

Children with Disabilities

Receiving Services from Child Welfare Agencies in Manitoba

Don Fuchs, University of Manitoba
Linda Burnside, Child Protection Branch
Shelagh Marchenski, University of Manitoba
Andria Mudry, University of Manitoba

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Executive Summary

Meeting the needs of children with disabilities creates significant challenges for child welfare agencies in Manitoba. The number of children with disabilities and their demands on care systems have increased as medical advances have reduced the mortality rate and increased the longevity of children with complex medical needs. Because of additional risk factors associated with disability, these already vulnerable children have a greater potential for requiring the support or protection of a child welfare agency than other children.

In recognition of the high care needs and the over-representation of children with disabilities in the child welfare system, this study was conducted to create a profile of children with disabilities receiving services from child and family services agencies in Manitoba. The profile created describes the number and distribution of children, the nature of their disabilities and their care needs. This information 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.

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.

Context

Two areas of knowledge provided the context for this research: the concept of disability and current knowledge of disabilities in children. The concept of disability has evolved in the past half century from a medical model, through a functional model, to an ecological model. Rather than seeing disability as a defect within an individual, disability is now understood to be the result of the interaction between an individual and their environment. The World Health Organization with the International Classification of Functioning Disability and Health (ICF) has been instrumental in establishing this perspective as the worldwide standard. The United Nations has enshrined the rights of children to services, family and education which serve to guide policy on children's issues.

The Manitoba Child and Family Services Act (1985) makes special provision for children with disabilities through the Voluntary Placement Agreement (VPA). Children with disabilities may be voluntarily placed in the care of an agency to access services or obtain care parents are unable to provide. Placement may be renewed until the age of majority and the parents maintain guardianship throughout the length of placement.

Although it is clear that disability occurs everywhere, its prevalence is difficult to determine. Efforts are hampered by the vast array of disability definitions that make comparisons problematic. In Canada, the Participation and Activity Limitation Survey (PALS) conducted in 2001 provides national and local prevalence rates (Statistics

Canada, 2002). According to PALS, the rate of disability in Manitoba (14.2%) was slightly higher than the national rate (12.4%). However, the rates of disability were noted to increase with age and the rates of children were reportedly low (1.6% for preschoolers and 4% for 5-14 year olds). The rates of disability in the Aboriginal population were considerably higher than the national rates. The Aboriginal Peoples Survey (APS) cited a rate of 39.1% for children in Manitoba (Statistics Canada, 2001).

Disabilities in children are particularly difficult to characterize because of the developmental nature of childhood. While developmental delays or developmental disabilities are the most frequently noted type of disability, there is no standard definition of the elements of functioning encompassed by those terms. They may include physical impairments, sensory impairments and mental retardation. The literature describes rates of developmental, sensory and learning disabilities as well as rates of psychological disorders and chronic health conditions. In Canada, among preschoolers with a disability 68% had a developmental disability. Of those 59% has an intellectual disability, 54% had a physical disability and 38% had another type of disability (Statistics Canada, 2002). Among school-aged children, 29.8% had a developmental disability and 31.8% suffered from a psychological disorder. The likelihood of children in care of a child and family services agency having Attention-Deficit or Attention-Deficit Hyperactivity Disorder was at least three times that of children not in care (Martens et al., 2004). Fetal Alcohol Spectrum Disorder, a serious social and health problem, is considered the most common cause of preventable intellectual disability. The incidence 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). The majority of children with a disability had more than one disability and some children had as many as 6 different types of disabilities. Boys were more likely to have disabilities than girls.

Children with disabilities are at greater risk of maltreatment and/or neglect than children without disabilities. They have been noted to suffer maltreatment at three times the rate of children without disabilities (Sullivan & Knutson, 2000). Specific types of disability are associated with increased levels of risk. Those with behavioural disorders face the greatest risk at 7 times the rate of children without disabilities.

Methodology

This study was exploratory and descriptive in design. The choice of research design was dictated by the need for a descriptive profile of children with disabilities who were involved with child welfare agencies in Manitoba.

For purposes of this study, children with disabilities were defined as those children whose ability to participate in age-appropriate activities of daily living was compromised by limitations in one or more areas of functioning. By definition, children with disabilities required adaptations to their environment to meet their special needs. This definition was intended to be broad enough to include children with congenital conditions, complex medical needs, chronic psychological or mental health concerns, Fetal Alcohol Spectrum Disorder and/or learning difficulties. Using this definition, which was intended to

conform to the WHO understanding of disability, a conceptual framework was developed. This framework conceptualized disability as one of the factors impacting the functioning of a child and his/her family. Functioning was also influenced by adaptive services and service providers. This view of disability and functioning included physical, medical, sensory, intellectual and mental health components. Adaptive services also comprised several elements: medical, mechanical, technical and personal support.

A data collection instrument was developed to gather information in each of the areas outlined by the conceptual framework. Because the project relied entirely on the information available in agency files, the data collection instrument was also shaped by the existing child welfare information gathering system.

Data collection took place between October 2004 and June 2005. Agencies throughout the province were asked to identify children who were receiving services on September 1, 2004 and who met the study's definition of disability. They were also asked to identify children who were not in care but who were in families currently receiving services. Research staff then visited each agency and reviewed the files of children identified. A review of randomly selected child in care files at each site served to check the accuracy with which agencies applied the disability definition. Agencies that participated in the data collection process represented 90% of the children in care and the resulting database is reflective of children in all regions of Manitoba: rural and urban, and north, south and central Manitoba.

Profiles of Children with Disabilities

The profiles of children with disabilities created by this research present a demographic description of the population and illustrate the nature and origin of disabilities, the functioning of children and the adaptive services they receive from child welfare agencies and other sources.

Using the definition as outlined, one third (1,869) of children in care in Manitoba on September 1, 2004 were found to have a disability. The children ranged in age from 0-20 years with a mean of 10.5 years. Boys accounted for 60% and girls for 40% of the children with disabilities in care. The higher proportion of boys was consistent across cultures of origin. The number of children with disabilities increased with age until age 13 when the numbers of both boys and girls began to decline. First Nations children comprised just over two thirds (68.7%) of children with disabilities. Their representation in the disability population approximated their representation in the overall child in care population. Most children with disabilities were permanent wards (69%) but a significant proportion (13%) was in care under a Voluntary Placement Agreement (VPA). The proportion of permanent wards was somewhat greater among First Nations children. The most frequently cited reasons for children with disabilities coming into care were related to the conduct or condition of their parents. Children in care under a VPA were the exception. Approximately half of those children were in care for reasons related to the conduct or condition of the child. Most children (75%) were placed in foster homes and only 2% required hospital or residential care at the time of data collection. The

proportion of children requiring more intensive care was greater among those under a VPA (41%) than among those who were permanent wards (16%).

A comparison of the demographics of children with disabilities and the general population of children in care revealed that children with disabilities were more often older, male and permanent wards than children without disabilities.

Disabilities were ordered in six main categories: intellectual, mental health, medical, physical, sensory and learning. The most common disabilities were intellectual which affected 75.1% of the children with disabilities and mental health which impacted 45.8% of children. More than half the children had more than one type of disability (58.1%) and the most common combination of disabilities was again intellectual and mental health. FASD was diagnosed in one third of children with disabilities (34.2%) or 11% of all children in care. Children with a mental health diagnosis were almost always (95%) given a diagnosis that fell in the Attention-Deficit/Disruptive Behaviour Disorders group. Attention-Deficit Disorders were the most frequently diagnosed (73%). FASD and ADHD were coincident in 39.1% of children with an FASD diagnosis. The remaining disability types affected smaller proportions of children with disabilities: medical disabilities 22%, physical disabilities 18%, sensory disabilities 5% and diagnosed learning disabilities 3%.

The majority of disabilities resulted from an unknown cause. Substance abuse was the origin of disability for 34.3% of the disability population and was a suspected cause for an additional 17.3% of those children.

To support functioning, 25.1% children needed assistance with the activities of daily living and 42.2% required medical support as described by the Unified Referral and Intake System (URIS) C. The majority of children were not age-appropriate in language (55.1%) or learning (62.8%). Of those with mental health disabilities, 84.4% required medication. Most children with disabilities were not able to achieve age-appropriate behaviour in dependability (76.4%), emotional modulation (72.0%), interpersonal interaction (64.4%), or awareness of risk (58.6%). Aggressive behaviour was problematic for 43% of children with disabilities. Other problem behaviours included sexually inappropriate behaviour involving 15.7% (294) and conflict with the law involving 11.3% (212).

The most frequently noted adaptive service was medication provided for 47.8% of children. Children with multiple disabilities were the most frequent recipients of services. Many organizations and agencies outside of CFS assisted in supporting children with disabilities. The greatest contributor was the education system which provided some form of additional support to more than 50% of children. By purchasing extra services for 18.5% of children with disabilities, CFS became the second most frequent additional service provider.

Implications

The findings of this study have significant implications for policy makers and practitioners who are in contact with children with disabilities in the child welfare system.

This study has demonstrated that children with disabilities are a significant proportion of the children in care in this province. Children with disabilities in care receive services in and through the child welfare system. The child welfare system is not currently structured in a manner to serve children with disabilities and their families. The data indicates that there are many children with disabilities and their families who are not receiving the services necessary to meet their needs from within the child welfare system or from other service sectors. To ensure that these children and their families receive the services they require, awareness of their needs and knowledge of how to address those needs must be the foundation of policy, program planning, staff training and service provision.

The large number of families and children with disabilities coming to the child welfare system creates increasing social and economic costs that must be addressed. There is a need for greater understanding, sensitivity and awareness within the child welfare system to more effectively address the issues and needs of families and children with disabilities.

Recommendations

This study has demonstrated through its findings and their implications the importance of research in the area of children with disabilities. Recommendations for the child welfare, education, disability and health care sectors include:

1. Develop policy to ensure intersectoral collaboration occurs between service sectors in the provision of services.
2. Develop and implement collaborative models with intersectoral teams of service providers to provide the necessary services to children with disabilities and their families.
3. Develop training programs on disabilities, including information on how intellectual and biological limitations affect functioning and how to deal with problem behaviour. This training should be available for all child welfare workers, foster parents and other direct care providers.
4. Develop and implement culturally appropriate prevention and service delivery programs. This would include: strengthening programs on prevention of FASD; providing services to families with children with FASD; understanding issues relating to disabilities; supporting families in dealing with the additional stress of caring for children with a disability; and linking available resources to families.

5. Continue the development of the information database on the needs of children with disabilities, specifically those involved with the child welfare system, and the development of a mechanism to ensure the information is integrated into the annual planning of agencies, their Authorities and government departments.

Conclusion

The importance of research in the areas of disability and the prevention of maltreatment of children with disabilities is evident. There is a great need for continued research to inform policy makers, planners and service providers. Ensuring that professionals are knowledgeable and that services are available is of utmost importance for the promotion of the safety, accessibility and social inclusion of families and children with disabilities.

I. Rationale and Significance

The number of children with complex medical, physical and developmental needs who are involved with mandated child welfare agencies has increased dramatically in the past decade. According to Krahn, Thom, Sokoloff, Hylton and Steinberg (2000), common risk factors for maltreatment such as poverty, social isolation and stress increase if a child has a disability. In addition, factors such as parents not understanding their child's disability, the child's long-term care requirements and inadequate supports contribute significantly to the risk of maltreatment for children with disabilities. Further, some children may not be involved with the child welfare system due to maltreatment, but due to their high care demands as a result of their disabilities and the inability of communities and services to fully meet the needs of these children and their families.

The capacity of the child welfare system to respond to the service needs of this growing number of children has become strained, particularly in light of the unique needs of children with disabilities and their families. Despite increased recognition of this issue, there has been little research aimed at developing a better understanding of the scope of the issue and the characteristics of the children requiring services. This research provides much needed data on the growing number of children with a wide range of disabilities receiving services in both Aboriginal and non-Aboriginal child welfare agencies.

The reason disability is particularly important in child welfare is that this population, already vulnerable because of disability, is very much over-represented in reported child abuse and neglect (particularly neglect). This is a serious social and economic concern. This project provides a significant knowledge contribution to policy, planning and practice in the field of child and family services. It also has significant potential for expansion to other provinces.

Research was conducted by the Faculty of Social Work of the 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. The research project was funded by Health Canada with the support of the Centre of Excellence for Child Welfare (CECW).

Using a broad definition of disability, this study set out to describe and analyze the population of children with disabilities who are involved with the child welfare system in Manitoba. More specifically, the project aimed to:

1. Create a profile of children with disabilities in care in Manitoba, which would identify the number and distribution of children with disabilities in care and describe the nature of their disabilities and their care needs.
2. Create a profile of children with disabilities involved with the child welfare system who use different forms of social services but who have not come into care.

3. Identify the key determinants that contribute to the admission to care for children with disabilities.

Research Questions

The following specific research questions were addressed in the design of the data collection instrument and process:

1. Who are the children with disabilities receiving child welfare services (both in-care and out-of-care services) in terms of age, culture/ethnicity, nature of disability, community of origin, school involvement, etc.?
2. For children in care, what kind of placement do they require?
3. For children in care, what level of care (i.e. service/placement costs) is required?
4. For children in care, what additional services are provided by the child welfare system to meet their needs?
5. For children not-in-care, what kinds of services are provided by the child welfare system to meet their needs?
6. What are the key factors associated with children with disabilities coming into care?
7. What other organizations are also providing services to children with disabilities who are involved with the child welfare system?

Relevance

This project adds significantly to the knowledge of children with disabilities, specifically those involved in the child welfare system. It provides much needed data on the growing number of children with disabilities and the special needs and service requirements of these children and their families. A better understanding of the scope of the issue and the characteristics of the children requiring services resulted.

This report is designed to provide an overview of children with disabilities who are involved with Manitoba child and family service agencies. The profile and the patterns of service use of those children having a disability will assist in front-line practice as well as policy decisions and recommendations.

Information Systems

The results of this project highlight the importance of specific information gathering systems to collect information related to disability as part of the provincial administrative data base. The Child and Family Services Information System (CFSIS) has been updated to include information on children with disabilities so that subsequent reporting on this population can be done with ease.

Profile of Children with Disabilities in Care

The population of children with disabilities in care has not been previously described. This project created a profile of children with disabilities who are in the care of a Manitoba child welfare agency. This profile includes the following information: demographics, nature of the disability, origin of the disability and the child's functioning. At the time this research project began, it was not possible to aggregate children with disabilities or to identify their needs using CFSIS. The research database can now be used for the production of reports meaningful to policy and programs for children with disabilities.

Profile of Children with Disabilities Receiving Services but Not in Care

Children with a disability who were not in care but receiving services were also examined whenever possible. This project was unable to develop an in-depth database for analysis of this population of children as they were difficult to identify. However, a partial profile of children known to child welfare was created and includes the following information: demographics, nature of the disability, origin of the disability, the child's functioning, as well as adaptations required and services they are receiving.

Determinants of Children Coming into Care

There are a number of critical questions concerning the relationship between disability and maltreatment. Are they coincident in this population? Are maltreatment and/or neglect the primary reasons for children with disabilities coming into care in Manitoba? This information is critical to meeting the child and family services system's goal of strengthening and supporting families. It will inform efforts to prevent children from coming into care. The profile of children in care and the partial profile of children receiving services can be used for the production of reports meaningful to policy and program development for children with disabilities involved with the child welfare system.

