological biology, their family system and the psychosocial environmental implications of both those factors. Effectively meeting the needs of these children begins with an understanding of the nature of their relationship with child welfare agencies.

This study is the second phase of the original research by Fuchs et al. (2005) identifying children in care with disabilities. It looks more closely at children with FASD and their history as they enter the child welfare system and come to rely on the parenthood of the state. It includes a review of FASD literature to provide a contextual background for the research. Research questions and methodology are outlined followed by a description of findings related to the legal status and placement history of children with FASD. This history is compared to children in care with other disabilities and with no disabilities. Implications for families, children and agencies are discussed, and recommendations and conclusions are shared.

This study was conducted by the Faculty of Social Work, University of Manitoba and the Child Protection Branch of the Manitoba Department of Family Services and Housing under the auspices of the Prairie Child Welfare Consortium. Funding was provided by Health Canada with the support of the Centre of Excellence for Child Welfare.

2. The Fetal Alcohol Spectrum Disorder Context

Fetal Alcohol Spectrum Disorder (FASD) encompasses a range of conditions that are caused by maternal alcohol consumption during pregnancy, which has lifelong implications for the affected person, the family, and society. Considered to be a completely preventable condition (Zevenbergen & Ferraro, 2001), the adverse effects of maternal consumption of alcohol have been noted throughout history but were first described as a pattern of disabling effects under the term 'Fetal Alcohol Syndrome' in the early 1970s (Overhoser, 1990). Although there are no national statistics on the rates of FASD in Canada, the incidence of FASD in Manitoba has been estimated at 7.2 per 1,000 live births (Williams, Obaido, & McGee, 1999) to as high as 101 per 1,000 live births (Square, 1997). American incidence rates of 9.1 per 1,000 live births have been reported (Sampson, Streissguth, Bookstein, Little, Clarren, Dehaene, Hanson, & Graham, 1997), but it should be noted that diagnosis of FASD may be delayed or missed entirely, affecting the accuracy of such statistics (Chudley, Conry, Cook, Looock, Rosales, & LeBlanc, 2005).

Because of the range of effects as a result of prenatal alcohol exposure, diagnosis of FASD can be complex (Chudley et al., 2005; Hay, 1999; Wattendorf & Muenke, 2005; Zevenbergen & Ferraro, 2001). Indicators include physical characteristics such as distinct facial features and inhibited growth, neurodevelopmental problems such as impaired fine motor skills, and behavioral and cognitive difficulties that are inconsistent with developmental level, such as learning difficulties, poor impulse control, or problems in memory, attention or judgement, often in conjunction with a confirmation of maternal alcohol use. Diagnosis is often most easily made between the ages of 4 and 14 (Lupton, Burd, & Harwood, 2004), but early diagnosis and intervention is strongly recommended to ameliorate the negative effects of FASD, through the provision of cognitive stimulation, speech and language therapy, educational supports, and other interventions (Sonmader, 2000).

The effects of FASD are manifested throughout the individual's lifespan (Streissguth, Barr, Bookstein, Sampson, & Olson, 1999; Zevenbergen & Ferraro, 2001). Infants who have been exposed to alcohol may show decreased arousal, sleeping problems, irritability, and feeding difficulties. Difficulties with speech, language development, and attention span are often identified in preschool years. Poor attention, impulsivity, and hyperactivity often persist throughout childhood and adolescence, leading to behavioural issues that arise in school settings, which only exacerbate the academic challenges that stem from learning disabilities and other cognitive impairments related to FASD. These academic and social difficulties often contribute to low self esteem, conduct problems and delinquent behaviors in adolescence. As adults, individuals with FASD are vulnerable to mental health problems, conflict with the law, alcohol and drug issues, and problems with employment (Streissguth, Barr, Koga, & Bookstein, 1996).

In addition to the personal implications for a person affected with FASD, the societal impact of FASD is profound (Lupton, Burd, & Harwood, 2004). Individuals with FASD often require high levels of medical care, residential services, special education supports, adult vocational services, and other social services throughout their lifetimes. The increased risk for deleterious outcomes in adulthood as a result of FASD (i.e. unemployment, homelessness, poverty, criminal activity, incarceration, and mental health problems) all have a social cost in terms of the support services, organizational structures, and associated financial costs that must be provided to respond to the needs of this vulnerable population (Lupton, Burd, & Harwood, 2004).

Given the difficulties facing individuals affected by FASD, it is not surprising that families who are caring for a child with this condition experience significant challenges. Little research exists with regard to the needs of families parenting a child with FASD (Wilton & Plane, 2006), although there is a growing body of literature examining the experiences of substitute caregivers (foster parents and adoptive parents) who increasingly are responsible for the care of children with FASD through the child welfare system (Barth, 2001; Brown, Bednar, & Wiebe, 2004; Brown, Sigvaldason, & Bednar, 2006; Gammon, 2002; Jones, 2004; McCarty, Waterman, Burge, & Edelstein, 1999; Warner, 1999). With parental substance abuse and its relationship to child abuse and neglect being one of the major reasons for the involvement of the child welfare system with families (Barth, 2001; Bartholet, 1999), it is not surprising that many children with FASD come into out-of-home care, often on a permanent basis (Jones, 1999). Increasingly, child and family services systems across Canada are recognizing the need to assist youth with FASD as they transition into adulthood, given the high risks they face as a result of their disabilities and the inability of adult support services to meet their particular needs and challenges (Child and Youth Officer for British Columbia, 2006; Reid & Dudding, 2006; Schibler & McEwan-Morris, 2006).

In their study of children in care with disabilities in child and family services agencies in Manitoba, Fuchs et al. (2005) found that 11.3% of the total number of children in care on September 1, 2004 were diagnosed with FASD. Further, a considerable number of children were suspected of having the condition, as they were in the process of being tested for FASD or were receiving services consistent with a diagnosis. Given the challenges and gaps in identifying and diagnosing FASD, it is reasonable to include children with suspected FASD in the Manitoba context, which would then infer that 17% of all children in care were affected by the condition. Overwhelming majorities (89%) of children with FASD were in permanent care of an agency and had limited contact with biological parents. Consequently, child welfare agencies in Manitoba have a significant care responsibility for these children until their age of majority, requiring agency staff and caregivers to be cognizant of the special needs of this population during childhood and adolescence and through the transition to adulthood.

3. Research Objectives

In recognition of the high care needs and the over-representation of children with disabilities in the Manitoba child welfare system as identified in the previous research of Fuchs et al. (2005), this study was aimed at developing a fuller understanding of the pathways into care for children with disabilities. Because of the significant proportion of Manitoba children in care identified with a diagnosis of FASD, understanding the relationship between this population and child welfare agencies is particularly important. Information on the evolution of child welfare interventions from an initial admission into care resulting in a first legal status, to subsequent legal statuses including the possibility of a permanent order of guardianship, has implications critical to prevention, intervention, and permanency planning for children with disabilities. It is also important to understand the role of Voluntary Placement Agreements (VPAs) as a tool for intervening with children with disabilities. Analysis of placements and a comparison of the pattern of placements of children with and without disabilities would provide valuable information that had not previously been examined in depth. Information on the placement and legal status histories of children and comparative analysis of children with and without disabilities is useful at all levels of the service delivery system, from practitioners to policy-makers, for enhancing capacity to meet the needs of children with disabilities.

Using the population of children identified in the Child and Family Service Information System (CFSIS) as having a disability, this study was designed to examine the legal status and placement history of those children and compare that history to the general child in care (CIC) population. More specifically, this project aimed to:

- Analyze the histories of children in care with disability, especially FASD, to determine their length of time in care, their age at coming into care, their placement history and their legal status history.
- Compare the legal status history of children who are permanent wards and those in care under Voluntary Placement Agreements.
- Compare the history of involvement with an agency of children with and without disabilities.

With these objectives in mind, it is important to also consider the legislative context within which decisions around children's placements in agency care are made. The *Child and Family Services Act* (1985) in Manitoba details requirements regarding the duration of time that children can remain in temporary care before an agency is required to make a more permanent plan for the child, particularly focusing on the needs of younger children to have timely opportunities for stable, consistent care-giving relationships within which attachments can form. As such, children who are admitted to care under the age of five are permitted to be in temporary care for a shorter period of time, with fewer allowable

renewals for temporary care, before a permanent plan must be made, requiring either that children be safely reunified with parents or become permanent wards of the state.

Voluntary placements, although contractual arrangements negotiated between parents and a child welfare agency, are also subject to time constraints when pertaining to the placement of younger children, to ensure that their rights to permanence are not compromised. Exceptions are allowed for children whose medical care needs or significant mental health conditions of a permanent nature warrant placement in a specialized setting to better meet their care demands. Similarly, exceptions are considered for children over the age of 14, presumably of an age where attachment issues are less predominant compared to younger children, who can be placed in care under a series of annual VPAs until age of majority at age eighteen.