Future Research

The results of this study also contribute to the interpretation and understanding of the results of other studies on children with disabilities. Further, they provide a basis for future inter-provincial comparisons across the three Prairie Provinces involved with the Prairie Child Welfare Consortium. This initiative makes a significant contribution to the future examination of policies, practices, funding models, placement development and the ongoing training needs of both child welfare practitioners and foster parents. Finally, it creates a data baseline for future research with children with disabilities receiving services from the child welfare system.

Organization of the Report

This provides a unique contribution to knowledge in an underdeveloped area of child welfare research. It contributes significantly to understanding the needs and services available to children with disabilities and their families. Consequently it offers a great deal of insight for policy makers and practitioners in the fields of child welfare, health, disability and education. Policies created to enhance service provision to these children and their families can be greatly improved by the increased awareness of the growing numbers of children affected as shown in this report.

The results of this research study will have significant implications for the strategic development of services for children with disabilities. The nature of services, the mechanism of service delivery, the emphasis and direction of resource development, as well as the training of professional and paraprofessional staff and foster parents, can all be informed by a profile of the children with disabilities in contact with mandated agencies in this province.

This report includes a contextual background and a literature review of disability definitions, types of disabilities and other disability related information. A description of the Manitoba context and administrative structure is provided in Chapter II. Chapter III describes methodology details and limitations. The project results are reported in Chapter IV and discussed in Chapter V. In Chapter VI implications for service delivery, policy and future research are provided. Chapter VII delineates the major recommendations and conclusions for this study.

II. Context

Historical Context

An examination of children with disabilities who are involved with the child welfare system must be cognizant of two areas of history: the evolution of the concept of disability and the relationship between disability and the child welfare system. While this report cannot do justice to a thorough investigation of either of these topics, a brief summary will help provide context for our research.

Defining Disability

On the continuum of human ability, those who encounter difficulty in fully and independently participating in whatever social context they find themselves have been variously labelled, shunned and marked as different or other. Our understanding of disability and our treatment of those who have been so identified has been part of a continued evolution. Considerable progress has been made from the time when illness and impairments were associated with shame and moral punishments. Three perspectives of disability are relevant to the context of our current research and the definition of disability adopted for the study.

Medical model.

Society has always had to find a means of dealing with those who are unable to independently support themselves. The concept of disability has been described as “the primary arbitrator between the deserving and undeserving poor” (Erevelles, 1996, p. 525). Certainly in decades past its usefulness as a means of categorizing persons for various types of support has been noted. That is, persons were identified according to their inclusion/exclusion on a list of conditions or impairments. This process was generally related to eligibility requirements for support services. The impairment perspective, perhaps best expressed in the medical model, considered disability to be a health problem that was situated in an individual’s body or mind. The medical model assumed that disability was an intrinsic characteristic of an individual apparent in defect and/or disease. The assumption of abnormality led to practices that were an attempt to *fix* individual defects. This model has been criticized for ignoring the role of social and physical environments in the disabling process. Further, defining disability as a defect within the individual made it a very short step to defining persons as defective and inferior.

Functional limitations model.

To address the shortcomings of the medical model, a functional approach to disability evolved. The functional approach attempted to broaden the concept of disability by incorporating non-medical factors such as social and physical environment. Capacities were considered, not simply symptoms or syndromes. However, the functional model continued to see disability in a linear relationship with impairment, an intrinsic individual biological cause. This was evident in the first attempt of the World Health Organization (WHO) to classify disabilities.

The International Classification of Diseases (ICD) is a system of coding diseases and health conditions that is recognized and used by health services around the world. The WHO is the body responsible for periodic revision of the ICD. The ICD does not acknowledge the social and environmental aspects of disability. In 1980, the WHO developed the International Classification of Impairments, Disabilities and Handicaps (ICIDH). It was the first major classification system to focus specifically on disability. As summarized by Social Development Canada (2004), the ICIDH defined disability as any reduction or lack of ability, caused by impairment, to perform an activity in a way considered normal for a human being. Simeonsson et al. (2003) have outlined the significant contributions of the ICIDH in advancing disability theory. Conceptualizing disability as a consequence of underlying health conditions attributable to disease or injury was a new approach. The ICIDH differentiated those consequences in three distinct levels of human experience: the body, person and society. Therefore, disability was understood as multi-dimensional and was made manifest at different levels of functioning in the form of impairments, functional limitations and the experience of disadvantage. These theoretical constructs were in addition to the utility of the system as a method of assigning numeric codes to each level of human functioning for clinical and administrative purposes. Although it represented progress, the ICIDH was encumbered with the disadvantages of the functional perspective. It had at its foundation a linear explanation of disability that saw disability as a consequence of disease. Further, it measured disability against a quantitative standard of normalcy.

Ecological perspective.

For the past decade, the ecological perspective has been the basis for understanding disability. Like the functional perspective, it is based on three distinct disability concepts: pathology, impairment and disability. However, it sees disability as a result of the interaction between the person and the environment. This shift in emphasis from the person as the source of limitations to the person-environment interaction as the focus of disability can be clearly seen in the work of the WHO in amending the ICIDH. For the first time, persons with disabilities and disability organizations were involved in developing the classification system. In 2001 the WHO released the International Classification of Functioning Disability and Health (ICF). The ICF conceptualizes disability as a complex phenomenon resulting from the interaction between health conditions and contextual factors. Health conditions include diseases, disorders and injuries that can be diagnosed and classified. Contextual factors include external environmental factors (such as social attitudes, architectural characteristics and legal structures) and internal personal factors (such as age, gender and coping styles). This perspective assumes that “functioning and behaviour are products of the person’s interaction with the environment” (World Health Organization, 2003, p. 2). An assessment of disability therefore involves “three levels of human functioning: at the level of the body or body part, at the level of the whole person and the whole person in the social context” (World Health Organization, 2002, p. 10).

Of interest to this study is further examination of factors associated with childhood disability. Effective measurement of childhood disability requires “...consideration of the mediating role of developmental and environmental factors. A central issue is that

children's environments change dramatically across stages of infancy, early childhood, middle childhood and adolescence.... The influence of the environment on the child's performance and functioning is thus particularly important to document in this phase of the life-span" (Simeonsson et al., 2003, p. 605).

Simeonsson et al. (2003) suggest that the development of measures specific to the ICF to assess disability in children should be guided by a number of considerations most importantly the framework of children's rights. The publication of the United Nations Convention on the Rights of the Child in 1989 provided the guidelines for policy on children's issues. Key principles underlying the convention include the child's right to be the first to receive services, to have their family protected, to have a family environment, to be protected from exploitation and to receive education. The UN convention on the Rights of the Child and the ICF complement each other. "One defines the rights of children and the second provides the framework for documenting the dimensions for which those rights are to be carried out" (Simeonsson et al., 2003, p. 606). Work is currently being carried out to develop a version of the ICF adapted specifically for children and youth (World Health Organization, 2003).

It was within this context of children's rights and the multi-dimensional perspective of disability offered by the ecological model that this research project developed its conceptual framework and operationalized a definition of disability.

Child Welfare Legislation

Children with disabilities may become involved in the child welfare system for two reasons: because they are in need of protection or because they have a disability. The correlation between disability and maltreatment has been established and will be discussed below. Historically, special provisions that affect the circumstances of children with disabilities have been part of child welfare legislation.

In Manitoba, The Child and Family Services Act (1985) currently allows parents or guardians to enter into an agreement with an agency for the placement of a child without transfer of guardianship where that parent or guardian is unable to make adequate provision for the care of the child. For circumstances related to the child, this is possible if either of two disability related conditions are met: 1) the child has a mental disability as defined by the Vulnerable Persons Living with a Mental Disability Act¹ or 2) the child suffers from a chronic medical disability requiring treatment which cannot be provided if the child remains at home [Section 14 (1)b]. The agreement, entitled a Voluntary Placement Agreement (VPA), may be entered into for a period not exceeding 12 months. In most circumstances, children can remain in care under a VPA for a maximum of 24 months. In the case of children with disability, a VPA may be renewed annually until the child reaches the age of majority [Section 14(3)].

¹ Mental disability as outlined in Definitions 1(1) of The Vulnerable Persons Living with a Mental Disability Act (1993) means "significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years, but excludes a mental disability due exclusively to a mental disorder..."

This designation of the child welfare system as a resource for parents of children requiring additional care due to disability predates the current Act. Section 14 of The Child Welfare Act (1974) allowed the Director of Psychiatric Services to place a child with a mental disability under the care of the Director. These provisions were partly vestiges of a time when parents were advised to institutionalize their intellectually impaired children. However, they were also economically expedient. The Canada Assistance Plan (CAP), introduced in 1966, provided for 50% federal cost-sharing of provincial social assistance and social services programs. Therefore, under CAP the cost of services provided to children with disabilities who were placed with an agency was cut in half. In 1996, the Canada Health and Social Transfer came into effect replacing the CAP. However, the child welfare legislation remains and mandates agencies as the choice for parents wishing to cost-share the expenses of providing adequate services and support for children with disabilities.

As we consider the determinants of children with disabilities entering the child welfare system, it will be important to remember that the child welfare system offers parents of children with disabilities an option that is not available to other parents. Consideration must be given to the degree to which this represents appropriate recognition of special need and supports the right of children to have their family protected.

Aboriginal Children in Care

Like some other jurisdictions in Canada (First Nations Child and Family Caring Society, 2005; Trocmé et al., 2005), Manitoba's children in care population reflects an over-representation of Aboriginal children. The reasons for this over-representation have been acknowledged to stem from historical events, most significantly colonization, residential schools, and the subsequent intervention by the mainstream child welfare system (McKenzie & Morrisette, 2003), resulting in disconnections from language, culture, and family. Coping with these disconnections has been challenging at best, and many struggle in their lives with alcohol dependence, violence, and other self-abusive behaviours. Research suggests that many First Nations children are removed from their families as a result of neglect (Blackstock, Trocmé, & Bennett, 2004; Trocmé et al., 2005). Neglect is considered to stem from poverty and poor housing, conditions which are endemic in the Aboriginal community and often beyond the control of individual families to change, and also from substance misuse (Trocmé, Knoke, & Blackstock, 2004). Further, the resources and services to assist Aboriginal families and their communities to address the issues of poverty, poor housing, and substance misuse are often inadequate (Trocmé, Knoke, & Blackstock, 2004).

The report of the Standing Committee on Human Resources Development and the Status of Persons with Disabilities (2003) found that the rate of disability is twice as high for Aboriginal Canadians compared to the non-Aboriginal population. For many Aboriginal children with disabilities, the required services related to their special care needs are often not available in their home communities, resulting in many families turning to the child welfare system to access supports and services. Additionally, the report indicates that the rates of Fetal Alcohol Spectrum Disorder (FASD) in some Aboriginal communities may

be significantly higher than in non-Aboriginal populations. As a result of the lack of services for Aboriginal children with disabilities and the factors related to neglect and the incidence of FASD, there is an increased risk of Aboriginal children with disabilities coming into care.

Disability Context

Prevalence of Disability

Worldwide “more than half a billion persons are disabled as a result of mental, physical or sensory impairment and no matter which part of the world they are in, their lives are often limited by physical or social barriers “ (United Nations, 2003-2004, United Nations Commitment to Advancement of the Status of Persons with Disabilities, para. 1).

The prevalence of disability in general and disability in children is difficult to estimate. In their review of services in the United States for children with developmental delay Betz et al. (2004) noted that there are more than forty definitions of disability used by state and federal agencies in their country. Such diversity within countries renders international comparisons even more problematic. The recourse is to cite national prevalence data with descriptive qualifiers.

In the United States, almost 4.5 million children ages 6-21 years of age have a disability that allows them to qualify for special educational services (US Department of Education as cited in Krahn, Thom, Sokoloff, Hylton & Steinberg, 2000). Research done in Oregon found that 80% of children with a disability had a disability that you can't see such as a learning disorder, speech and language disorder, mental retardation and mental health disorders (Krahn, et al., 2000).

Australia also gathers data on disabilities in the general population using surveys completed by the Australian Bureau of Statistics. As there is no set definition of disability used, whether or not a child is described as having a disability varies depending on context. In 1998, they found that approximately 7.6% of the general population of children aged 0-14 had a disability (Australian Institute of Health and Welfare, 2004).

Statistics Canada offers two major sources of information on the rate of disability in this country. In 1991, information gathered by the Health and Activity Limitations Survey (HALS) found 4.2 million Canadians, approximately 16% of the population, reported some level of disability (Statistics Canada, 1991). Of those reporting a disability 3.9 million lived in households and 300,000 lived in institutions (Federal/Provincial/Territorial Ministers Responsible for Social Services, 1998, p. 7). Also in 1991, the Aboriginal People's Survey (APS) indicated that the rate of disability among First Nations persons was 31.3% or about twice that of the general population (Province of Manitoba, 2001). In 1991, 183,630 Manitobans or 17.6% of the population indicated some level of disability. Of those persons with disabilities, 15,190 were in the 0-14 age group (Province of Manitoba, 2005).

In 2001 the Government of Canada sponsored a second major national survey of persons with disabilities – the Participation and Activity Limitation Survey (PALS). This survey gathered information on children (aged 14 and under) and adults (aged 15 and older) in Canada who self reported a disability. Persons with a disability were defined as having a “physical or mental condition or a health problem that restricts their ability to perform activities that are normal for their age in Canadian society” (Office for Disability Issues, 2003, p. 7). The PALS excluded from its sample people living in institutions, and the residents of the Yukon, Northwest Territories, Nunavut and First Nations reserves. With those exclusions, PALS found the overall rate of disability in Canada to be 12.4% varying from 1.6% among pre-school children and increasing with age to 53.3% among adults 75 and older (Office for Disability Issues, 2003, p. 2). Among children the study reported 26,210 preschool children or 1.6% of the preschool population, and 154,710 or 4.0% of children aged 5-14 had a disability. In both age groups approximately 57% had a mild or moderate disability and 43% had severe to very severe disabilities.

In Manitoba the rate of disability indicated by PALS was 14.2% of the population. The Aboriginal Peoples Survey (APS) reported in 2001 the rate of diagnosed medical conditions in Aboriginal children in Manitoba was 39.1% and in Winnipeg 42.0% (Statistics Canada, 2001).

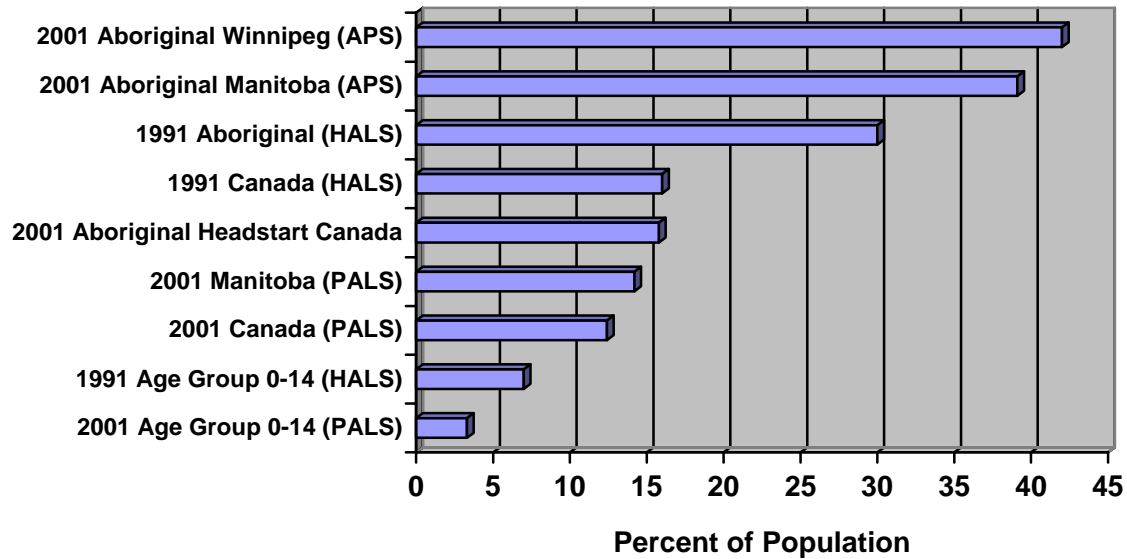
Aboriginal Head Start indicated that in 2001 of the 3,536 children enrolled in their program across Canada, 214 children were diagnosed with a special need and an additional 319 were identified by staff with a special need for a rate of 15.8% (Public Health Agency of Canada, 2001).

Figure 2.1 offers a visual comparison of these reports. It must be viewed cautiously as the terms of reference for each survey vary according to the definition of disability used and the application of the definition. Some reports have relied upon a diagnosed condition (e.g. 2001 APS), some have used self-reports (HALS & PALS) and others a combination (Aboriginal Head Start).

Further detail on the rate of disability in age groups as reported in PALS (Statistics Canada, 2002, p. 7) is summarized in Table 2.1.

Although terms of reference vary, it seems clear that the rates of disability in the population increase with age, and senior citizens experience the highest rates in the general population. There appears to be agreement that rates of disability are disproportionately higher in the Aboriginal population than the general population. Also, the rate of disability in Manitoba is somewhat higher than the Canadian rate.

Figure 2.1
Comparison of the Rates of Disability Reported for Canada, Manitoba and
Aboriginal Populations



Types of Disability

The difficulties with definitions encountered in comparing overall disability rates are replicated in reviewing studies of particular disabilities. Kendall-Tackett, Lyon, Taliaferro and Little (2005) describe eight different common types of disabilities. A brief explanation or example of each is provided.

1. Emotional and behavioural disorders – diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 1994).
2. Pervasive Development Disorders – includes but is not limited to Autism and Asperger’s Syndrome
3. Mental retardation – mild to severe mental retardation or developmental delay
4. Brain injury, communications and learning disorders – including speech and language disorders and neuropsychological defects
5. Physical impairments – such as Cerebral Palsy, Muscular Dystrophy and amputation
6. Sensory impairment – hearing impairments and vision impairments (more than just glasses)
7. Other health related disabilities – diabetes, HIV/AIDS, heart disease, juvenile arthritis
8. Multiple disabilities – children who have a disability that fits in more than one of the above categories

Table 2.1
Population With and Without Disabilities and Disability Rates by Age Groups 2001

| Age group | Total population | Population without disabilities | Population with disabilities | |
|----------------|------------------|---------------------------------|------------------------------|------|
| | Number | | | % |
| Canada Total | 28,999,770 | 25,390,510 | 3,601,270 | 12.4 |
| 0-14 | 5,546,020 | 5,365,090 | 180,930 | 3.3 |
| 0-4 | 1,641,680 | 1,615,480 | 26,210 | 1.6 |
| 5-9 | 1,914,220 | 1,843,850 | 70,370 | 3.7 |
| 10-14 | 1,990,110 | 1,905,760 | 84,350 | 4.2 |
| 5-14 | 3,904,330 | 3,749,610 | 154,720 | 4.0 |
| 15-24 | 3,883,690 | 3,732,670 | 151,030 | 3.9 |
| | | | | |
| Manitoba Total | 1,036,270 | 888,690 | 147,580 | 14.2 |
| 0-14* | | | 7,920 | 3.8 |
| 0-4 | | | 1,210 | 1.9 |
| 5-9 | | | 3,130 | 4.3 |
| 10-14 | | | 3,580 | 4.8 |

*Manitoba rates from Friendly & Beach, 2005, p. 84

Other studies such as the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP) described by Kendall-Tackett et al. (2005) only monitor the prevalence of certain types of disabilities, in this case those classified as “developmental delays”. Mental retardation, cerebral palsy, vision impairment and hearing impairment were included as types of developmental delays. In Kendall-Tackett et al.’s study, these disabilities would encompass three separate categories (mental retardation, physical impairments and sensory impairments).

Developmental delays.

Information found in the PALS survey (Statistics Canada, 2002, p. 12) indicates that the most common disability for preschoolers is developmental delay. The research found 68% of children ages 0-4 years old with a disability had a developmental delay. In 2001, this group was further broken down to demonstrate that 59% had an intellectual delay, 54% had a physical delay, and 38% had another type of delay. For school-aged children the PALS survey broke the developmental delay category down into more specific types of disabilities. A comparable category would be developmental disability, where 29.8% of school-aged children with a disability were affected.

Using annual reviews of records at schools, hospitals, and other sources, Boyle, Doernberg, Holmgreen, Murphy and Schendel (1996) found that the rates for mental retardation varied by age, race and gender. Children who had an intelligence quotient (IQ) equivalent to 70 or less were considered to have mental retardation. The overall prevalence for children (ages 3-10) was 8.7 per 1,000 children with approximately two

thirds of cases being considered mild. The prevalence of mental retardation was found to vary by age with a rate of 5.2 children per 1,000 in the youngest group increasing to 12.3 per 1,000 for children aged 9-10. The increase in prevalence occurred in those who had mild to moderate mental retardation. The prevalence of those with severe or profound mental retardation stayed relatively constant across the age groups (Boyle et al., 1996).

Boyle, Decoufle, and Yeargin-Allsopp (1994) noted that 17% of children ages 0-17 have a developmental disability based on data from the 1988 National Health Interview Survey – Child Health Supplement completed in the United States. They found that developmental disabilities had a substantial impact on the functioning of affected children with 3.5 times more hospital-days, 2.5 times more likely of repeating a grade in school, twice the number of school-days lost, and 1.5 times more doctor visits than children without these disabilities.

Chronic health conditions.

Asthma, severe allergies, complex medical needs, cerebral palsy, autism, heart disease/conditions as well as other conditions were identified as chronic health conditions in the PALS survey. They affected 1.0% of preschoolers and 2.6% of older children. For preschoolers with a disability, chronic health conditions caused activity limitations for 62.6%. For older children with a disability, this number increased slightly to 65.3% (Statistics Canada, 2002). Again it is important to note that the types of disabilities and conditions grouped together here are not necessarily the same categories used in other studies.

Individual rates for some of these chronic health conditions were available from other studies. Boyle et al. (1994) found that 0.2% of children aged 0-17 had Cerebral Palsy. In the 1996 study by Boyle et al., 2.4 per 1,000 children ages 3-10 had Cerebral Palsy.

Mental health.

For school aged children, the PALS survey found that 31.8% of children with a disability suffered from a psychological disorder (Statistics Canada, 2002). No specific breakdown of disorders was reported.

For children ages 4-18 the likelihood of having Attention Deficit Disorder (ADD) or Attention-Deficit Hyperactivity Disorder (ADHD) was at least three times greater for those children who were wards of the public trustee or child and family service agencies, in long-term care facilities, prisons and psychiatric facilities. For males it was 13.6% compared to 4.6%, and for females it was 4.8% compared to 1.3% (Martens et al., 2004).

In a study by Bertrand et al. (2001), Autism Spectrum Disorder was defined to include Autistic Disorder, Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS), and Asperger's Disorder. The prevalence of Autism Spectrum Disorder was 6.7 cases per 1,000 children (ages 3-10 years). The prevalence for children whose condition met full diagnostic criteria for Autistic Disorder was 4.0 cases per 1,000 children, and the prevalence for PDD-NOS and Asperger's Disorder was 2.7 cases per 1,000 children. A

study by Yeargin-Allsopp et al. (2003) found the prevalence for Autism was 3.4 per 1,000 with a male-female ratio of 4:1.

Sensory.

According to the PALS survey, 13.1% of children aged 0-14 years were affected by hearing loss and 9.2% had vision impairment (Statistics Canada, 2002, p. 9). In the United States, Boyle et al. (1996) found that the rate of moderate to severe hearing impairment was 1.1 per 1,000 children, and the rate of vision impairment was 0.8 per 1,000 children.

Learning disabilities.

The definition of learning disabilities created by the Association for Children with Learning Disabilities is:

A generic term that refers to a heterogeneous group of disorders due to identifiable or inferred central nervous dysfunction.... They are not due primarily to visual, hearing or motor handicaps, to mental retardation, emotional disturbance, or environmental disadvantage, although they may occur concurrently with any of these (as cited in Wiener & Siegel, 1992, p. 342).

A 1988 survey conducted by the Canadian Council for Exceptional Children found a wide variance in the number of children with a learning disability within the five provinces who participated (Wiener & Siegel, 1992). The percentage of children with a disability within the total population of children for each province was 10.2% (Quebec), 7.0% (Nova Scotia), 3.1% (Ontario), 1.7% (Saskatchewan) and 1.3% (British Columbia). The American study by Boyle et al. (1996) found that 6.5% of children had a learning disability.

Fetal Alcohol Spectrum Disorder.

Fetal Alcohol Spectrum Disorder (FASD) is a serious social and health problem for the child welfare, health and education systems in North America. FASD was recently coined to encompass the wide range of disorders caused by ethanol consumption. This includes full-blown 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 prenatal exposure to alcohol, growth deficiency, evidence of central nervous system neurodevelopmental abnormalities and facial dysmorphology among others.

Sokol, Martier and Ager (1989), reported that Fetal Alcohol Syndrome (FAS) is considered to be the most common cause of preventable mental retardation in the United States. Studies suggest that FAS may be more prevalent in disadvantaged or impoverished populations such as African Americans and Hispanics in the United States (Lewis, 1994; Jacobson, Jacobson, Sokol, Chiodo, & Corobana, 2004). In northeastern Manitoba, Williams, Odaibo and McGee (1999) found the prevalence of FAS to be 7.2 per 1,000 live births. Another Manitoba study, (Square, 1997) found that 55-101 children per 1,000 live births had either FAS or Partial FAS.

Children with alcohol-related disorders often have cognitive and behavioural difficulties that cause them to have problems in school and society. Koren and Nulman (2002) identified numerous common problems faced by these children and their families. These included: Attention-Deficit Disorder, inability to foresee consequences, inability to learn from previous experience, inappropriate or immature behaviour, lack of organization, learning difficulties, poor abstract thinking, poor adaptability, poor impulse control, poor judgment as well as speech, language and other communication problems.

Burgess (1994) believes it is necessary to support children with FAS or FAE in both school and beyond. Based on the experiences and wisdom of educators and families in Canada and the United States, she sets out some basic principles for educating these children:

- 1) In addition to academic skills, children should be taught functional skills like social interaction, solving problems, making decisions, getting and keeping a job, etc. that will help them become more independent.
- 2) Whenever possible develop an individualized program for the child which includes behaviour management strategies that promote independence.
- 3) Have reasonable expectations of the child based on both their IQ and any biological limitations that may exist.
- 4) Behaviour interventions may not work as the child may have trouble understanding or may forget the rules. This may be shown through challenging behaviour, which is in itself a form of communication.

While FASD is preventable, there are considerable difficulties with gathering information on maternal alcohol consumption. Umlah and Grant (2003) noted that women may feel shame or guilt related to their substance abuse. They also frequently come from families with significant problems such as poverty, and domestic violence which may make them distrustful of professionals. Chudley et al. (2005) also noted that difficulties may arise as some women may not consider their drinking to be important and consequently may under report maternal alcohol consumption.

Multiple disabilities.

Advances in medical technology have extended the lives of children with multiple disabilities and complex medical needs (Brett, 2004). Kendall-Tackett et al. (2005) describe a child who has more than one type of disability as having multiple disabilities. In the PALS survey, 49.1% of preschoolers and 71.8% of school-aged children with a disability had multiple disabilities (Statistics Canada, 2002, p. 13).

Often the needs of the child with disabilities are met within the home, usually by the child's mother. For children with multiple disabilities, this burden of care may be particularly difficult. Brett (2004) found that some parents felt they had established positive support networks while others felt alone, isolated, unsupported and like they were unable to cope any longer. Some parents of children with complex or multiple disabilities felt that asking for support was an admission of failure.

Cass, Price, Reilly, Wisbeach and McConachie (1999) suggested using an interdisciplinary model when working with children with multiple disabilities. This would allow both parents and professionals to determine priorities regarding the complex care and management issues faced by these children, their families and medical professionals.

Disabilities and Gender

PALS found that boys were more likely than girls to have a disability. Boys were also more likely to have most types of disabilities (Statistics Canada, 2002). This corresponded with the results found by the Australian Bureau of Statistics survey for children 0-14 years of age. Boys were almost twice as likely to have a disability as girls with 192,800 boys and 103,600 girls having a disability (Australian Institute of Health and Welfare, 2004).

Taylor and Rogers (2005) found that boys were more likely than girls to have developmental delays, in which they included Tourette's, early forms of Schizophrenia and learning disabilities. The PALS survey (Statistics Canada, 2002, p. 11) found that boys were also more likely than girls to have both learning disorders (68.9% compared to 58%) and psychological disorders (34.6% compared to 26.9%).

Child Protection and Children with Disabilities

There is considerable evidence that children with disabilities are at increased of maltreatment. Crosse, Kaye, and Ratnofsky (1993) found that in the United States, children with disabilities were 1.7 times more likely to be abused than children without disabilities. Sullivan and Knutson (2000) completed a study in Omaha, Nebraska with a sample of 50,278 children between the ages of 0-21 years of age. They identified 4,503 children who were maltreated either through neglect and/or physical, emotional or sexual abuse. Of those children who were maltreated, 1,012 had a disability. For non-disabled children the rate of maltreatment was 11%, while the rate for disabled children was 31%. This meant that children with a disability were 3.4 times more likely to be maltreated than non-disabled children.

As part of this study, Sullivan and Knutson (2000) also compared children by type of disability to non-disabled children in terms of their risk for the four types of maltreatment they identified. Children with behavioural disorders were found to be at the highest risk of abuse. They were seven times more likely to be neglected, and/or be physically or emotionally abused, and five and a half times more likely to be sexually abused. Speech and language difficulties resulted in five times the risk of disabled children suffering neglect and physical abuse, and three times the risk of being sexually abused. Children with a developmental delay had four times greater risk of all four types of maltreatment. Deaf and hard of hearing children had twice the risk of being neglected or emotionally abused and were almost four times more likely to be physically abused. Those children with learning and orthopedic disabilities had twice the risk of all types of neglect.

Sullivan, Knutson, Scanlan and Cork's study (as cited in Krahn et al., 2000) also found that children with a disability were more likely to be abused or neglected. Specifically they were 1.6 times more likely to be physically abused, 2.2 times more likely to be sexually abused, and 1.8 times more likely to be neglected. In addition, the risk of abuse for these children increased if they had multiple disabilities. In Oregon, Krahn et al., (2000) found that the presence of a disability increased the effects of poverty, social isolation and stress on the likelihood of abuse occurring. Limited parental understanding of a child's disability, inadequate supports and long-term child care needs further increased the odds that a child with a disability would be maltreated.

Cooke and Standen (2002) completed a study on abused and neglected children in the United Kingdom. Questionnaires were sent out to the 121 chairs of the area Child Protection Committees. Information from the 73 who responded demonstrated that there was a lack of statistical information on children with disabilities involved with child protection committees. Children with disabilities were less likely than children without disabilities to be put on the child protection registry of child victims.