These legislative requirements can have a significant impact on the length and type of involvement children have with the child and family services system, especially when young children are in need of protective services related to parental functioning (as was found to be the case for the majority of Manitoba children with disabilities in care in the 2005 study by Fuchs et al., 2005) or require supportive services as a result of the child's care needs. Therefore, it is important to view the findings of this study within this legislative context, as children who are admitted to care at preschool ages may be predisposed to different care trajectories than school age children and adolescents.

4. Methodology

This project sought to examine the legal status and placement histories of children with disabilities and compare this to the histories of children without a recorded disability in the care of mandated child protection agencies in Manitoba as of December 1, 2005.

The initial task was to confirm that the disability population from the first research project was accurately portrayed in the Child and Family Services (CFS) administrative database. Child and Family Services Applications (CFSA) is the data system used by child welfare agencies within Manitoba. It has two main components: Child and Family Services Information Systems (CFSIS) and the Intake Module. For the purpose of this study, CFSIS was used, as this component of the system tracks cases beyond the initial intake process. Special queries done through CFSIS established that the disability demographics of the children sampled for the second study were comparable to the demographics reported for the sample in the first study (Fuchs et al., 2005). This confirmed that the information from the first study of children with disabilities was accurately entered into CFSIS as of September 1, 2004.

Using CFSIS, two groups of children in the care of mandated child protection agencies in Manitoba were created: 1) children with a disability and 2) children without a disability as recorded on their CFSIS file. The children included in these groups had to have had an open Child in Care (CIC) or Child in Care Supervision (CIC - SUP) file on CFSIS as of December 1, 2005. Also, to be included in this study, children had to have been born and had their first legal status on or before September 1, 2004. A special query from CFSIS provided demographic information for both disability and no disability groups.

To create comparable groups for further examination, the children were further divided into groups based on legal status and disability. Children were sorted by disability into three exclusive categories: children with either diagnosed or suspected FASD (FASD); children with a disability other than diagnosed or suspected FASD (CWD No FASD); and children without a disability (No disability).

Legal status provided an additional dimension to the groupings. Groups of children were further divided according to their legal status as either a permanent ward (PW) or a child under a Voluntary Placement Agreement (VPA) as of December 1, 2005. The PW group also included children who were PWs but were currently in transition planning. Children with other legal statuses such as those under apprehension or temporary wards as of December 1, 2005 were not examined as they may not have had sufficiently detailed legal and placement histories.

This method created six comparison groups:

1. FASD PW (permanent wards with FASD)
2. FASD VPA (voluntarily placed children with FASD)

3. CWD PW No FASD (permanent wards with a disability that was not FASD)
4. CWD VPA No FASD (voluntarily placed children with a disability that was not FASD)
5. No Disability PW (permanent wards with no disability)
6. No Disability VPA (voluntarily placed children with no disability)

Random Sample

From the six mutually exclusive comparison groups that were created, six random sample groups were drawn. To make the amount of data manageable within the resources available for this project, one quarter of each group (25%) was chosen randomly from lists generated by the CFSIS system to create the sample. The sample groups are shown in Table 4.1.

Table 4.1
Random Sample Group Sizes

Disability	Random Sample (25% of Total)	
	PW n	VPA n
FASD	122	18 or 20*
CWD No FASD	94	38
No Disability	329	165

*Due to the small size of the FASD VPA group, all children who had adequate information on their CFSIS files were included. Sample size differs for analysis of legal status (20) and placement (18) due to the availability of file information.

Members of the research team reviewed the legal status and placement history information on CFSIS for those children identified as part of the random sample. Any children who had missing or conflicting legal status or placement history information were excluded from the random sample. Children excluded from the random sample were replaced with additional randomly chosen children to keep the 25% proportion of the comparison groups. As legal status and placement histories were examined separately and the amount of legal status and placement history information was not necessarily consistent within one file, children may have been included in the random sample for one set of analyses but replaced in the other.

Analysis

The special queries that generated our total population of children who had an open CIC or CIC – SUP CFSIS case in Manitoba as of December 1, 2005 were produced by CFSIS in Excel. The preliminary query was validated by randomly checking information for 20 children in care against their actual CFSIS files. It was determined that the special query had created an accurate total population. Initial findings were used to create the comparison groups used for further analysis. Responses to the special CFSIS queries were received in Excel format and the analysis was conducted using that tool.

Limitations

When comparing the random sample groups, it is important to consider the impact of the wide variation in group size. The strategy of using a randomly chosen sample of 25% of the population for 5 of the 6 groups maintained the comparative size difference between the disability and legal status groups of children in care. This difference must constrain any conclusions drawn from comparing groups that range in size from 18 or 20 children to 329 children.

5. Findings

This section presents the major findings of the study: the legal status and placement histories of both children with disabilities and children without disabilities who are permanent wards or placed voluntarily.

Gender and Age

The children selected as part of the random sample ranged in age from 1.26 to 18.68 years. Children who were permanent wards but had no disability (No Disability PW) had the youngest mean age (\underline{M} = 10.26 years), with the permanent wards with FASD (PW FASD) group being only slightly older (\underline{M} = 10.66 years). The oldest group was found to be children with disabilities who were in care under VPAs (\underline{M} = 14.16 years). A comparison of the ages of children is provided in Table 5.1.

Table 5.1
A Comparison of Mean Age in Years as of December 1, 2005 by Disability and Legal Status Group

Group	N	Mean Age as of Dec 1/05	SD	Median Age as of Dec 1/05	Min.	Max.
CWD VPA No FASD	94	14.16	3.65	15.66	3.65	17.82
FASD VPA	20	13.80	3.11	14.73	7.13	17.29
CWD PW No FASD	38	12.28	4.19	13.18	1.85	18.49
No Disability VPA	165	11.56	5.16	13.22	1.45	17.96
FASD PW	122	10.66	4.26	10.79	1.67	18.68
No Disability PW	329	10.26	4.85	10.75	1.26	18.48

Legal Status

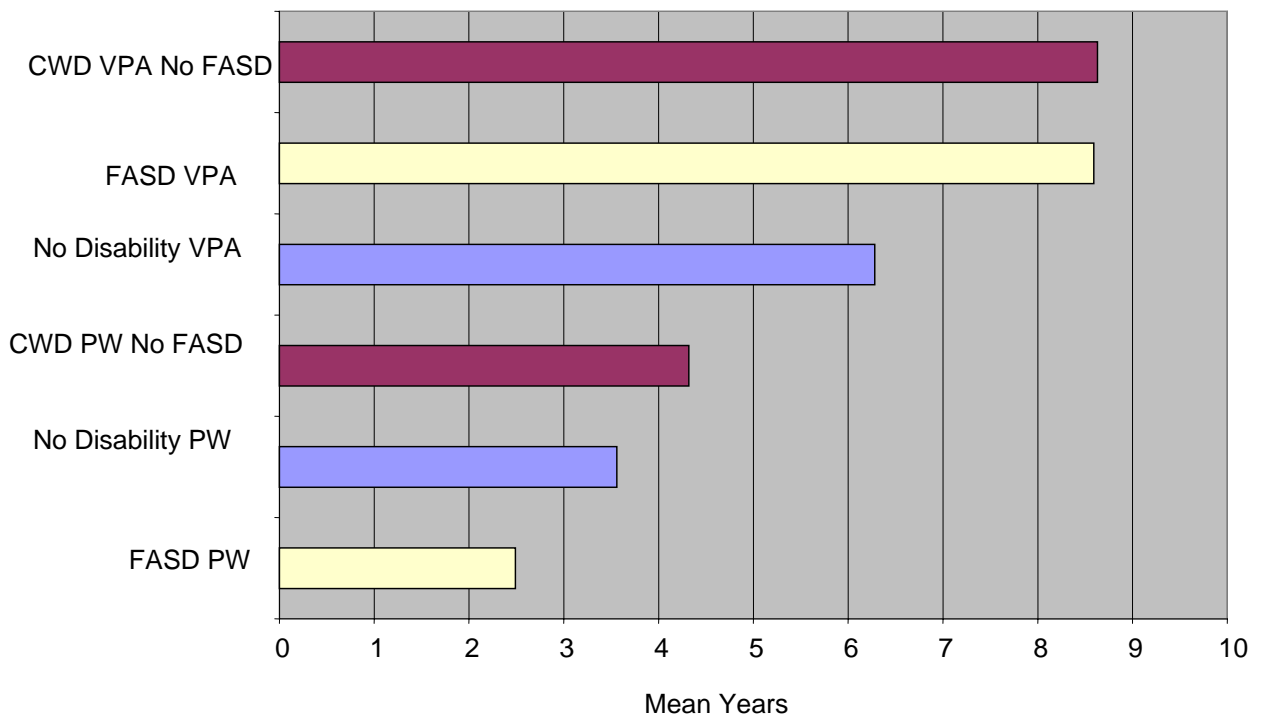
For the purposes of the second phase of the research project, only children who were permanent wards or under a VPA on December 1, 2005 were examined as part of the six comparison groups. Although they were all either permanent wards or under a VPA on that date, their legal status histories could consist of a variety of legal statuses and may have included Apprehension, Temporary Ward, Permanent Ward (PW), Transition Planning, Voluntary Placement Agreement (VPA), Voluntary Surrender of Guardianship

(VSG) and/or Unknown legal statuses. The legal status of children was derived from the recordings in CFSIS.