These results were contradicted in a study by Morris (1999) who determined that boys with disabilities were four times more likely than boys with no disability to be registered as victims on one county council child protection register. It was noted that since disability was not clearly defined, Morris' results should be treated with caution.

There were several recommendations made as a result of Cooke and Standen's study (2002) including: 1) recording and computer forms that allow child protection and child disability teams to identify children with disabilities being investigated for abuse; 2) using a computer system which can effectively extract statistical information on abused disabled children; 3) creating training programs for staff members of both teams on abuse awareness, definition of disability and forms of recording; and 4) creating a clearly defined protocol to ensure better communication between child protection teams and child disability teams. In a Manitoba report, Brown, Moraes, Bednar and Mayhew (2004) made several similar recommendations to promote the successful foster placement of children with disabilities. These included the training of foster parents and social workers in the nature and requirements of disabilities.

Placing Children with Disabilities in Care

When examining family factors that influence out-of-home placement decisions, Llewellyn, Dunn, Fante, Turnbull, and Grace (1999) examined the experiences of 167 families with a child with a disability that required a high level of support. To be eligible the families had to have a child between the ages of 0-6 with a physical, intellectual, sensory or multiple disability. Parents and/or service providers could identify the child as having a great need for supports which the general child service system was unable to meet.

Researchers identified three types of families: those who did not want to place the child (75%), those who were undecided (19%) and those who were actively seeking or had

already sought a placement (6%). There was no difference between the three types of families in terms of being proactive, finances, father's involvement, mother's availability and religion. There was however a difference in terms of values and beliefs about caring for the child, change in family circumstances and messages received about out of home placement.

Summary

Disability occurs as a consequence of the interaction of the individual and their environment. The literature presents a somewhat confusing picture of the prevalence of disability in children in Manitoba. There does, however, appear to be a significantly higher rate of disability in Aboriginal children compared to the general population. It is clear that many children do have disabilities that are reflected in their intellectual, psychological, physical, medical and/or sensory functioning. Developmental delays and psychological disorders are the most commonly described disabilities in children. Boys have disabilities more often than girls. Multiple disabilities affect the majority of children with disabilities. Unfortunately, children with disabilities are at increased risk of maltreatment and neglect.

III. Methodology

Research Design

This study was exploratory and descriptive in design. The choice of research design was dictated by the need for a descriptive profile of children with disabilities who were involved with child welfare agencies in Manitoba. There has been a dearth of research in this area. When the project was initiated, it was not possible to determine the number of children in care with disabilities. There was no existing information on which to base any hypotheses for this research. The study examined a single sample of children in the care of mandated child protection agencies in Manitoba on September 1, 2004. It also gathered information on children in families whose CFS file was open at the time of data collection in that agency.

The initial tasks included the development of a definition of disability, the creation of a data collection instrument, the design of data collection process and the pre-testing and refining of the definition, instrument and process. These initial tasks were informed by a conceptual framework that was developed for the project and stands as one of the first products of the study.

The conceptual framework attempted to incorporate the elements of the ecological or biopsychosocial model of disability. This meant it needed to include body components, the person as a whole and the environment. The framework situates the child as a whole (represented by their functioning) within the family and subject to the influences of their internal characteristics of assets and impairments and external environmental factors. The environmental factors identified as relevant to this research are adaptive services and service providers.

Definition of Disability

Establishing the definition of disability was a critical first task in the development of this project. It was important that the definition met three criteria:

- Broad – It needed to capture a wide enough sample to provide as much information as possible, i.e. present the big picture.
- Concise – It needed to be easily interpreted and consistently understood by a variety of workers and agencies.
- Relevant – It needed to recognize current thinking in the field of disability so that results were meaningful and comparable to existing and future research studies.

Based on disability as redefined by the World Health Organization, we developed a conceptual framework that became the structural matrix for identifying, describing and analyzing children with a disability. Disability was conceptualized as shown in Figure 3.1 as one of the factors impacting the functioning of a child and his/her family. Functioning was also influenced by adaptive services and service providers detailed in (Table 3.1).

Figure 3.1
Conceptual Framework

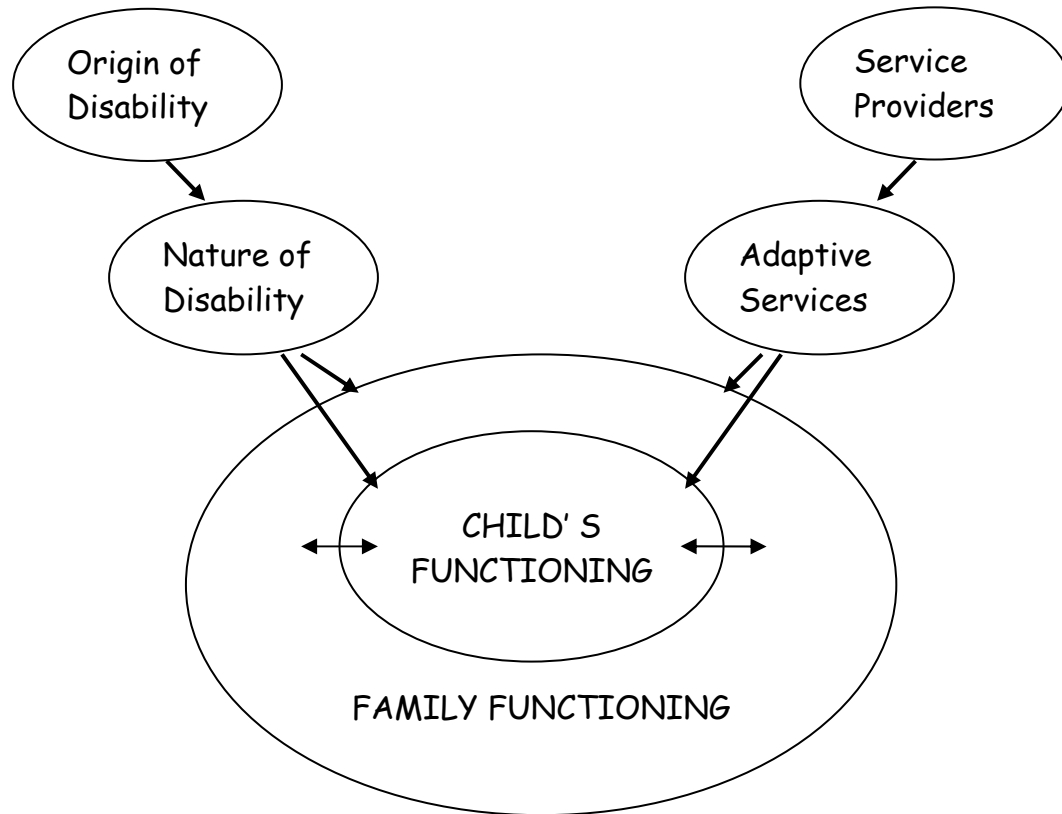


Table 3.1
Components of Factors Related to Functioning

| Factor | Components | |
|-----------------------------|---|--|
| Origin of Disability | <ul style="list-style-type: none"> ▪ Genetic ▪ Medical | <ul style="list-style-type: none"> ▪ Injury ▪ Substance abuse |
| Nature of Disability | <ul style="list-style-type: none"> ▪ Physical ▪ Medical ▪ Sensory perceptual | <ul style="list-style-type: none"> ▪ Cognitive intellectual ▪ Mental health |
| Functioning & Service Needs | <ul style="list-style-type: none"> ▪ Physical ▪ Medical ▪ Sensory perceptual | <ul style="list-style-type: none"> ▪ Cognitive intellectual ▪ Mental health ▪ Behavioural |
| Adaptive Services | <ul style="list-style-type: none"> ▪ Medical ▪ Mechanical | <ul style="list-style-type: none"> ▪ Technical ▪ Support |
| Service providers | <ul style="list-style-type: none"> ▪ Government ▪ Non-government | |

Our view of disability and functioning included physical, medical, sensory, intellectual and mental health components. Adaptive services also comprised several elements: medical, mechanical, technical and personal support.

The definition that was developed was an attempt not to classify children but to describe their health in the context of personal and environmental factors. Therefore children with disabilities were defined as those children whose ability to participate in age-appropriate activities of daily living is compromised by limitations in one or more areas of functioning. More specifically, the definition included children with congenital conditions (e.g. Spina Bifida, Down Syndrome) as well as children who have experienced life changing illness or injury. It included children with complex medical needs and those with chronic psychological or mental health concerns. It also included children with Fetal Alcohol Spectrum Disorder (FASD) and children with learning disabilities.

Plans for the care of children with disabilities always included adaptations to the environment (home, school) that were necessary to meet their special needs. Environmental adaptations might be described as medical care (e.g. essential medication routines, physiotherapy), mechanical aids (e.g. wheelchairs, prostheses), technical devices (communication aids, computer programs) and/or personal support services (e.g. 24 hour supervision or in-home support workers).

Excluded from the study were children who required special care as a result of difficult to manage behaviour that was not related to a diagnosable condition.

Measures

Development of Instrument

Two factors shaped the development of the data collection tool: the conceptual framework of disability that was adopted by the project and the existing child welfare information gathering system. Because we were relying entirely on information that could be found in the agency files, it was important that the tool be designed to collect information that was likely to be available. To this end, the information that was currently in the CFS database was reviewed. Files of level 5 children with disabilities housed at the Child Protection Branch were examined. Formats for social histories, annual reviews and special needs requests as well as child care instruction sheets were also useful in estimating the nature of information that would be typically found in agency files. This investigation resulted in the decision to limit the research project by excluding financial information. The system for recording financial expenditures including special needs varied by agency and expenditures could not be easily or reliably attached to individual children.

Knowing what information would likely be available, it remained to design the tool so that information could be gathered related to the domains outlined within the conceptual framework established for the study. As previously indicated and illustrated in Figure 3.1, the framework was structured to include the nature of disability and its origin as well

as adaptive services and service providers as factors influencing child functioning. Therefore, in addition to basic demographic information, information was gathered on the nature of the disability (or disabilities) and associated impact on physical, medical, sensory, intellectual or mental health. Where indicated, the origin of the condition was also noted. The tool further gathered information on the child's current functioning physically, medically, intellectually and behaviourally. Finally the nature of the adaptive services provided including medical, mechanical, technical, and/or personal and their source was recorded. Review of the file information suggested that using functional information as a criterion for inclusion in the study would present difficulties. The functioning information tended to be somewhat less available and more subjectively recorded. Therefore, criterion for inclusion was based on a medical diagnosis of a chronic condition affecting functioning. Suspected diagnoses were also considered. The data collection instrument is appended (Appendix A).

Items on the tool were derived and or adapted from a variety of sources. Categories used for placement, reasons for care, culture of origin, and culturally appropriate authority were taken directly from the Child and Family Services Information System (CFSIS). Construction of the items relating to the nature of functioning was informed by a review of items in the International Classification of Functioning (ICF) (WHO, 2001), by the assessment tool Looking After Children (Flynn & Ghazal, 2002), and Matheson's (2001) description of conceptual factors from the Functional Assessment Taxonomy (FAT). Medical supports were categorized using the Unified Referral and Intake System (URIS) as outlined in Appendix B. URIS is a method of classifying health care procedures. It was developed as a joint initiative of the Manitoba departments of Family Services and Housing; Education, Citizenship and Youth; and Health (1999) to standardize description of health care supports required by individuals. Specific disabilities, mental health conditions and origins of disability were added to the tool as they arose during data collection.

Coding Decisions

Many decisions were made to clarify definitions used in the study and ensure that information could be reliably collected by more than one researcher. Some of those decisions are important to understanding the nature of the information collected.

Intellectual Disability for the purpose of this study included anyone with an assessment of developmental delay, Fetal Alcohol Spectrum Disorder or cognitive impairment. Cognitive impairment has been variously interpreted. As one of the purposes of this study was to get the broadest possible picture of children affected by disability, those children with borderline IQ were included. That meant that anyone assessed with an IQ of less than 80 was included as having a cognitive impairment, although some jurisdictions, including Manitoba, set the IQ criteria at 75.

Fetal Alcohol Spectrum Disorder (FASD) was used as an umbrella term to include all diagnosed Fetal Alcohol Syndrome, Partial Fetal Alcohol Syndrome, and Fetal Alcohol Effects. To be recorded as diagnosed, the child's file had to include a physician's

assessment, Child Development Clinic (CDC) assessment or Clinic for Alcohol and Drug Affected Children (CADEC) assessment. If the child was awaiting assessment, or was receiving services related to FASD as though the diagnosis had been made, the child was counted as suspected. At no time was social worker assessment deemed enough evidence for counting as a diagnosis. An assessment of being “at risk” of FASD was not counted as diagnosed or suspected. The FASD50 category was created to include any children who might be suspected of FASD due to a history of prenatal substance abuse and non age-appropriate development but for whom assessment was limited by lack of access to or availability of diagnostic services.

Learning disability in this study was intended to be distinct from global intellectual deficiency. It was defined as a disability affecting the learning of individuals who otherwise demonstrated average abilities essential to thinking and reasoning.

Further Use of Measure

Gathering the data for this research was time consuming and labour intensive. It necessitated travel throughout the province to agencies and outreach offices and manually reviewing thousands of files. In the future this information will be available simply by requesting summary reports from CFSIS. The items on the measure developed for this study have been incorporated into the CFSIS system. The information that was gathered in this study is being entered into the updated CFSIS system. This will make more detailed analyses of the current data possible. It will also establish a baseline for future comparison. The amended information system will require workers to identify and describe children with disabilities. Examples of the disability screens that workers will use have been appended (Appendix C). In addition more detailed information on the child’s educational history will also be gathered. These changes will make it possible to track the placement history of children with disabilities hopefully leading to more clearly understanding what factors are associated with children with disabilities coming into the care of a protection agency. The changes to the system will allow more detailed assessment of service delivery and service delivery over time. This will assist in identifying gaps and evaluating the effectiveness of services. The incorporation of the research tool into the existing information system is a concrete outcome of this research project.

Sampling

In view of the number of child in care (CIC) cases in Manitoba and the constraints on resources available to the study, it was necessary to design a process that did not involve the review of every case. To avoid that eventuality and still include every agency or office unit in the province, it was determined that agency staff would make the initial identification of children with disabilities. Agencies/units were provided with a list of children who were in their care on September 1, 2004. From that list, they identified children who met the criteria for disability as outlined in the research definition. The identification of children meeting the definition was the only required involvement of CFS agency staff for inclusion in the research project. Members of the research team

reviewed the files of those children identified. Data were collected using the profile sheet developed. In addition, random sampling of files not identified was added to the research protocol. This provided a means of verifying that the disability definition was reliably applied to children in care. When referred cases were eliminated from the child in care case lists, researchers requested every third remaining file for review as a random sample. Where more than 5% of the random files were found to meet the criteria for disability (i.e. an error rate of 5% or greater), all the files on the particular caseload with the above 5% error rate were reviewed.

Data Collection

To enlist the support of the four child and family services Authorities, members of the research team attended a meeting of the Standing Committee on October 5, 2004 and presented information about the project, explained what would be required of CFS agency staff and answered questions. The members of the Standing committee appreciated the usefulness of the information to be collected in the study and endorsed the participation of their agencies. Initial information describing the project was forwarded from the Authorities to their constituent agencies.

With the support of the Authorities, agencies were contacted and data collection began. Because it was not possible to fully anticipate the amount of time it would take to access agency records and to maximize the data collection within the time allowed, the agencies and units with the largest concentrations of children in care were approached first. Therefore, the first units reviewed were the Winnipeg permanent ward units. These were followed by CFS of Western Manitoba and then smaller Winnipeg and rural units.

Another consideration in the scheduling of data collection was the timetable for the devolution of cases to their chosen Authority of Service. During the study, Manitoba was in the process of a restructuring of the child and family services system to facilitate the provision of more culturally appropriate services, resulting in a transfer of files among agencies, mainly from mainstream agencies to First Nations and Métis agencies. Some agencies had completed file transfers at the time of data collection (e.g. CFS of Western Manitoba and CFS of Central Manitoba). Where devolution of files had occurred prior to data collection but after the September 1, 2004 data collection date, data was gathered from the agency holding the file on September 1, 2004. This was possible because transferring agencies maintained the original files and transferred copies of materials to the receiving agency. To complete data collection in Winnipeg units prior to their scheduled transfer of files in April 2005, collection of data from all Winnipeg units was made a priority early in 2005. The timing of northern data collection was delayed to allow northern units of the General Authority to complete their file transfer process. The scheduling of data collection in the Island Lake CFS agency had to wait for the lake to be clear of ice.

Our initial approach to many agencies required a full explanation of the project, its intent and the extent to which agency workers would be required to assist. With very few exceptions, agencies were interested in being involved in a project looking at children with disabilities. It was important that the required involvement of agency staff was

limited. In general, researchers contacted agency directors and supervisors to arrange data collection. One notable exception was the contact with the Awasis Agency of Northern Manitoba. This agency was in the process of conducting its own research related to children with complex medical needs. With the assistance of the Awasis worker involved in their project, our researchers met with several agency personnel from a variety of Northern First Nations communities. This information sharing meeting facilitated the inclusion of agencies in Cross Lake, Island Lake, Nelson House and Norway House. The cooperation between the Awasis project and this project extended to shared data collection in Nelson House, Cross Lake and Norway House.

Once a mutually acceptable time was agreed on, the project staff travelled to the agency's main office and, in some cases, to their outreach office as well to gather data using the tool designed for the project. Agencies were asked in advance to identify children with disabilities from the list of children in care on September 1, 2004 and also to identify children with disabilities in families currently receiving services. Most agencies were able to use the definition of disability to provide lists of children with disabilities. Where agencies did not provide lists, researchers used one of the following alternatives: the special rate was used as an initial determinant of disability; workers were consulted to produce a list on the spot; or researchers undertook a full file review. Within the agencies, the procedure for data collection varied according to agency protocol regarding files. In some instances, files were stored in central filing systems or at workers' desks. In other settings, files were handled only by clerical staff and brought out according to lists that had been provided or had been developed as part of the random sample process.

Two main researchers completed the majority of the data collection across Manitoba. To increase efficiency and due to time restraints, the data collection team was expanded in some areas of Manitoba. Two University of Manitoba social work students assisted in data collection, one with Anishinaabe Child and Family Services and the other in Thompson. Two Child Protection Branch staff assisted with data collection in the North Region offices of Thompson, The Pas and Flin Flon. As previously indicated, the project manager from the Awasis program related to Children with Complex Medical Needs also assisted with data collection in Nelson House, Norway House and Cross Lake.

Individuals who assisted with data collection received training from the main research staff². This included an introduction to the data collection tool and code book outlining coding decisions. In addition, several file reviews were completed under the supervision of the research staff to ensure consistency amongst reviewers.

Children in Care

Data collection began in October 2004 and concluded in June 3, 2005. In total, the files at 45 office sites for 21 agencies were reviewed representing 5,088 children in care. A total of 2,381 files were referred and 2,300 of those were reviewed. The 81 that were not reviewed were unavailable for a variety of reasons. Some were sealed after a child reached age of majority. Some were not in the office because of court proceedings.

² The social work student assisting in the North was trained by another northern assistant.

Others were not found due to the preparation and movement of files related to the devolution to the Authorities. Of the files referred, 577 did not meet the established criteria for disability. An additional 803 files were selected as the random sample. From the sample, 102 children were identified with a disability. Because in some instances the number of additional children with disabilities found in the random sample exceeded our 5% error tolerance, an additional 156 files was reviewed. Of those, a further 51 were found to meet the criteria for disability. From the review of 3,259 files of children in care, 1,869 children meeting our definition were identified.

While we were not successful in including every agency in Manitoba, our total of agencies with 5,088 children represents the equivalent of 90% of the children who were listed in the CFSIS system³ on September 1, 2004. Data collection was completed in every unit of Winnipeg CFS that provided services to children on an ongoing basis (e.g. Intake units were excluded). Data collection was also completed for nine of the ten agencies in the General Authority. The Métis Authority did not have assigned cases on September 1, 2004 and children now under their jurisdiction were reviewed prior to transfer. Data collection for the five Northern Authority agencies was completed in three of their agencies and partially completed in two agencies. Six of the seven Southern Authority agencies were also completed. This degree of inclusion ensures that the database is widely representative of agencies throughout the province including rural and urban areas, and provincial and mandated agencies in north, south and central Manitoba.

Children Not in Care but Receiving Services

Children not in care but living in families who were receiving services were a secondary focus of the data collection. Agencies referred 264 family files for review. From those files, 226 children with disabilities were identified and profiled. There was no random sample of family files. The referral of family files was inconsistent with only 25 sites making referrals and one site offering 20% of the referrals.

Data Analysis

Preliminary Analyses

The first preliminary analysis was conducted on the data collected during the pre-test phase. In August 2004, the definition, tool and method were pre-tested in two Winnipeg CFS units. The units represented a total child in care caseload of 170 in addition to families with open files. A sample analysis was completed on the 74 cases of children with disabilities that were found. Based on the test experience, minor adjustments were made to the data collection instrument to increase its specificity. The very preliminary findings on the analysis of 74 cases were used to demonstrate the utility of the project and presented for that purpose to the four Authorities in October 2004.

³ In five agencies that were reviewed, the number of CIC recorded on CFSIS was inaccurate. This created a slight difficulty in calculating the precise percentage of children in care with a disability. For purposes of calculation we have used the September 1, 2004 CFSIS total of 5,664 children in care.

A second preliminary analysis was conducted in January 2005 for inclusion in the interim report to the funders. By January, 43% of children in care had been reviewed and 1,039 children with disabilities had been profiled. An additional 61 children with disabilities but not in care were also identified for a total of 1,100 children included in the preliminary descriptive analysis.

Primary Analysis

Data was entered into the statistical program SPSS 13 by individual research staff and merged into a single database. The database was checked for missing entries and errors by checking the range and frequency of variables. Variables that were related or dependent were checked for matching frequencies. Errors were corrected by referring to the original data profiles. Any duplicate profiles were eliminated. Once errors had been corrected and there were no duplicates, the names of children were deleted from the database. Missing data was coded in two ways. Where researchers had failed to complete an item, it was coded as “coder error”. Where data was not available from the file it was coded as “no data”.

Statistical Significance

In accordance with standard practice, a statistical significance level of .05 was adopted for this study.

Limitations

Limitations to this study should be noted in the areas of research design, sampling and measurement.

Design

The design of this study employed a file review. The information collected had to first be available in the file and the resulting profiles cannot be more accurate than their source. There may have been children who met the disability definition but were not counted because their file was not complete or up to date. Research information was also dependent on the accuracy and immediacy of the filing systems used by agencies. Agencies varied considerably in their approach to information retention. It is also possible that information on the file was missed by the researchers. The files of some children included many volumes and early diagnostic information may not have been found in spite of best efforts from the researchers. Also, as previously indicated, some of the files that were identified for review were not available. The timing of this research project coincident with the restructuring of the child welfare service delivery system created some degree of difficulty with access to files that would not otherwise have occurred. In some instances, files were unavailable because workers were away updating files for transfer.

Sampling

The project attempted to complete data collection in every agency in the province. However, gathering a complete sample presented a number of challenges and we were unable to meet this goal. First, we were not successful in completely accessing every agency. We were unable to gather any data from one agency and gathered partial data from two others. A fourth agency was not approached due its extreme distance and small CIC caseload (12 children). In general, data collection in the most northerly communities was hindered by the limited cost effectiveness of travelling long distances to access the files of a small number of children.

Second, there were limitations in the accuracy and comprehensiveness of the CFSIS database which we were using to identify children in care. CFSIS was used consistently throughout the research project for demographic information. However, some agencies do not use the CFSIS system at all and others have incomplete data entered into the system. This creates some inaccuracy in the actual numbers of children in care in the Province. This project had no way to quantify the missing children. In agencies where we collected data and the CFSIS lists were inaccurate, agencies provided us with more complete lists of their children in care. Although an undetermined number of children have not been included, we do know that the study has applied its sampling technique to 5,088 children in care files when CFSIS was reporting 5,664 children in care files. That is the equivalent of 90% of the files that were open on September 1, 2004.

Sampling difficulties were particularly noted in the area of children receiving services but not in care. For children in care we were able to provide agencies with lists and create random sample lists. For children not in care, we were entirely dependent on the recollection of and identification by agency staff. Some agencies identified a number of children living in families who were receiving services but many agencies did not identify any children not in care. The result is a small convenience sample that cannot be considered representative.

Measurement

There are a number of ways in which inaccuracies may have been incorporated into the profiles. Consistency is of utmost importance to reliable data collection. Most of the data was gathered by two researchers who worked side by side and consulted regularly on any questions arising from the files. However, four other research assistants also contributed to the database. Three of the assistants were trained by the staff researchers and one assistant was trained by another assistant. Training and provision of a codebook were designed to enhance consistency. However, multiple researchers increased the possibility of inconsistency and lack of interrater reliability. In addition, there were some areas where there appeared to be obvious inconsistency in the interpretation of file information. This was most notable in the area of disability = learning disability and origin of disability = family trauma. Both of these variables appeared to be over reported by research assistants. Also, although the coding decision was that only diagnosed FASD would be included as origin = substance abuse, a number of children with

suspected FASD were reported as origin = substance abuse. While it was possible to correct the suspected FASD origin, we were not able to reliably alter the other reported variables without returning to the files. As this was beyond the scope of the project, the possibility of inaccuracy in these areas remains as a limitation of the study. A further source of error lay in the potential for subjective interpretation of information. This subjectivity might be in the person writing in the file or the researcher reading the file. Areas of functioning and the severity of problem behaviour were particularly vulnerable to personal judgment. For example, there might be significant differences in the way in which workers would describe the same behaviours. Also, in many cases, researchers needed to extrapolate from the information available on the file and make a determination on the social and emotional age-appropriateness of a child's behaviour. If there was limited information, or the information was unclear or contradictory then the item would be scored as "no data". However, it must be recognized that these items create ongoing challenges to consistency and therefore the reliability of results.

IV. Profiles of Children with Disabilities Involved with the Child Welfare System

This chapter presents the major findings of the study. It uses the study's theoretical framework as the means to characterize the profiles of children with disabilities. The chapter presents the demographic profiles of the children and describes the nature and origin of their disabilities. Also, it outlines the findings relating to their functioning, service needs and the type of services they received. Finally, the chapter offers a brief review of results relating to children with disabilities not in care but receiving services and a summary of the major findings of this study.

General Demographics

Gender and Age

As noted previously, the files of 3,259 of the 5,664 children in care on September 1, 2004 were examined. Our examination found that 1,869 or 33% of the total number of children in care met the disability criteria outlined by our research definition. The majority of children with disabilities were male, with 1,126 males (60.2%) and 743 females (39.8%).

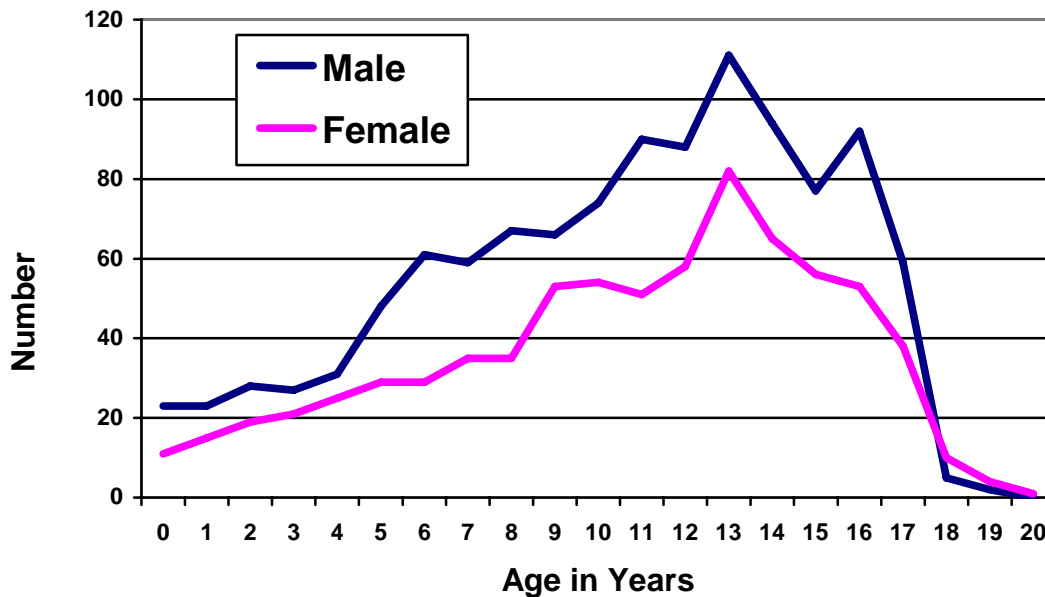
The children ranged in age from 0-20 years with a mean age of 10.5 years. There was no significant difference in age based on gender (males: \underline{M} = 10.6 years, \underline{SD} = 4.5, females: \underline{M} = 10.4 years, \underline{SD} = 4.5). The highest number in both genders was in the latency stage of childhood. A comparison of the ages of children by gender is provided in Figure 4.1.

Culture of Origin

Information provided in CFSIS or in the files was used to determine a child's culture of origin. If a culture of origin was not assigned in either place then the child's culture of origin was listed as undetermined. Of the 1,869 children in care with a disability, 1,472 (78.8%) were of Aboriginal descent. A further breakdown of the culture of origin of children with a disability shows: 1,213 Treaty (64.9%), 368 non-Aboriginal (19.7%), 188 Métis (10.1%), 69 Non-status (3.7%), and 2 (0.1%) Inuit. An additional 29 (1.6%) had an undetermined culture of origin.

Significant differences were found between the mean ages of children in the three main culture of origin groups. The mean ages were: 9.9 years for First Nations children, 11.4 years for Métis children, and 12.2 years for non-Aboriginal children. The groups were compared using independent samples t-tests. The difference between First Nations (\underline{M} = 9.94, \underline{SD} = 4.5) and Métis [\underline{M} = 11.40, \underline{SD} = 4.24, p = .00] was significant. The difference between the First Nations children (\underline{M} = 9.9, \underline{SD} = 4.5) and the non-Aboriginal group [\underline{M} = 12.20, \underline{SD} = 4.00, p = .00] was significant as was the difference between the Métis (\underline{M} = 11.40, \underline{SD} = 4.17) and the non-Aboriginal group [\underline{M} = 12.20, \underline{SD} = 4.00, p = .03].

Figure 4.1
Age of Children by Gender



There was a gender difference found for children in care with a disability based on culture of origin. First Nations included 72.4% of the total number of girls (538) and 66.3% of the total number of boys (746). There were 16.6% girls (123) and 21.8% boys (245) who were non-Aboriginal, and 9.3% girls (69) and 10.6% boys (119) who were Métis. In addition, 1.7% of girls (13) and 1.4% of boys (16) had an undetermined culture of origin.