Age at First Legal Status

Figure 5.1 clearly illustrates the differing mean ages in the six groups. Children with FASD who were PWs were the youngest at the time of their first legal status (\underline{M} = 2.49 years, Mdn = 1.29 years, \underline{SD} = 3.12) and children with a disability (but not FASD) who were under VPAs were the oldest (\underline{M} = 8.63 years, Mdn = 9.5 years, \underline{SD} = 5.24). The mean age difference between the two groups was 6.14 years. Children in other groups fell in between with the No Disability PW group (\underline{M} = 3.56 years, Mdn = 2.5, \underline{SD} = 3.52) and the CWD PW No FASD group (\underline{M} = 4.32 years, Mdn = 3.8 years, \underline{SD} = 3.58) having their first legal status on average as pre-schoolers and the No Disability VPA group (\underline{M} = 6.28 years, Mdn = 5.4 years, \underline{SD} = 5.15) and the FASD VPA group (\underline{M} = 8.59 years, Mdn = 9.6 years, \underline{SD} 5.02) having their first legal status after becoming school age.

Figure 5.1
A Comparison of Mean Age at First Legal Status in Years by Legal Status Disability Groups



In the first study, the reason most commonly identified for children coming into care was conduct of the parent. So while these children may later be diagnosed with FASD, disability is not the reason that they came into care at such a young age. Limitations of the information system prevent a more explicit understanding of the presenting issue at the time of admission to care. However, given the later diagnosis of FASD, it would not be unexpected to find a high proportion of cases with parental substance abuse as a presenting issue.

Although this finding is based on a very small VPA sample size, it is interesting to note that children with FASD who are in care under VPAs do not have their first legal status until significantly later than permanent wards with FASD. It is unknown if the children with FASD under VPAs were living with their birth families, with other permanent caregivers, had more family support or if there is some other reason for this difference. It will be important to examine this group further in future research to better understand the reasons for some children with FASD being admitted to care at a later age than other children with FASD.

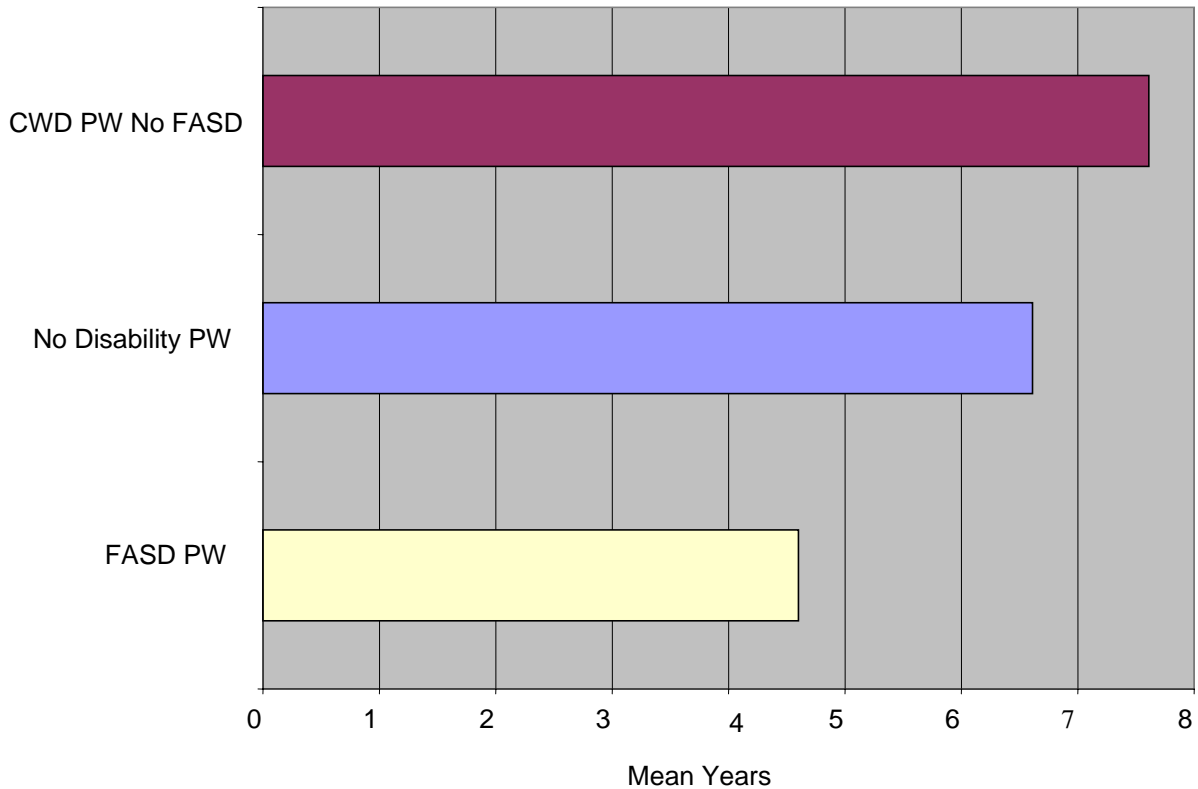
Mean Age at Becoming a Permanent Ward

Information provided in CFSIS was used to calculate the age at which a child first became a permanent ward. Using our three permanent ward random sample groups it was determined that children with FASD became permanent wards at the youngest age (\underline{M} = 4.6 years, Mdn = 3.43 years, \underline{SD} = 4.03) (see Figure 5.2). Children with no disability were 2.01 years older than children with FASD (\underline{M} = 6.61 years, Mdn = 5.82 years, \underline{SD} = 4.4) and children with a disability but no FASD were the oldest at the point of permanent guardianship (\underline{M} = 7.61 years, Mdn = 7.52 years, \underline{SD} = 3.84). Again, it is important to note that while children with FASD became permanent wards at the youngest age, these children were not necessarily diagnosed with FASD when they came into care or at the time they became permanent wards.

Length of Time from First Legal Status to Becoming a Permanent Ward

Children with permanent ward status were further examined to determine the length of time from their first legal status to the time they became permanent wards. Figure 5.3 shows that the FASD PW population had the shortest period of time between the two legal statuses (\underline{M} = 2.11 years, Mdn = 1.30 years, \underline{SD} = 2.07). At just over 2 years on average between their first legal status and becoming a permanent ward, this was almost a year shorter than other children who became permanent wards. The No Disability PW group was just over 3 years (\underline{M} = 3.05 years, Mdn = 2.12 years, \underline{SD} = 2.65), as was the CWD PW No FASD group (\underline{M} = 3.29 years, Mdn = 2.41 years, \underline{SD} = 2.71). This may be due in part to the legal status legislative requirements under *The Child and Family Services Act* (1985) that apply to children who are involved with the child welfare system

Figure 5.2
A Comparison of Mean Age Children Became Permanent Ward in Years by Disability Groups



at different ages, as discussed earlier. Since the PW FASD group on average is first involved with the system at 2.49 years of age, the amount of time they can be in care under temporary status is less than children who are older than 5 years of age when they first come into care.