Culturally Appropriate Authority

As part of the restructuring of the child and family services system in Manitoba, persons involved with a child and family services agency were assigned a Culturally Appropriate Authority (CAA) based on their cultural ethnicity in relation to the four child and family services Authorities. The four Authorities are the First Nations of Southern Manitoba Child and Family Services Authority (Southern Authority), the First Nations of Northern Manitoba Child and Family Services Authority (Northern Authority), the Métis Child and Family Services Authority, and the General Child and Family Services Authority. Of the total number of children in care with a disability, 857 (45.9%) were from the Southern Authority, 415 (22.2%) were from the Northern Authority, 374 (20.0%) were from the General Authority, and 200 (10.7%) were from the Métis Authority. The CAA of an additional 23 (1.2%) children was not yet noted in the file.

Legal Status

The legal status of children was derived from the recordings in CFSIS or from the Child Care Instruction Sheets found within the file. Children, who were permanent wards, made up the largest group with 1,284 (68.7%) children. There were 236 (12.6%) children under Voluntary Placement Agreements (VPA), 130 (7.0%) under apprehension and 93 (5.0%) who were temporary wards. In addition, there were 38 (2.0%) children who were in care under a Voluntary Surrender of Guardianship (VSG), 37 (2.0%) with an Order of Supervision, and 2 (0.1%) who were in transition planning.

The ages of the main legal status groups were examined: temporary wards (\underline{M} = 9.14 years), permanent wards and VSG (\underline{M} = 10.64 years), and those placed under a VPA (\underline{M} = 11.79 years). An independent-samples t-test was conducted to compare the mean ages of the permanent ward and the VPA groups. There was a significant difference between the age of the permanent wards (\underline{M} = 10.64, \underline{SD} = 4.34) and those in care under a VPA (\underline{M} = 11.79, \underline{SD} = 4.07, $p = .00$).

The proportion of legal status varied in culture of origin groups. VPAs were used most often for non-Aboriginal children 30.7% (113) compared to First Nations children 7.5% (96) and Métis children 14.5% (10). Correspondingly, a greater proportion of First Nations children became permanent wards 75.4% (968) compared to both Métis children at 67.6% (127) and non-Aboriginal children at 48.4% (178). The chi square calculation for grouped legal status and culture of origin groups showed differences were significant ($p = .000$).

Reason for Coming into Care

Reason for coming into care was derived from CFSIS or the Child Care Instruction Sheets found within the file. Only the most recent reason for coming into care was recorded. 'Conduct parent' (738 or 39.5%) and 'Conditions parent' (323 or 17.3%) were the two most common reasons for children with disabilities coming into care. 'Conduct parent' refers to unspecified reasons related to the parent that require a child to come into care. 'Conditions parent' refers to the temporary or permanent incapacity of parents to fulfill their parental role. Such conditions may include physical handicap, mental illness, emotional illness, severe physical illness and mental deficiencies.

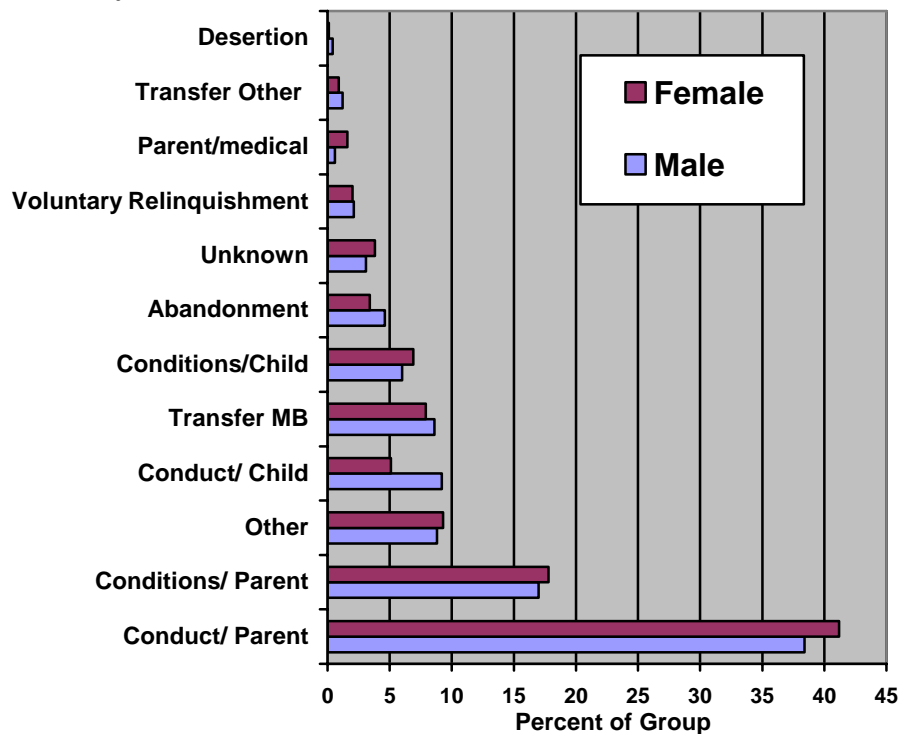
More children with disabilities were found to come into care as a result of the conditions or conduct of the parents than the conditions or conduct of the child. It was found that 142 (7.6%) of children came into care because of conduct of the child and 118 (6.3%) due to conditions of the child. 'Conduct child' refers to such behaviours as running, blatant defiance, etc. that made it difficult for parents to continue with the responsibility of parenting the child. 'Conditions child' refers to temporary or permanent conditions, such as a mental or physical handicap, that make it difficult for the parents to continue with parenting responsibilities for the child.

Other reasons for coming into care include ‘Abandonment’ (77 or 4.1%), ‘Voluntary relinquishment’ (39 or 2.1%), ‘Conduct parent medical refusal’ (19 or 1.0%), and ‘Desertion’ (5 or 0.3%). ‘Abandonment’ refers to the parents leaving the area without starting a plan for the child or indicating when they might return. There is no intent to return. ‘Voluntary relinquishment’ indicates a thought-out decision by the parents to allow an agency to make a permanent plan for the child. ‘Conduct parent medical refusal’ refers to the inability or refusal of parents to provide appropriate medical care for the child/ren. ‘Desertion’ implies that a meaningful relationship exists between parent and child and that a conscious decision to renounce this relationship is made.

Some reasons for care describe administrative procedures such as: ‘Transfer in from a Manitoba agency’ (this would include transfers to Aboriginal agencies that took place before September 1, 2004) that applied to 156 (8.3%) children and ‘Transfer in from out of province agency’ that accounted for 21 (1.1%) children. An additional 168 (9.0%) children were classified as other and for 63 (3.4%), reason for coming into care was unknown.

A gender comparison of reasons for coming into care showed little difference between genders in most categories. It was however interesting to note that for ‘Conduct parent’ there was a greater proportion of females (41.2% or 306) than males (38.4% or 432) while in ‘Conduct child’ the proportion of males was (9.2% or 104) compared to females (5.1% or 38). See Figure 4. 2.

Figure 4.2
Reasons for Care by Gender

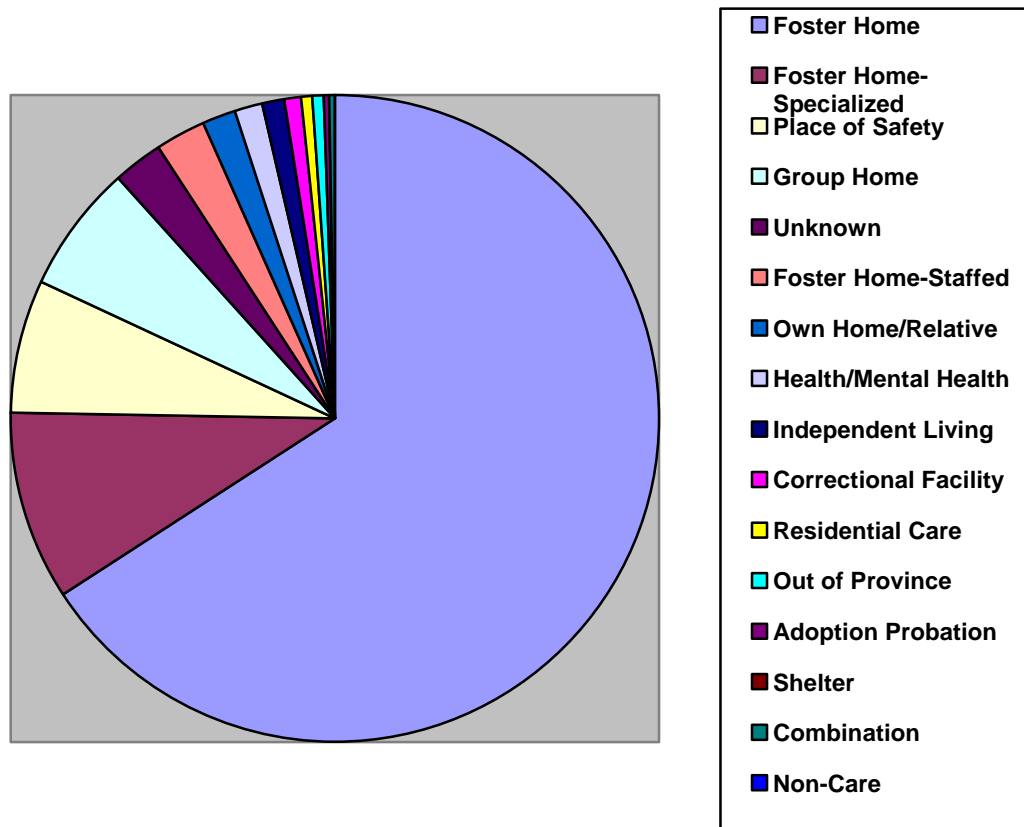


Reasons for care were analyzed by legal status. Permanent wards (61.2%) tended to be in care as a result of parent conduct (42.3%) and parent conditions (18.9%). In contrast, conduct and conditions of parents accounted for only 25.9% of the reasons for care of children under a VPA. For 49.6% of VPAs the reason for care was related to the child ('Conduct child' 29.7% and 'Conditions child' 19.9%). For a chart and complete table of reasons for care by legal status see Appendix Figure A 4.1 and Table A 4.1.

Placement

The child's residence on September 1, 2004 was considered to be their placement. Approximately 84% (1,568) of children in care with a disability were in a foster or group home: foster home 65.7% (1,228), foster home specialized 9.6% (179), group home 6.3% (118), and foster home staffed 2.3% (43). Although this was a population of children with disabilities, only 1.5% (28) children were in health or mental health facilities (hospital) and 0.6% (12) were in residential care. Other placements included: 16.7% (26) place of safety, 1.7% (32) own home/relative (non-pay), 1.1% (20) independent living, 0.4% (7) out of province, 0.3% (6) adoption probation, 0.1% (2) a combination of placements, 0.1% (2) in a shelter, and 0.1% (2) in a non-care situation. An additional 2.6% (48) had an unknown placement. This is shown in Figure 4. 3.

Figure 4.3
Placement of Children with Disabilities



When comparing placement by gender, it was found that proportionately more females (N = 518 or 69.7%) were in foster homes than males (N = 710 or 63.1%). Although numbers were small, males were proportionately more often in staffed foster homes (male = 35 or 81.4% & female = 8 or 18.6%) and correctional facilities (male = 13 or 81.3%, female = 3 or 18.8%).

Examining placement by legal status showed that most permanent wards, 73.8%, were placed in foster homes (947) while a much smaller proportion of those under a VPA, 40.7%, were in foster homes (96). The proportion of children requiring more intensive care placements was greater among those under a VPA than permanent wards. For VPAs specialized foster homes = 12.7% (30), staffed homes = 6.4% (15), group homes = 13.1% (31), health/mental health facility = 7.6% (18), and residential care = 0.8% (2). For permanent wards specialized foster homes = 10% (128), staffed homes = 1.2% (16), group homes = 4.1% (53), health mental health facility = 0.4% (5) and residential care = 0.5% (7).

Family Involvement

Family involvement referred to contact between the child and the parent, guardian or person who was the primary caregiver before the child came into care. It did not include sibling, grandparent or other family visitations if those relatives were not the guardian or primary caregiver at time of coming into care. This required the researchers to estimate how often there was family involvement based on notes found within the files.

It was most common for children in care with a disability to have no contact with their families (598 or 32.0%). This was true for 344 (30.6%) boys and 254 (34.2%) girls. The second largest group, 454 (24.3%) children had regular monthly or more visits (males = 276 or 24.5%, females = 178 or 24.0%). There were 352 (18.8%) children who had irregular visits (males = 209 or 18.6%, females = 143 or 19.2%). Only 76 (4.1%) children had less than monthly visits (males = 43 or 3.8%, females = 33 or 4.4%). For an additional 389 (20.8%) children, family involvement was unknown or did not apply.

As would be expected, family involvement varied with legal status. Regular family contact monthly or more occurred for 53.0% of children under a VPA and for 15.4% of permanent wards. Files showed no family contact for 5.7% of children under a VPA and 41.6% of permanent wards. Contact was irregular for 12.7% of VPAs and 20.7% of permanent wards.

Level 5 Children

Level 5 children are those children whose care needs are extremely high. Their level of care is assessed by a provincially-led committee that reviews a detailed submission from the agency regarding the child's functioning. The review process is intended to ensure that children meet the criteria for Level 5 status, their care plans meet the children's needs and the associated costs of care are appropriate. Due to the high costs that are frequently associated with the care needs of Level 5 children, the funding for their care is

provided by the Province rather than by the agency. There are generally about 120 Level 5 children at any given time.

Of all children with disabilities, 6.0% (112) were identified as requiring the highest level of care. The gender breakdown for level five children was 59.1% (68) male and 40.9% (47) female. Mean age of level five children was 12.26 ($SD = 3.90$) and the median was 13. Permanent ward was the legal status of 58.9% (66) children and VPA was the status of 30.4% (34) children. Culture of origin varied from the general population with 49.1% (55) being First Nations, 41% (46) were non-Aboriginal, and 9.8% (11) were Métis. Accordingly, the largest proportion of these children or 42% (47) were under the General Authority, with 31.3% (35) under First Nations South, 17% (19) under First Nations North and 9.8% (11) under the Métis Authority. The most frequently noted reasons for coming into care remained predominantly related to parents 41.9%, (conduct parents 36, conditions parents 11). However, for 25.9% of level five children, the reason for care was related to the child (conduct child = 14, conditions child = 15). Only 2 (1.8%) level 5 children were living in health or mental health facilities. The majority, 55.4%, were placed in foster homes (62). Most of the remaining level 5 children were housed in specialized foster homes 15.2% (17), group homes 10.7% (12) or staffed homes 4.5% (5).

Comparison of Child in Care Population and Children with Disabilities Population

With the demographic profile of children with disabilities (CWD) complete, it was possible to compare the demographics of CWD and the demographics of the children in care (CIC) population as a whole. Using the 5,664 children listed in CFSIS as in care on September 1, 2004, we compared the gender proportion, age, and frequency of legal status, culture of origin and Culturally Appropriate Authority occurring in each group. This comparison was muddied by the fact that the total CIC group used for comparison included the CWD group. Although the following is not a comparison of mutually exclusive groups, it does present an additional perspective on the children with disabilities.

Gender comparison.