Mean Number of Legal Statuses

The number of legal statuses a child had from the first admission to care (resulting in the first legal status for that child) until December 1, 2005 was calculated and compared across the legal status disability groups. Permanent wards tended to have fewer legal statuses than children under a VPA (see Table 5.2). Permanent wards with FASD had the least number of legal statuses (4.75) which corresponds to these children having the least

Figure 5.3

A Comparison of Mean Time from First Legal Status to Becoming a Permanent Ward in Years by Disability Groups

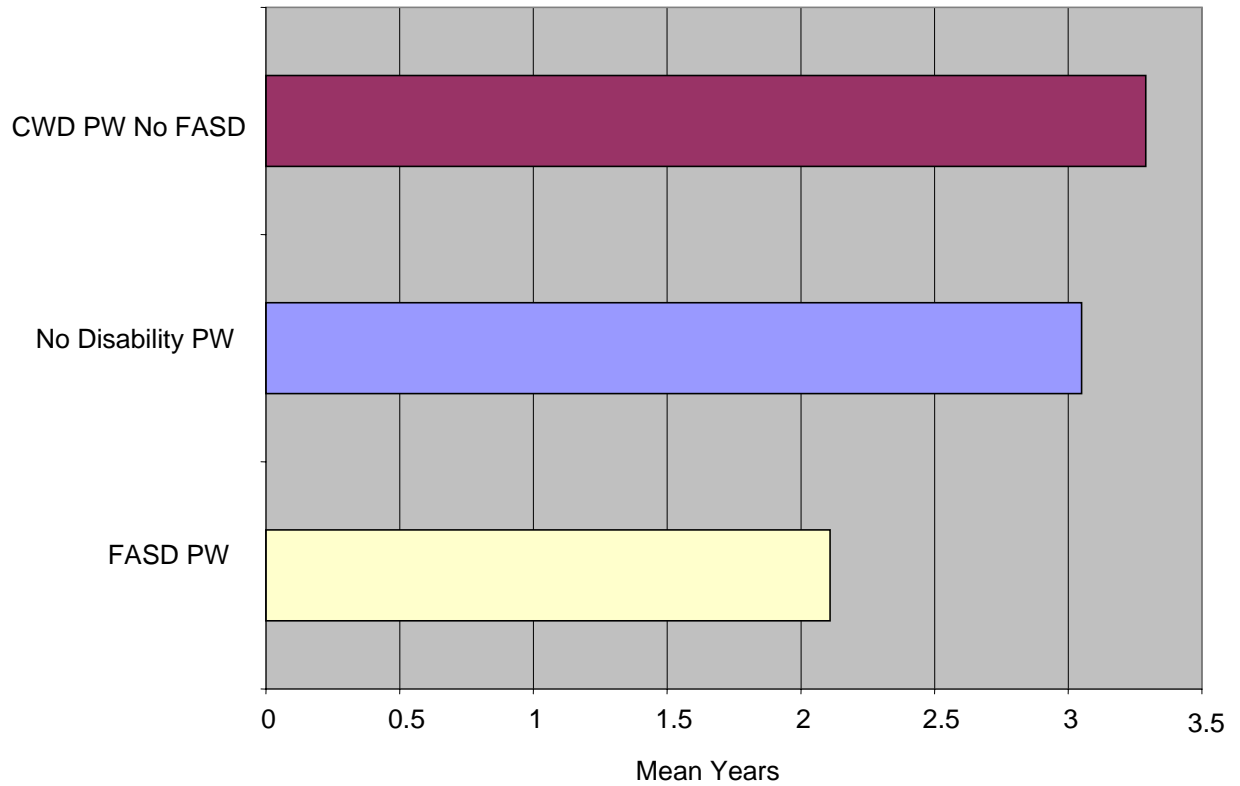


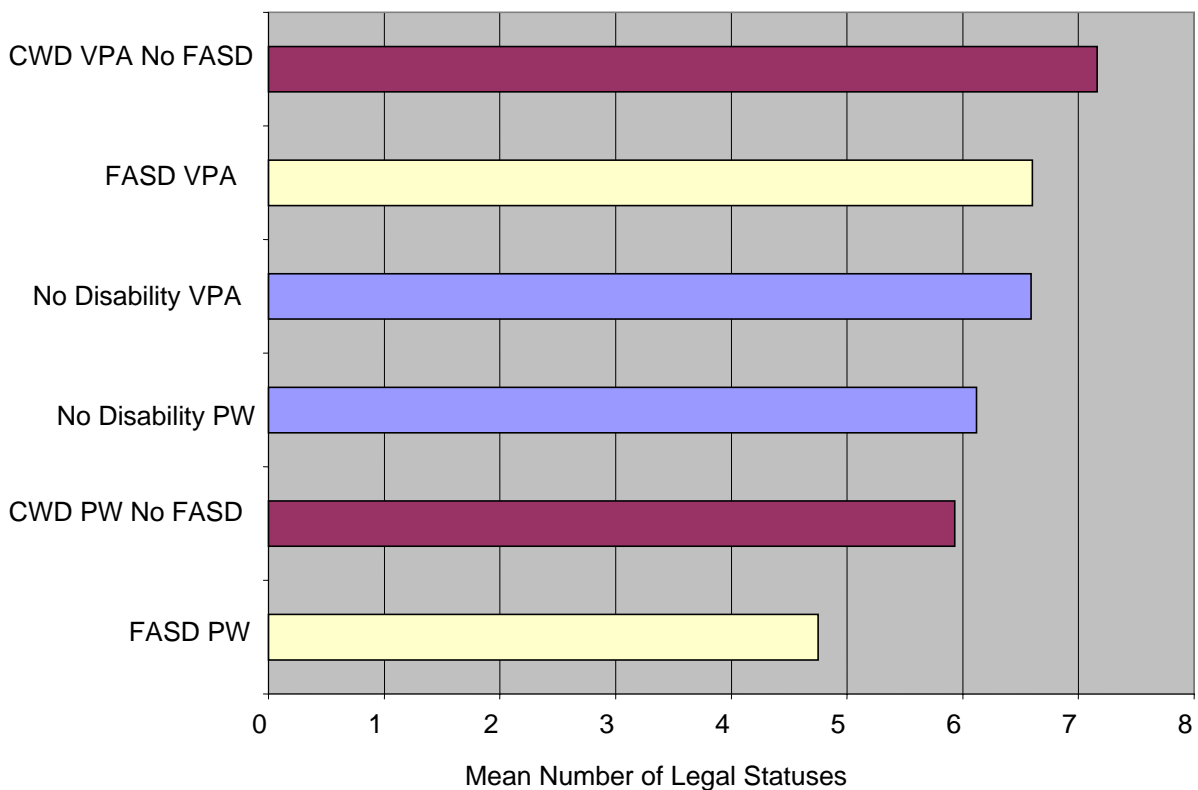
Table 5.2

Mean Number of Legal Statuses by Disability and Legal Status Groups

Group	N	Mean # of Legal Statuses	SD	Median # of Legal Statuses	Min.	Max.
CWD VPA No FASD	38	7.16	4.33	6	1	17
FASD VPA	20	6.60	4.08	6	2	17
No Disability VPA	165	6.59	3.81	6	2	28
No Disability PW	329	6.12	3.69	5	2	35
CWD PW No FASD	94	5.93	3.36	5	2	17
FASD PW	122	4.75	3.12	4	2	17

amount of time between their first legal status and becoming a permanent ward. Children with a disability (no FASD) and under a VPA had the most legal statuses (7.16), reflecting the frequent renewals of VPAs that may occur. This finding is not unusual in that VPAs are often negotiated for short periods of time with opportunities for renewal as long as the total duration of time does not exceed 24 months, with unlimited renewals for children over 14 or with a permanent medical or mental disability as defined in legislation. Figure 5.4 illustrates the difference in the mean number of legal statuses.

Figure 5.4
A Comparison of Mean Number of Legal Statuses by Disability and Legal Status Groups



Length of Time with a Legal Status

The mean length of time that children from the different groups were in the care of a child welfare agency was calculated. It was determined that children under a VPA were in care for a shorter length of time than children who were permanent wards (see Table

5.3). Children under a VPA with no disability spent the least amount of time in care while permanent wards with FASD were in care the longest.

Table 5.3
Mean Time with a Legal Status (From First Legal Status to December 1, 2005) in Years by Disability and Legal Status Groups

Group	N	Mean Time in Years	SD	Median Time in Years	Min.	Max.
FASD PW	122	7.45	3.17	7.67	1.46	16.30
CWD PW No FASD	38	6.82	3.29	6.28	1.68	16.09
No Disability PW	329	5.61	3.16	5.12	0.81	16.51
CWD VPA No FASD	94	4.86	3.78	4.24	0.22	14.47
FASD VPA	20	2.98	1.57	2.38	1.53	7.10
No Disability VPA	165	2.34	1.91	1.92	0.12	15.59

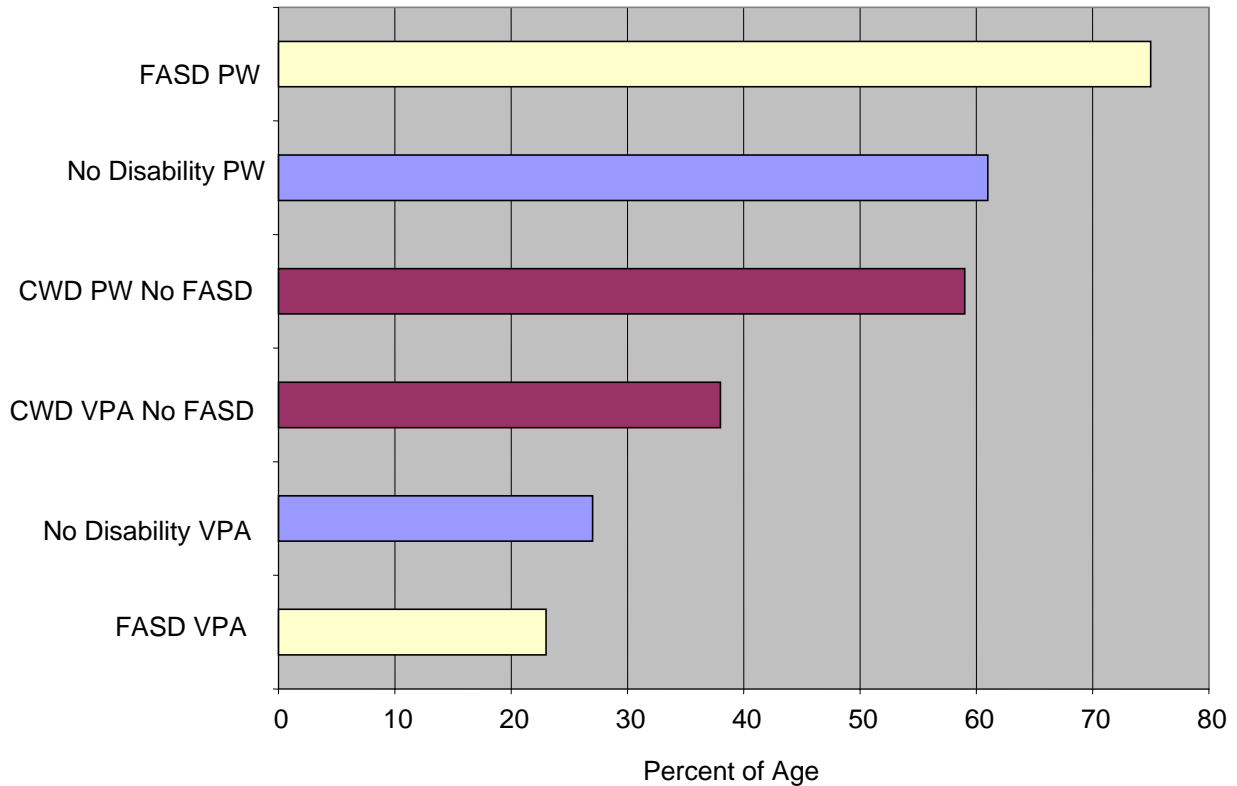
Because the age of children is a factor that influences the length of their total time in care, a more accurate comparison of the relative time spent in care by the legal status disability groups could be made by comparing the children's time in care as a proportion of their age. Again it was found that children under a VPA were in care for a shorter proportion of their life, while children who were permanent wards spent a greater portion of their lives in care. Of particular importance to note was the finding that children with FASD spent over 70% of their lives in care of a child welfare agency in Manitoba. This is portrayed in Figure 5.5.

Placement

While the legal status and placement status of children are linked, there may be differences between the amount of time children have a legal status and the amount of time they are actually in an agency supported placement. The history of a child with an agency may involve a variety of placement arrangements and it was important to understand whether the placement history of children varied by their disability.

To make this research compatible with the National Outcome Measures Project, an initiative of the national Directors of Child Welfare to develop consistent outcome indicators for children in care, a similar definition of placement was adopted. Placement was defined as any period of residence lasting 14 or more days with the exception of

Figure 5.5
A Comparison of Time with a Legal Status as a Proportion of Age by Disability and Legal Status Groups



hospitalizations and time in a correctional facility. Periods of placement were not broken by hospitalizations or correctional placements of any length or by home visits or other absences of less than 14 consecutive days. Home visits or other absences greater than 14 days that were not hospitalizations or correctional placements were counted as breaks in placement even if the child returned to the same agency placement after the absence.

Length of Time in Placement

The mean length of time in placements of children in the six legal status by disability groups was determined and compared. As would be expected, permanent wards spent the longest time in placement. However, of the permanent wards, those with FASD spent the most time in child welfare agency placements ($\underline{M} = 7.20$ years, $\text{Mdn} = 7.42$ years, $\underline{SD} = 2.97$), in comparison to permanent wards with other disabilities ($\underline{M} = 5.98$ years, $\text{Mdn} = 5.67$ years, $\underline{SD} = 2.98$), and permanent wards with no disabilities ($\underline{M} = 5.08$ years, $\text{Mdn} =$

4.32 years, SD = 3.12). As shown in Figure 5.6, the VPA groups did not follow the same pattern. Children with FASD in care under a VPA were in placements much less time (M = 2.72 years, Mdn = 2.22 years, SD = 1.70) than other children with disabilities (M = 4.73 years, Mdn = 3.28 years, SD = 4.16), although their time in placement was greater than children with no disabilities (M = 1.69 years, Mdn = 1.49 years, SD = 1.43). Comparing the legal status groups within each disability category showed a wide variation in the mean lengths of time in placement. For children with disabilities other than FASD, the difference in mean length of time in placement between PWs and VPAs (1.25 years) was small compared to the differences between the means of the No Disability groups (3.39 years) and the FASD groups (4.48 years).

Number of Placements

The mean number of placements experienced by children in care in the six legal status disability groups was determined and compared. See Table 5.4. Children with FASD, both VPAs (M = 3.67 years, Mdn = 3 years, SD = 1.97) and permanent wards (M = 3.48 years, Mdn = 3 years, SD = 2.58), recorded the greatest mean number of placements. The other VPA groups had the least mean number of placements: No Disability VPA (M = 2.74 years, Mdn = 2 years, SD = 2.27) and CWD VPA No FASD (M = 2.63 years, Mdn = 2 years, SD = 2.01).

Length of Placements

The total time in placement for each child was divided by their total number of placements to determine the mean length of placements for each child. A mean of those means was calculated for the established legal status disability groups and a comparison was made across groups. The results of that comparison are shown in Figure 5.7. As anticipated the children who were permanent wards tended to have longer placements than children in care under a VPA. The exception was children with a disability other than FASD. For those children, the mean length of placement (M = 3.23 years, Mdn = 1.39 years, SD = 4.27) was similar to the greatest mean length of placement found for the FASD PW group (M = 2.63 years, Mdn = 2 years, SD = 2.01). The longer length of placement for this VPA group may reflect a different use of the VPA. A number of children with severe disabilities and/or complex medical needs are placed in facilities such as the St. Amant Centre. Although parents may be initiating this type of long-term planning for their children, they are required to enter into a Voluntary Placement Agreement with an agency in order to complete the placement. These severely compromised children may require placement from an early age for the duration of their lives.

Figure 5.6
A Comparison of Mean Years in Placement by Disability and Legal Status Groups