In the CWD group, the ratio of males to females was 60.2% males and 39.8% females. That gender proportion was not representative of the CIC population as a whole where the male to female ratio was 53% males to 47% females.

Age comparison.

Comparison of CWD and CIC is limited to information that is reported on the CIC population using the CFSIS system. Only the CWD data was entered into the SPSS program. Therefore in Table 4.1 we are comparing the frequency of age groups of CIC and CWD rather than means. As shown, the preschool CWD group represents a smaller proportion of the total CWD population and the other age groups are, correspondingly, more frequently found than in the total CIC population.

Legal status comparison.

Knowledge of The Manitoba Child and Family Services Act would make comparison of the proportion of permanent wards and those under Voluntary Placement Agreements (VPA) in the disability group and the total group important to consider. ‘Permanent ward’ is a collapsed category that includes both permanent wards and those in permanent care as a result of a Voluntary Surrender of Guardianship. In the total CIC population, permanent wards (2,909) were 51.4% of the population. In the CWD group there were 1,322 permanent wards representing 70.7% of the group. In the total population of 5,664 there were 694 VPAs, the equivalent of 12.3% of the population. In CWD, the legal status for 236 children (12.6% of the group) was VPA. Complete detail on comparative legal status is presented in Table A 4.2. (Please note that all tables with an “A” designation are found in the Appendix).

Table 4.1
Comparison of the Age Group Distribution of All Children in Care and Children with Disabilities

| Age Groups | All Children in Care | | Children in Care with Disability | |
|---------------|----------------------|-------|----------------------------------|-------|
| | N | % | N | % |
| 0 – 5 Years | 1391 | 24.6 | 300 | 16.1 |
| 6 - 12 Years | 2137 | 37.7 | 820 | 43.9 |
| 13 – 20 Years | 2136 | 37.7 | 749 | 40.1 |
| Total | 5664 | 100.0 | 1869 | 100.0 |

Culture of origin comparison.

Overall the proportion of cultural origin groups in the population of children in care is similar to the proportions in children with disabilities. First Nations children make up 70.1% (3,963) of the children in care and 68.7% (1,284) of the children in care with disabilities (here, First Nations includes Treaty status, Non-status and Inuit). The proportion of non-Aboriginal children in care is 17.5% (993) but the proportion of non-Aboriginal children with disabilities is 19.7% (368). Métis children represent 9.0% (509) of children care and 10.1% (188) of children with disabilities. The only difference that can be noted is that the non-Aboriginal group was proportionately more represented and the Aboriginal population proportionately less represented in the disability group than the total group. The over-representation of males in the CWD group can be seen clearly within each culture of origin. In every culture of origin, the CIC population more closely approximates a 50:50 gender split (excluding the Inuit where N = 10.) In the CIC population the non-Aboriginal group continues to be the group with the greatest overrepresentation of males. The frequency and percent of children’s culture of origin in the CIC and CWD groups and the gender proportion for each of the culture of origin groups is appended in Table A 4.3.

Comparison – summary.

Children with disabilities are more often older, male and permanent wards than the general CIC population. They are also slightly more likely to be non-Aboriginal than children in care without disabilities.

Culturally Appropriate Authority Demographics

Demographic profiles of children within each of the four Culturally Appropriate Authorities (CAA) were created for comparison. Comparing the gender proportion in each Authority, the largest difference was found for children with disabilities in the General Authority with 66.6% (249) males and 33.4% (125) females. First Nations Authorities had comparatively higher proportions of females. In the Southern Authority, males were 58.1% (498) and females were 41.9% (359) of the Authority group and in the Northern Authority, males were 58.6% (243) and females were 41.1% (72) of the group. The Métis Authority had approximately the same percentage of males 61.2% (122) and females 39.0% (78) as the total population in care with a disability.

Children in the First Nations Authorities were younger than the children in the General Authority. The mean ages for the children within each CAA were: 9.6 years for the Northern Authority, 10.11 years for the Southern Authority, 11.08 for the Métis Authority and 12.24 years for the General Authority. This is compared to the mean age of 10.52 years for all the children in care with a disability.

For each Culturally Appropriate Authority, approximately 50% or more of the children were permanent wards. Larger percentages of permanent wards were characteristic of the First Nations Authorities. The proportions of permanent wards were 77.9% (668) of children in the Southern Authority, 69.6% (289) of children in the Northern Authority, 66.5% (133) of children in the Métis Authority and 49.7% (182) of children in the General Authority. A complete breakdown of legal status by CAA is found in the Appendix Table A 4.4.

The most frequent reason for children coming into care in all four Authorities was conduct of the parent. This corresponded with what was found for all children in care with a disability. Parent conduct was cited as the reason for care for 37.7% (323) of children in the Southern Authority, for 45.1% (187) of children in the Northern Authority, for 48.5% (97) of children in the Métis Authority and for 33.4% (125) of children in the General Authority. A complete breakdown of the reasons for coming into care by CAA is found in the Appendix Table A 4.5.

Nature of Disability

Disabilities

Six main types of disabilities were examined by researchers. These were intellectual, mental health, medical, physical, sensory and learning disabilities. The most frequently reported disabilities were intellectual and mental health disabilities. It was found that

75.1% (1,403) of the children had an intellectual disability while 55.6% (1,039) were diagnosed with or suspected to have a mental health disability. Smaller proportions were found for medical disabilities 22.4% (419), physical disabilities 17.9% (334), learning disabilities 6.1% (114) and sensory disabilities 4.8% (90). It is important to note children may have more than one disability in one or more categories.

Intellectual disabilities.

Intellectual disabilities describe developmental delays, cognitive impairments and FASD. Of the 1,403 children in care with an intellectual disability, 963 (68.6%) had some type of FASD. This included 631 (45.0% of children with an intellectual disability) with diagnosed FASD, 314 (22.4%) with suspected FASD, 12 (0.9%) with FASD50, and 9 (0.7%) with Neurological Behaviour Disorder. In addition, there were 706 (50.3%) children with a developmental delay and 401 (28.6%) with a cognitive impairment. Of those children who had intellectual disabilities, 596 (42.5%) had more than one intellectual disability.

Mental health disabilities.

Of the 1,039 children with a mental health disability, 856 (82.4%) had a diagnosed and 318 (30.6%) had a suspected disorder. This included 135 (7.2%) children with both a diagnosed and suspected mental health disability.

Mental health disabilities were grouped based on categories adapted from DSM-IV (American Psychiatric Association, 1994) for ease of analysis and discussion. The following mental health categories were created:

1. Pervasive Development Disorders – Autism Spectrum Disorder, Schizoid, and Psychotic Disorder
2. Attention-Deficit and Disruptive Behaviour Disorders – Attention-Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder, Conduct Disorder, Disruptive Behaviour Disorder, Behaviour Disorder, Impulse Control Disorder, Intermittent Explosive Disorder, Severe Emotional Behavioural Disorder, Emotional Behavioural Disorder, Pyromania, and Tourette's Disorder
3. Eating Disorders – Anorexia, Bulimia and Pica
4. Mood Disorders – Depression, Mood Disorder, Suicidal, Bi-Polar Disorder, Dysthymic Disorder, Borderline Personality Disorder, and Dissociative Disorder
5. Anxiety Disorders – Anxiety Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder, Anti-Social Disorder, Social Phobia, Attachment Disorders, Complicated Bereavement Disorder, Adjustment Disorder, and Trichotillomania
6. Sleep Disorders – Any diagnosed sleep disorder
7. Other disorders of infancy, childhood, or adolescence – Abuse Victim Disorder, Relationship Disorder, Substance Abuse Disorder, Sexual Deviant Disorder, Gender Identity, Narcissistic Disorder, Paraphilia, Amnestic Syndrome, and Family Sexual Dysfunction

The largest number of children affected by diagnosed and/or suspected mental health disorders was found in the Attention-Deficit and Disruptive Behaviour Disorders group. In fact, 95.3% (816) of children with a diagnosed mental health disability and 58.3% (187) of children with a suspected mental health disability were affected by this type of disorder. Anxiety Disorders were the next most prevalent with 29.8% (255) of children diagnosed with a mental health disability and 30.2% (96) of children with a suspected mental health disability. See Figure 4.4.

While 41 different mental health disorders were identified in the files, only the most common mental health conditions will be discussed. The most frequently reported diagnosed conditions were Attention-Deficit Disorders 620 (72.4%), Attachment Disorder 111 (13.0%), Autistic Spectrum Disorder 72 (8.4%), Oppositional Defiant Disorder 79 (9.2%), and Depression 79 (9.2%). Other frequently found diagnosed disorders included: Suicide 66 (7.7%), Anxiety Disorder 52 (6.1%), Conduct Disorder 54 (6.3%), Post-Traumatic Stress Disorder 34 (4.0%), Parent Child Relationship Disorders 28 (3.3%) and Adjustment Disorder 28 (3.3%). See Figure 4.5. A complete list of mental health disorders and suspected disorders is appended Table A 4.6 and Table A 4.7.

There were 30 different suspected mental health disorders however only the most common mental health conditions will be discussed. The most frequently reported suspected mental health conditions were Attention-Deficit Disorders 133 (41.8%), Attachment Disorder 47 (14.8%), Autistic Spectrum Disorder 28 (8.8%), Depression 27 (8.5%) and Oppositional Defiant 25 (7.9%). Other frequently found suspected mental health disorders are Suicide 20 (6.3%), Anxiety Disorder 19 (6.0%), Post-Traumatic Stress Disorder 18 (5.7%), Bipolar Disorder 14 (4.4%), and Conduct Disorder 11 (3.5%).

Medical disabilities.

Of the 419 (22.4%) children with a medical disability or chronic health problem, asthma was the most frequently noted disorder affecting 149 (35.6%). The other most common medical disabilities were seizures 123, (29.4%), heart problems or disease 77 (18.4%), feeding difficulties 63 (15.0%), respiratory problems 27 (6.4%), life threatening allergies 22 (5.3%), diseases of the skin 19 (4.5%), kidney and renal disease 13 (3.1%), Diabetes 13 (3.1%) and digestive disorders 12 (2.9%). There were an additional 11 medical conditions each affecting less than 2.0% of children. Some children were noted to have more than one chronic health condition. A complete list of medical disabilities is included in Table A 4.8.

Physical disabilities.

Physical disabilities were those disabilities that affected a child's physical functioning. Of the 334 (17.9%) children in care with a physical disability, 185 (55.4%) had a motor delay, 77 (23.1%) had Cerebral Palsy, 72 (21.6%) had a general physical disability, 33 (9.9%) had a Cleft Palate, 23 (6.9%) had Hypotonia and 21 (6.3%) had Scoliosis.

Figure 4.4
Frequency of Types of Mental Health Disorders

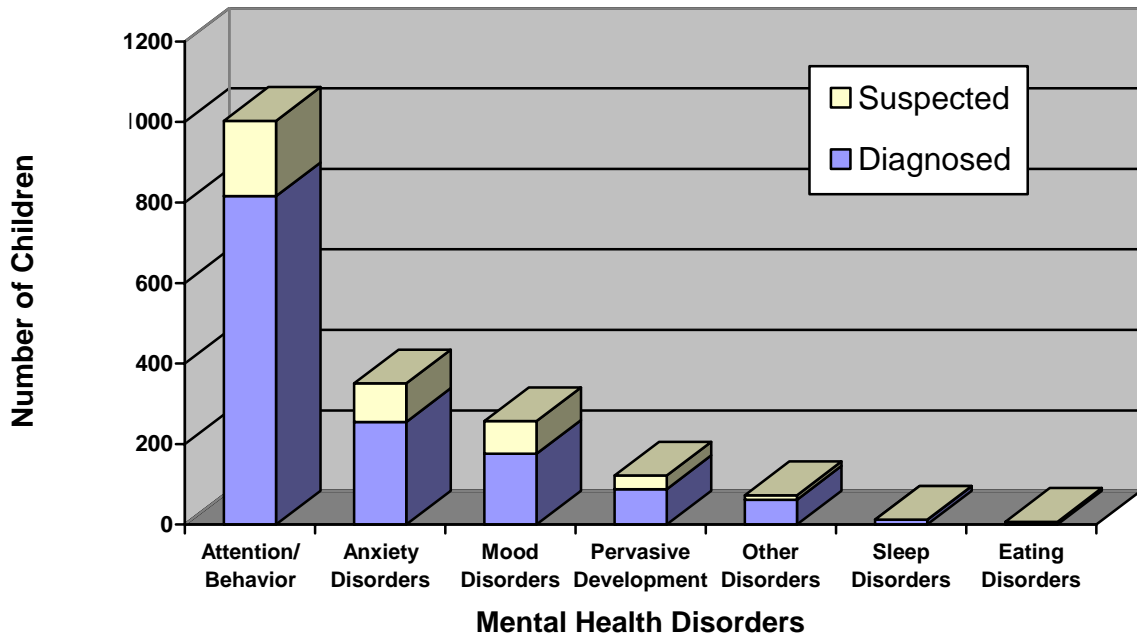
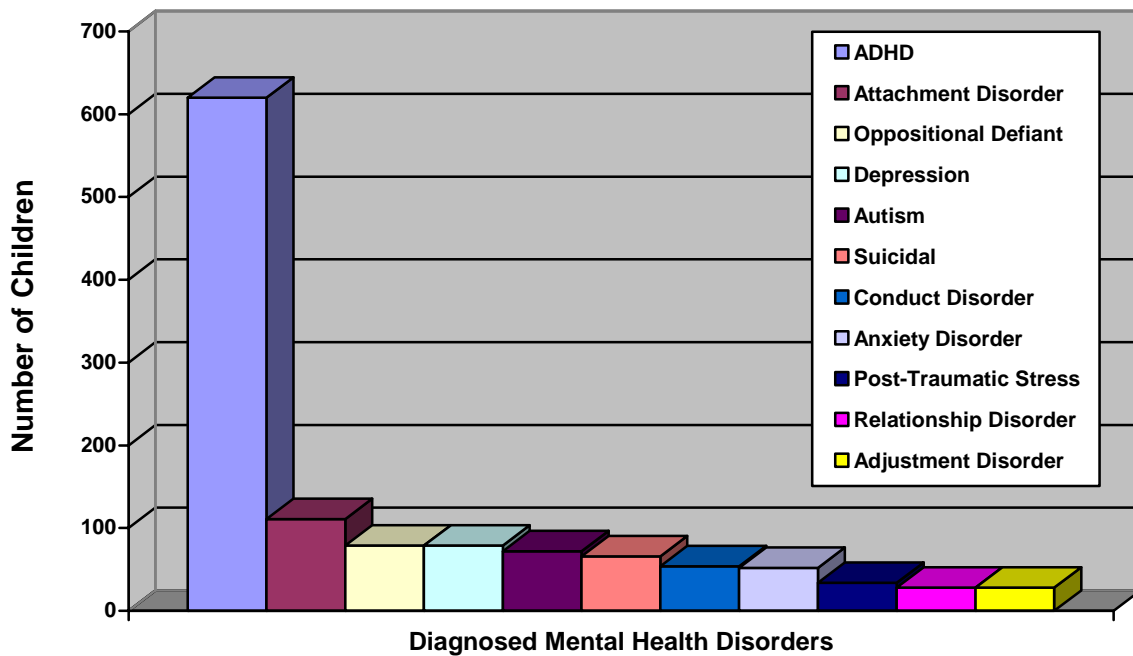


Figure 4.5
Frequency of Most Often Diagnosed Mental Health Disorders



Learning disabilities.