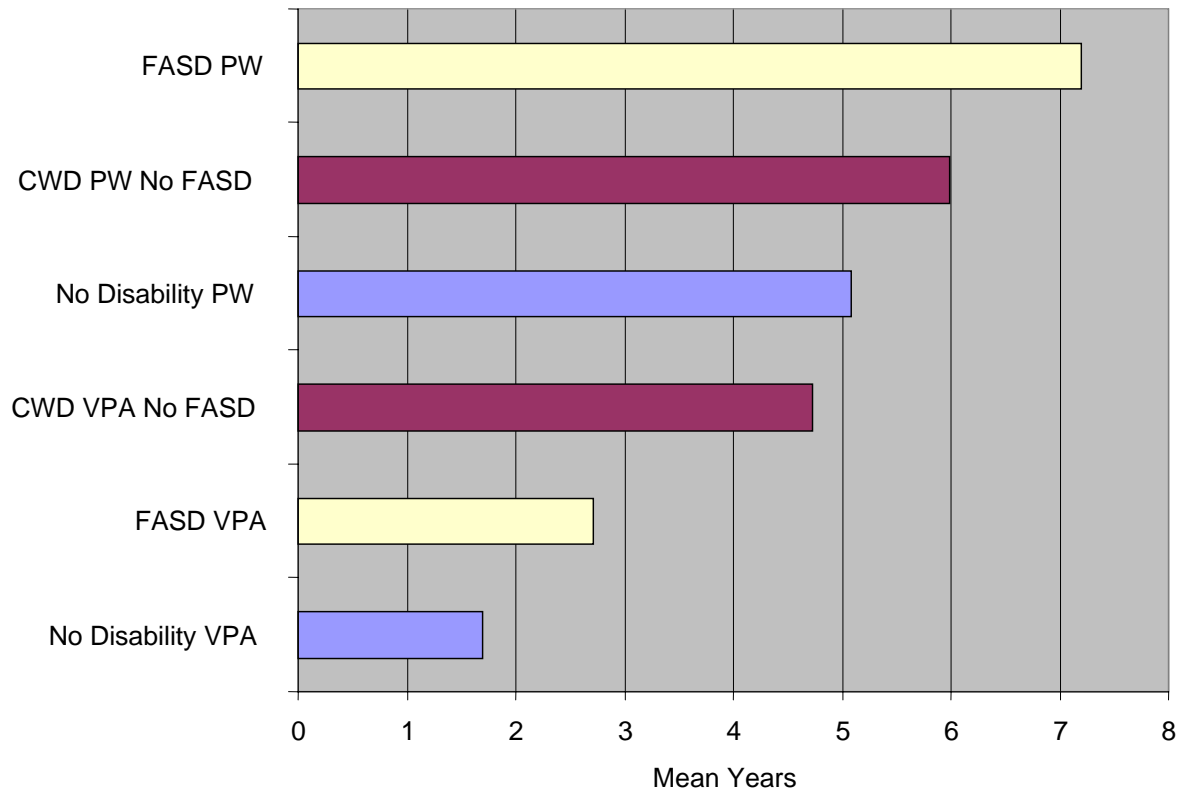
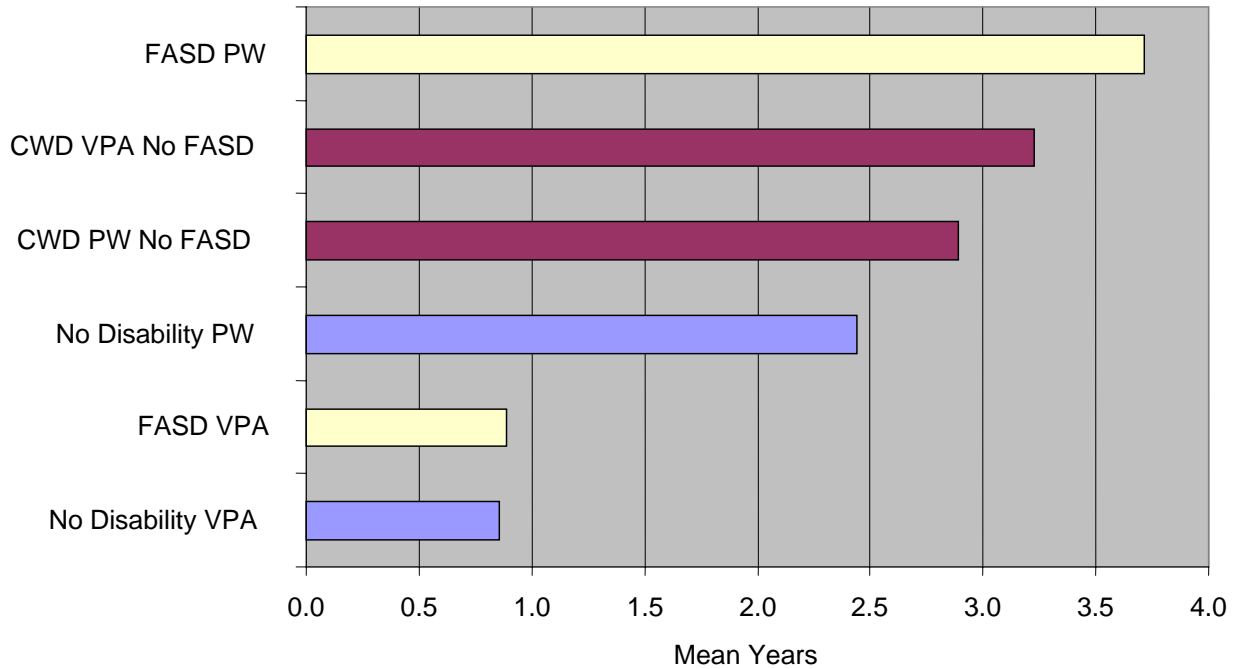


Table 5.4
A Comparison of Mean Number of Placements for Disability and Legal Status Groups

Group	N	Mean #	SD	Median #	Min.	Max.
FASD VPA	18	3.67	1.97	3	1	8
FASD PW	122	3.48	2.58	3	1	12
CWD PW No FASD	94	3.18	1.87	3	1	9
No Disability PW	329	3.08	2.10	2	1	12
No Disability VPA	165	2.74	2.27	2	1	14
CWD VPA No FASD	38	2.63	2.01	2	1	9

Figure 5.7
A Comparison of Mean Length of Placements



Years in Placement as a Proportion of Age

The total length of time each child had spent in an agency placement was calculated as a proportion of their age as of December 1, 2005. A mean of the proportions was determined for each disability legal status group. The comparison of mean proportions showed that children with FASD spent on average greater than 70% of their lives in care ($\underline{M} = 73.14\%$, $\text{Mdn} = 76.52\%$, $\underline{SD} = 23.51$). This was a higher proportion than permanent wards with no disabilities ($\underline{M} = 59.22\%$, $\text{Mdn} = 58.35\%$, $\underline{SD} = 26.68$) and considerably higher than permanent wards with other disabilities ($\underline{M} = 53.08\%$, $\text{Mdn} = 52.34\%$, $\underline{SD} = 23.09$). There was a noticeable difference in the extent to which children with disabilities other than FASD spent time in placement under the provisions of a VPA compared to children with no disabilities or children with FASD. Where children with FASD or no disability in placement under VPA were placed for approximately 20% of their lives, children with disabilities other than FASD spent about 35% of their in lives in placement. See Table 5.5.

Table 5.5
Mean Years in Placement as a Proportion of Age

Group	N	Mean Years in Placement as % of Age	SD	Median %	Minimum %	Maximum %
FASD PW	122	73.14	23.57	76.52	14.86	100.00
No Disability PW	329	59.22	26.68	58.35	4.78	100.00
CWD PW No FASD	94	53.08	23.09	52.34	11.55	99.93
CWD VPA No FASD	38	34.45	28.62	22.95	1.25	98.67
FASD VPA	18	21.36	13.72	15.70	1.42	53.94
No Disability VPA	165	19.91	22.76	12.19	0.62	99.73

7. Discussion

This discussion will focus on comparing the legal status and placement histories of the legal status and disability groups previously identified. It will examine the permanent ward groups across disabilities, the VPA groups across disabilities and finally the FASD groups across legal statuses.

Permanent Wards

It is clear from these findings that permanent wards who receive a diagnosis of FASD have come into care for the first time at a younger age (2.49 years) than children with no disability (3.56 years) and at a considerably younger age than children with other disabilities (4.32 years). The data also demonstrates that children in the FASD group become permanent wards more quickly than children in either of the other permanent ward groups. Their time from first legal status to a permanent order was approximately 2 years compared to 3 years for other children. This fast track, compounded by an earlier initial legal status, results in the children with FASD becoming permanent wards at a much earlier age, approximately 4 years of age compared to 6 years of age for children with no disabilities and over 7 years of age for children with other disabilities.

Given the shorter time period between first legal status and the granting of permanent guardianship, one would expect that the FASD permanent ward group would have a lower mean number of legal status changes¹. That is precisely what the data demonstrates. The FASD group of permanent wards averaged less than 5 changes in legal status and the other PW groups averaged 6. This means that fewer opportunities are occurring for these children to be re-united with their families of origin. Once the children are in care, they move comparatively quickly and directly to becoming permanent wards. As previously discussed, this shortened pathway into care for children with FASD may be entirely a consequence of the conditions imposed by *The Child and Family Services Act* (1985). What this research demonstrates is that the conditions specified in the Act appear to have a greater impact on the legal status history of children with FASD, as a result of their younger age at admission to care.

The placement history of permanent wards mirrors their legal status history. PWs with FASD spent the longest time in placements, on average more than 2 years longer than children with no disability. Possibly as a consequence of being in care longer, they have a higher number of placements than other permanent wards. This appears to be the case because, although they have a higher mean number of placements, the mean length of their placements is also greater than that of other permanent wards. There is no evidence

¹ Although there are rare exceptions to this rule, it is generally true that once a child becomes a permanent ward, he/she will have no more legal statuses.

here that children with FASD are any more disadvantaged in terms of placement changes than other children in care.

Finally both the legal and placement histories confirm that permanent wards with FASD are spending on average close to three quarters of their lives in the care of an agency, about 15 % more than any other children who are permanent wards.

Voluntary Placement Agreements

While the sample of children with FASD in care under a Voluntary Placement Agreement is very small compared to the other groups, it does include the entire population of children in Manitoba in that group for whom legal and placement histories were complete. Clearly, VPAs are seldom used by families of children with FASD.

When VPAs are used, they tend to be used for less time for children with FASD than for children with other disabilities but for longer than children with no disability. The children with FASD had a mean of 2.98 years with a legal status compared to 4.86 years for children with other disabilities and 2.34 years for children with no disability. The same pattern was true for the total length of time in placements. However, all the VPA groups were similar in the mean number of legal statuses.

There was a considerable variation in the mean length of placements among the VPA groups. The mean length of placement for the FASD group (0.89 years) was much shorter than the mean length of placement experienced by the children with other disabilities group (3.23 years) and was very similar to the mean length of placements of children in the no disability group (0.86 years).

The pattern that emerges shows that far fewer families of children with FASD use a VPA than other families involved with child welfare agencies in Manitoba. When a VPA is used for children with FASD, it is used for less total time than for children with other disabilities but this appears to be the result of shorter periods of placement rather than fewer placements. The children with FASD actually had a higher mean number of placements (3.67) than children with other disabilities (2.63). The mean number of placements of children with disabilities other than FASD might be expected to be lower due to the children in long term care in a facility such as St. Amant. These children would tend to continue in one placement throughout their placement history.

FASD Groups

There are some notable differences between children with FASD who become permanent wards and those whose relationship with an agency is proscribed by a Voluntary Placement Agreement. The age of first legal status is markedly different. Permanent wards with FASD had their first legal status on average at age 2.49 years and VPAs with FASD did not have a legal status until 6 years later at a mean age of 8.59 years.

The mean number of legal statuses for children under a VPA (6.60) was also greater than the mean number for children who became permanent wards (4.75). Although the VPA group had more legal statuses, the amount of time they spent with a legal status or in a placement was significantly less than children in the permanent ward group. For example, the mean total length of time in placements was 7.20 years for permanent wards compared to 2.72 years for children under a VPA. This difference was reflected in the proportion of their life spent in a placement which was more than 70% for Permanent wards but just over 20% for children with VPA status.

Summary

Children with FASD who become permanent wards tend to become children in care of an agency at a much earlier age than other children with disabilities or children with no disabilities. Once in care, they are more likely to continue in agency placements than other children. They become permanent wards more quickly than other children. While VPAs provide a means of supporting families of children with other disabilities, they are not commonly used for children with FASD. Again, it must be stressed that it is not the condition of FASD that results in the early admission to care, as the diagnosis of the condition tends to occur at a later age once the children are already in care, but variables connected to the functioning of the child's parents which cannot be adequately remedied before the legislation requires the agency to pursue permanent guardianship.

8. Addictions Foundation of Manitoba

Recognizing the significant number of alcohol-affected children in the child welfare system, it was of interest to learn more about the possible number of children in the Province who might be similarly affected. There are currently no reliable provincial statistics identifying the number of children with FASD in the general population. To begin to develop an awareness of the scope of this issue, information was obtained from the Addictions Foundation of Manitoba (AFM)² on women of child-bearing age (19 to 45 years) who were involved with an addictions program in 2005-2006, the year of the study.

AFM provided summary data on women who participated in screening for addictions-related programs. Their screening tool is a self-report questionnaire completed by all potential AFM clients. AFM cautions that the information gathered in the initial screen may be influenced by a number of biases. It is subject to the shortcomings of a self-report survey, notably selective completion of items. Also, because it is an intake document, at the time of completion a level of trust between the client and the organization has not been established. People may under-report circumstances to protect themselves or may over-report to speed their entry into programs. In the area of parenting, parents may be particularly reluctant to accurately disclose information related to their children for fear that reporting will result in the involvement of a CFS agency.

Keeping these cautions in mind, AFM reports that in 2005-2006 the number of women in the 19-45 year age group who participated in screening was 1212. The number of respondents varied from item to item in the screen with a range for general questions from a high of 1212 answering the question "How many children do you have?" to a low of 584 answering "Have you ever attempted suicide?" The average number of respondents to general questions was 1084. Although women might be involved with AFM for any addiction, over 90% reported feeling a need to cut down on alcohol or drug use.

Involvement with Children

Of particular interest to this study is the potential number of children in situations of maternal alcohol abuse. In this population, 65 women (6% of respondents) were pregnant at the time they filled out the screen. The number of women who responded to the question "How many children do you have?" was 1200. Of those, 312 reported no children, 230 had one child, 264 had two children, 207 had three children, 104 had four

² The data cited in this report was obtained October 19, 2006 by a special query to the Addictions Foundation of Manitoba directed through Mr. David Patton, Director, Research & Quality Monitoring.

children, 70 had five children and 52 had six or more children. Based on their report and using six as the maximum number of children, we can conclude that these mothers account for at least 2,457 children. Although 312 women reported having no children, 669 women indicated that they had no children living with them. A comparison of the number of children women reported and the number they reported living with is shown in Table 8.1.

Table 8.1
Comparison of mothers' responses to 'How many children do you have?' and **'How many children live with you?'**

Number of children	Winnipeg Region		Western Region		Northern Region		Total	
	Total*	Living with mother	Total	Living with mother	Total	Living with mother	Total	Living with mother
None	250	504	44	108	18	57	312	669
One	149	146	30	37	24	30	203	213
Two	197	117	30	23	25	20	264	160
Three	132	55	48	23	27	13	207	91
Four	67	16	18	7	19	11	104	34
Five	37	7	18	6	15	6	70	19
Six or <	27	6	9	4	16	4	52	14
Total women	859	851	209	208	144	141	1212	1200

* Records number of women responding to each child number category

This summary shows that 357 women who reported being mothers had no children living with them. Further, because more mothers report living with one child than women report having one child, it is clear that some mothers of more than one child are not living with all of their children. This is also demonstrated for mothers of more than one child by the consistently lower totals of multiple children living with their mothers than multiple children reported by mothers. There are a number of possible reasons for the discrepancy in these totals. Some of these children may be adults living independently. Women may be living with grandchildren in addition to or instead of their children and counting them as children they are living with. Children may be currently living with their father or in a private arrangement. Alternatively, mothers may have been less than candid about their family situation and indicated that children are not living with them when indeed they are.

Although there may be other explanations for children not living with their mothers, many of these mothers have, at least temporarily, lost custody of their child/ren to an agency. Child and Family Services (CFS) was noted as the referral source for 234 women. When asked about specific events happening in the past year, 370 women reported the loss or apprehension of a child to a CFS agency. It is not possible from the information provided to determine how many children were involved or whether there were previous apprehensions. However, the screening tool does gather information on current involvement with the legal system. Of 479 women who indicated being involved with the legal system, 156 reported a Child & Family Services Order as the nature of that involvement. When asked if alcohol was related to their involvement in the court system, 291 women indicated that it was. In summary, there is evidence that approximately one third of women screened for acceptance into an AFM program have been involved with a child and family service agency.

Characteristics of Women in the Sample

It is possible to summarily describe the group of women 19-45 years completing the AFM screening in 2005-2006. The majority, approximately 70%, are from the Winnipeg region, which includes the city of Winnipeg and extends as far west as Portage la Prairie and includes all of southeast Manitoba. The Western Region with a main office in Brandon and an area extending from the US border in the south to Swan River in the north provided services to 17% of this group of women. The remaining 12% were northern residents served by the Northern Region with offices in Thompson, Flin Flon and The Pas.

Education - Approximately half of the women (615 or 51%) had not completed high school, 181 (15%) had less than grade 9, and 434 (36%) had incomplete high school. Of the remaining half, 244 (20%) had completed high school, 203 (17%) had some college or university and 99 (8%) had a college or university degree.

Employment - Only 309 (26%) of these women were employed: 202 (17%) employed full-time and 107 (9%) part-time. Women most commonly described themselves as unemployed 578 (49%). Another 119 (10%) described themselves as homemakers.

Income – For those completing this item, household incomes were generally low with 365 (31.7%) reporting an income of less than \$10,000 and 175 (15%) citing the \$10,000 to \$19,000 category. Only 244 (21%) women reported household incomes above \$20,000 with 88 of those in the \$20,000 to \$29,000 range. This item was poorly completed: 287 (25%) responded “don’t know” and another 80 (7%) declined to answer.

Marital Status – Present marital status was single for 661 (57%), married/common-law for 283 (25%), divorced/separated for 164 (14%), and widowed for 10 (1%).

Mental Health – Half of the women (541) described themselves as having been seen at some time for emotional or mental health issues and 594 (53%) have at some time been prescribed antidepressant medications. Emotional or mental health issues were serious enough to have resulted in hospitalization for 231 (22%). Violent behaviour when either sober or straight was reported by 329 (29%) women and self-reports of violent behaviour increased to 620 (55%) when using alcohol or other drugs. An overdose of drugs or alcohol was reported by 339 (31%) women in the group and had occurred within the past 12 months to 157 women. Medical attention was received by 232 women as a result of their overdose. The overdose was reported as intentional by 161 (49%) of the respondents. In the preceding 12 months, 76 women reported an occurrence of more than one overdose and 28 women reported 5 or more occurrences. Suicide attempts were reported by 352 women resulting in hospitalization for 210. The number of attempts women had made ranged from 121 women reporting one suicide attempt to 72 women reporting 5 or more attempts.

Summary

In Manitoba in 2005-2006, more than 1200 adult women of child-bearing age were screened for services related to addictions. These women tended to be single, unemployed, many with less than a high school education, of low economic status and half had a history of emotional or mental health issues. They were mothers to 2500 children but were not currently custodial parents to all of their children.

9. Implications

FASD presents a significant issue for child welfare agencies. Large numbers of children with FASD find themselves in the care of a child welfare agency. They spend a greater proportion of their lives in agency care than other children. This makes them more reliant than any other group of children examined here on the parenthood of the state. Therefore, their needs must be anticipated and strategically addressed. This creates a range of implications for service delivery, policy and prevention.

Implications for Service Provision

Social workers need to be aware of the possibility that children for whom they are providing service may be alcohol-affected. Workers need to know the characteristic physiology and behaviour patterns that are an indication of the condition and pursue the assessment of children suspected of having this disability. In addition to understanding how this disability affects the child's functioning and service needs, workers need to be trained to recognize and help alleviate the additional stressors faced by families caring for a child with FASD. Because children with FASD come into care earlier and spend more of their life in placement, workers must recognize the even more critical role of permanency planning for them. There are some services available in the community for children with FASD and/or their families. Workers need to know about the availability of services in their region and be able to advocate for FASD-related services for both children in care and children in danger of coming in to care and their caregivers.

Similarly, expertise related to FASD is critical for foster parents and other direct service providers. They must be prepared to manage the unique needs of children with this condition. Recognizing the long-term placement needs of these children, foster parents need to be able to make a long-term commitment to their care. They must be aware of the additional stresses that may result from caring for children with FASD and develop some reliable stress management strategies.

It is not enough to plan for the needs of children while they are in care. Every year increasing numbers of children who have been identified with FASD will be transitioning out of care and into the community. The shift to independence is difficult for all children with disabilities. This is due in part to the significant differences in the structure of service delivery for children and adults. The move to independence for persons with FASD is further complicated by the nature of their disability. They are often not eligible for services related to cognitive impairments because their level of intellectual functioning is above the eligibility criteria. There are few adult services directly related to FASD. As adults, their disability tends to be invisible but their behaviour can present many challenges. Long-term planning for children with FASD needs to include special attention to their transition into adulthood.

In summary, workers, foster parents and other service providers must be prepared to provide the kind of care that best supports children presenting with this configuration of needs.

Implications for CFS Policy

This research project demonstrates the importance of gathering disability information in child welfare administrative data systems. Because children were identified in CFSIS as having a disability, and in this case a particular disability, it was possible to gather information on their histories. Initially gathering the disability data took several months of reviewing paper files and many miles of travel throughout the province (Fuchs et al., 2005). Once information was entered into the Child and Family Services Information System, it could simply be retrieved by query. The importance of having this information easily available for policy and planning cannot be overestimated.

Connections to FASD expertise must be made to adequately provide for the needs of alcohol-affected children. Whether this means increasing the expertise within CFS or integrating FASD services with other service providers, it is essential to have knowledge and skill related to FASD available to every affected child in care. This might include hiring policies that require coursework in FASD for social workers, core module training in FASD for workers on the job, or the creation of specialist positions within CFS to provide consultation and connection to external services. It might also include closer connection to Healthy Child Manitoba and their early intervention programs and collaboration with Children's Special Services to benefit from their expertise in managing disability. The availability and accessibility of such services and resources in remote and isolated communities must also be addressed, which requires the involvement of federally funded programs for on-reserve communities.

The review of the number of women of child-bearing age who are involved with AFM gives a cursory indication of the scope of addiction issues among women in this province. The potential for children to be affected by alcohol both biologically as a result of prenatal exposure and environmentally as a result of postnatal exposure is significant. The child welfare system appears to be a primary intervener with this high risk population. CFS policy direction and resource allocation need to recognize the prevalence and complex needs of this group.

Other Policy Implications

Beyond the scope of Child and Family Services, the AFM data emphasize the importance of prenatal alcohol prevention programs and the potential need for supports for women and families. It is also an indication of the continued importance of early childhood intervention and identification of children and families requiring support.

The availability of FASD diagnostic services throughout the province for children of all ages is fundamental to service planning and provision. Manitoba has high quality assessment services but is lacking in quantity. Assessment services at the Clinic for Alcohol and Drug Exposed Children are based in a central clinic in Winnipeg with limited accessibility for rural or Northern residents. Working to capacity, the central clinic is only able to focus on children under the age of 12 years.

Within the department of Family Services and Housing, there is the potential to develop a service model across divisions that would encompass the provision of early childhood intervention and child care, family supports, vocational/employment strategies, independent living supports, and affordable housing. Integrated service delivery on this scale would make social inclusion of persons with FASD possible. An integrated approach would reduce the demand on the overly subscribed child welfare system and provide greater access to the range of appropriate services required by children with FASD disabilities and their families.

10. Future Research

A number of significant questions arise from this research. They are related to best practices in service provision, policy, and prevention.

Service Provision

Although children in care with FASD have now been identified and their legal and placement histories described, they are still largely unknown. What are the reasons they come into care, what is the nature of their relationship with their family of origin, their siblings, and their extended family? Are there opportunities for maintaining family relationships? What are the needs of sibling groupings of children with FASD? What are the factors that make it possible for some placements to be sustained over long periods of time? A longitudinal study of a cohort of children from families dealing with addictions would offer an opportunity to obtain information of immeasurable value.

The knowledge that children with FASD are spending such a large proportion of their lives in care makes it even more important to understand their needs and be able to meet them. Most children in care are in foster homes. What are the support needs of foster families who are fostering children with FASD? If children are in long term foster care, what is the best way to increase the stability of their placements?

As children with FASD enter adulthood, it is clear that they will need some continuing support. What is their success in achieving independence? What is the most effective way to assist them in their transition out of agency care? What is happening in other jurisdictions?

The research identified two groups of children with FASD: one group that became permanent wards at a young age and a second much smaller group that was able to remain out of care for many years longer than the permanent ward group. The second group spent a shorter period of time in care via the use of a VPA(s). What variables account for the different age of admission to care among the two groups? What differences in these populations make one group more successful in the community than the other? Can these differences provide instruction that will lead toward best practices?

Policy

The findings show that children with FASD come into care earlier and become permanent wards more quickly than other children. This raises the question of the efficacy of the permanency planning provision of *The Child and Family Services Act* (1985) in relation to children with FASD. It appears that the Act's intention to meet the needs of children for a stable permanent home have a particular impact on children with FASD because they enter the child welfare system at an earlier mean age than other

children. If there was more time to support families struggling with addictions, would it be possible for more children with FASD to return to their families of origin? This issue may not be adequately addressed without a concurrent increase in community addiction services to better and more quickly support families when addiction issues arise and children must come into care. In a related question, can voluntary placement agreements be used more effectively to maintain parental involvement in the care of children with FASD?

Prevention

It is said that of all disabilities, FASD is the one that is most preventable. The information from AFM identifies a high risk population of women. What type of prevention programs would be most successful in addressing a high risk population? Although beyond the scope of the child and family services system, it would be of great importance to prevent children coming into care by reducing the incidence of FASD.

11. Recommendations and Conclusions

The implications of this research lead to the following recommendations:

- That CFS emphasize the importance of knowledge and skill acquisition related to children with FASD for workers and service providers particularly foster parents;
- That continued support be available for early childhood intervention programs for children with FASD;
- That a comprehensive and culturally sensitive prenatal alcohol prevention program be developed and implemented;
- That Manitoba increase its capacity for FASD diagnosis of children including children in the middle and teen years in accessible settings throughout the Province;
- That Manitoba Family Services and Housing explore the integration of its services, and the services of other departments, to provide the seamless delivery of health and social support services to children and families with FASD disabilities;
- That Manitoba Family Services and Housing continue to assess the needs and develop effective programs to support adolescents with FASD as they transition out of care; and
- That Manitoba work with the federal government toward the establishment of addiction and diagnostic supports and services on reserve to women of child-bearing age and their families.

FASD is a disability that impacts the legal status and placement histories of children in care in Manitoba. Because children with FASD enter the child welfare system at a younger age and spend a greater proportion of their lives in care than other children, their needs present an additional challenge to the child welfare system. The data on the increasing number of children coming into care and the prevalence data from the Addictions Foundation Manitoba would indicate there is some growing degree of urgency for health, education and the child welfare system to develop effective integrated health and service policy and programs to respond to the growing numbers of children and families with FASD.

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