Learning disabilities are distinct from global intellectual deficiencies as they affect learning in children who otherwise demonstrate at least average abilities essential to thinking and reasoning. There were 114 children in care with disabilities who fit this definition of a learning disability. There were 57 children with diagnosed and 57 with suspected learning disabilities (3.0% for each).

Sensory disabilities.

Children with a severe or profound vision and/or hearing impairment were considered to have a sensory disability. Of the 90 (4.8%) children with sensory disabilities, 43 (2.3%) had vision impairments and 43 (2.3%) had hearing impairments. An additional 4 (0.2%) children had both vision and hearing impairments.

Demographic Characteristics of Children in Disability Groups

Gender.

A significant difference was found in the proportion of male and female children affected by mental health and medical disabilities. Among children in care with disabilities, males (60.0% or 676) were diagnosed with and/or suspected to have a mental health disability while that was the case for females (48.9% or 363). The difference was significant ($p < .000$). For medical disabilities the opposite was found, with a larger percentage of females (24.8% or 184,) than males (20.9% or 235) being affected ($p = .048$). There was no significant difference in the proportion of males and females impacted by the other four types of disabilities. See Table 4.2. Once again it is important to note that children may have more than one type of disability.

Table 4.2
Type of Disability by Gender

| Type of Disability | Female | | Male | |
|-------------------------|--------|------|------|------|
| | N | % | N | % |
| Intellectual impairment | 560 | 75.4 | 843 | 74.9 |
| Mental health disorders | 363 | 48.9 | 676 | 60.0 |
| Medical disabilities | 184 | 24.8 | 235 | 20.9 |
| Physical disabilities | 141 | 19.0 | 193 | 17.1 |
| Learning disabilities | 37 | 5.0 | 77 | 6.8 |
| Sensory disabilities | 44 | 5.9 | 46 | 4.1 |
| Total | 743 | | 1126 | |

Culture of origin.

A comparison was made of the percentage of children from each of the three cultures of origin by types of disabilities. First Nations children had the largest percentage of children affected by intellectual disabilities (80.5% or 1,034) and the lowest percentage of children affected by mental health disabilities (50.5% or 649). The opposite was found

for non-Aboriginal children with a smaller proportion of children being affected by intellectual disabilities (58.4% or 215) than mental health disabilities (71.2% or 262). Disabilities by culture of origin are depicted in Figure 4.6 and described in Table 4.3. The percentages do not equal one hundred as the children may have more than one type of disability. Multiple disabilities will be discussed in further detail later in this chapter.

The largest percentage of children affected by diagnosed mental health disabilities was in the non-Aboriginal group. ADHD was most commonly found in non-Aboriginal children, with 44.8% (165) of this group of children being affected. This second largest group was Métis children, with 34.0% (64) of the children having ADHD. First Nations children had the lowest percentage of children at 30.3% (389).

The two mental health disorders where non-Aboriginal children did not make up the largest group were Attachment Disorder and Suicide. In these cases it was found that the largest percentage of children affected were Métis. See Table A 4.9.

Multiple Disabilities

It was previously noted that children can have more than one disability within each type of disability. They can also have multiple types of disabilities. This was the case for more than half of the children, with 58.1% (1,085) of the children having two or more disabilities. The mean number of disabilities is 1.82 disabilities per child. It was found that 41.9% (784) of the 1,869 children in care with a disability had one disability. In terms of multiple disabilities, 39.0% (729) of children had two types of disabilities, 14.7% (274) had three types, and 4.0% (75) had four types. In addition, 0.4% (7) of children had five different types of disabilities.

It is important to note that 58.6% of the Aboriginal, 58.2% of the non-Aboriginal children and 54.8% of the Métis children had two or more disabilities. Among the cultures of origin, non-Aboriginal children had the highest percentage of children with three to five disabilities. A more complete breakdown of the number of disabilities based on culture of origin is found in the Appendix Table A 4.10.

The mean number of disabilities for the three different cultures of origin was determined. Non-Aboriginal children had the largest mean number of disabilities per child (1.91), followed by First Nations children (1.81). Métis children had the lowest mean number of disabilities per child (1.71). In addition, for those children with an undetermined culture of origin the mean number of disabilities was 1.86.

The most common co-occurrence of disabilities involved intellectual and mental health disabilities. The striking reality is that of 1,869 children, 1,796 (96.1%) children have a mental health or intellectual disability or both. Only 73 (3.9%) children had neither disability. There were 514 (27.5%) children who had both mental health and intellectual disabilities. Of the children with only one of the two types of disabilities, 393 (21.0%) children had only a mental health disability and 757 (40.5%) had only an intellectual disability.

Figure 4.6
Type of Disability by Culture of Origin

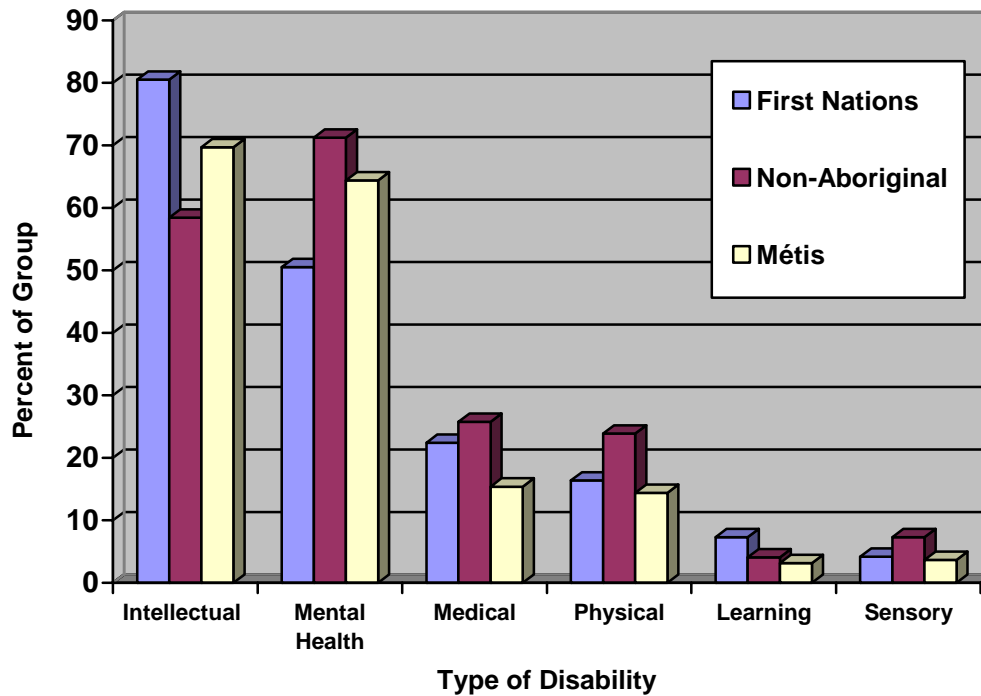
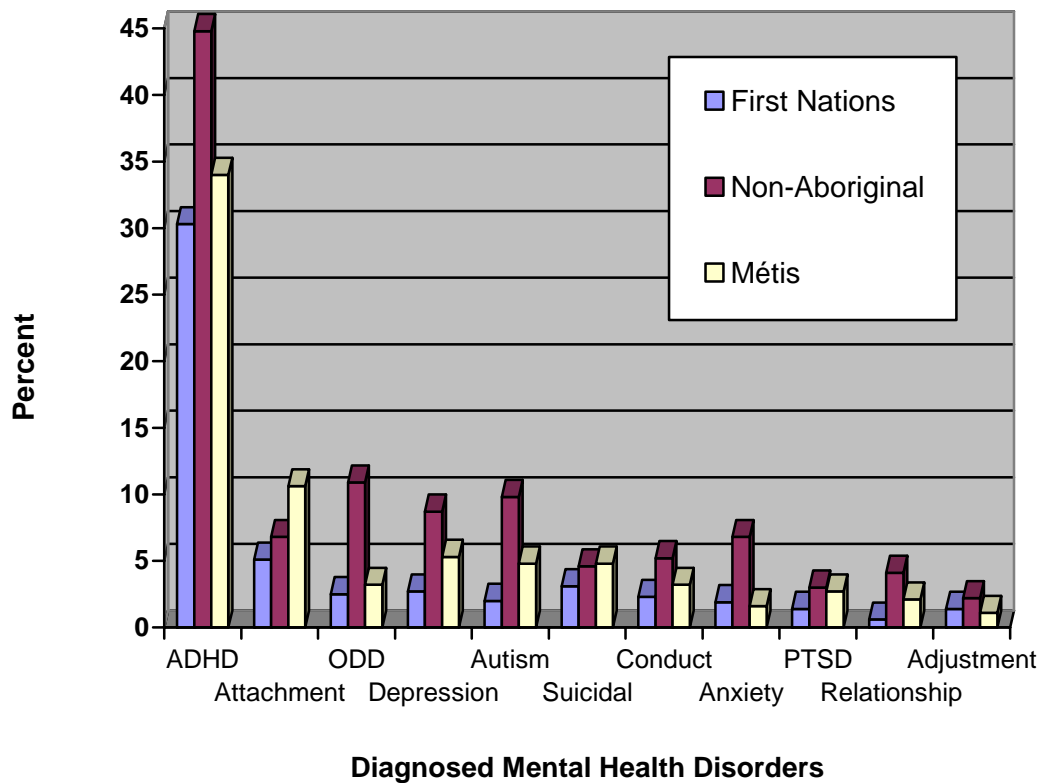


Table 4.3
Type of Disability by Culture of Origin

| Culture of Origin | Type of Disability | | | | | | | | | | | |
|---------------------------|--------------------|------|---------------|------|---------|------|----------|------|----------|------|---------|-----|
| | Intellectual | | Mental health | | Medical | | Physical | | Learning | | Sensory | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| First Nations N = 1284 | 1034 | 80.5 | 649 | 50.5 | 287 | 22.4 | 211 | 16.4 | 94 | 7.3 | 54 | 4.2 |
| Non-Aboriginal N = 368 | 215 | 58.4 | 262 | 71.2 | 95 | 25.8 | 88 | 23.9 | 15 | 4.1 | 27 | 7.3 |
| Métis N = 188 | 131 | 69.7 | 121 | 64.4 | 29 | 15.4 | 27 | 14.4 | 6 | 3.2 | 7 | 3.7 |
| Not determined N = 29 | 23 | 79.3 | 7 | 24.1 | 8 | 27.6 | 8 | 27.6 | 6 | 20.7 | 2 | 6.9 |
| Total N = 1869 | 1403 | | 1039 | | 419 | | 334 | | 114 | | 90 | |

Figure 4.7
Diagnosed Mental Health Disorders by Culture of Origin



Fetal Alcohol Spectrum Disorder (FASD)

Demographics.

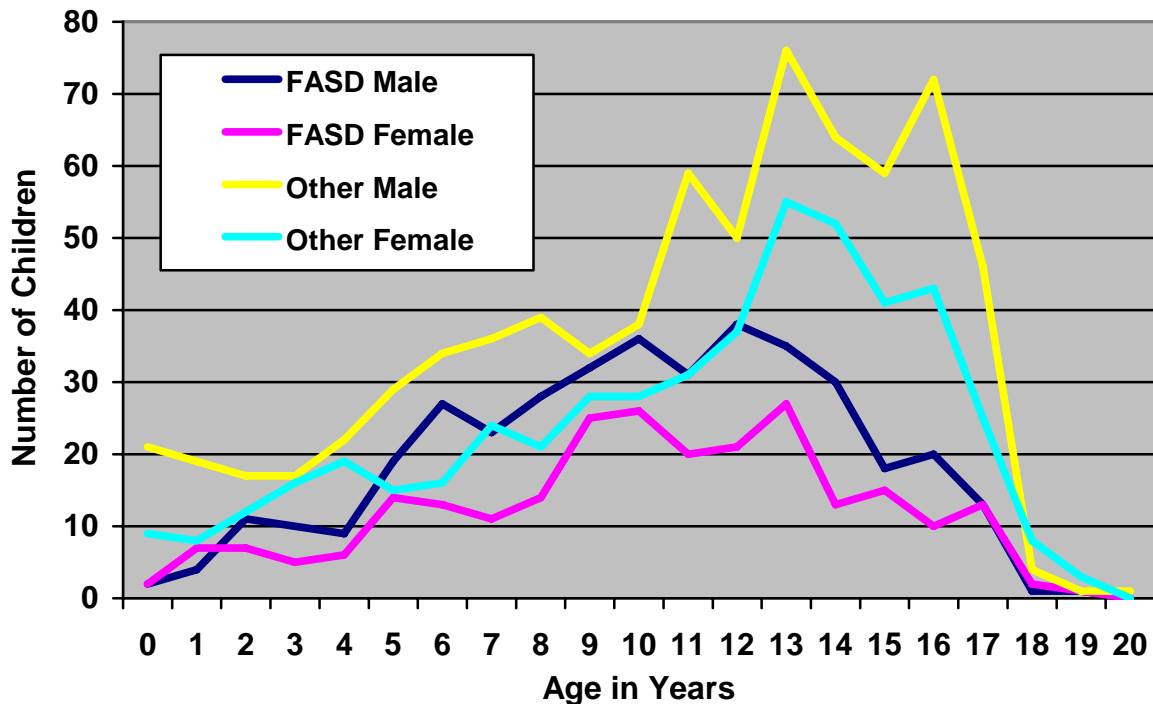
Of the 1,403 children with intellectual disabilities, 631 were diagnosed with Fetal Alcohol Spectrum Disorder (FASD). An additional 9 children were diagnosed with Neurological Behaviour Disorder subsequent to substance abuse. For further analysis, these categories have been collapsed and 640 children will be described as having diagnosed FASD. This diagnosed population represents 34.2% of the children with disabilities in care or 11.3% of the total number of children in care on September 1, 2004 (based on the CFSIS total for number of children in care). Children with diagnosed FASD represent 45.6% of children with an intellectual disability.

The proportion of males to females among those diagnosed with FASD was the same as that found in the general disability population. Of the 640 children, 60.6% (388) were male and 39.4% (252) were female. This compares to the 60.2% and 39.8% male: female ratio in the general disability population (N = 1,869) and to the 60:40 distribution in the non-FASD affected group (N = 1,229, M = 738, F = 491).

The mean age of the FASD group was 10.08 years with a median of 10 years. This meant the FASD group ($M = 10.08$, $SD = 4.107$) was significantly younger than the non-FASD group ($M = 10.75$, $SD = 4.678$, $p = .002$). The magnitude of the differences in means was very small (eta squared = .005) meaning that only 0.5 percent of the differences in age were explained by the FASD diagnosis.

While the gender distribution of FASD and non-FASD groups is similar and the age differences are small, the age gender profiles of the groups present quite differently as shown in Figure 4.8. The numbers of children in the non-FASD groups continue to increase well beyond the peak numbers in the FASD groups.

Figure 4.8
A Comparison of the Age by Gender Distribution Profiles of FASD and Non-FASD Affected Children



The overwhelming majority of children with FASD (89.1%) were in permanent care of an agency [permanent wards = 556 (86.9%) and VSG = 14 (2.2%) for a total of 570 (89.1%) in permanent care]. In the non-FASD population, those in permanent care made up 61.2% (752) of the group. Similarly, the use of VPAs differed sharply between these groups with 3.1% (20) of the FASD group coming into care via a VPA and 17.6% (216) of the non-FASD group using a VPA.

The culture of origin of children with FASD was: 521 (81.4%) Treaty, 55 (8.6%) Métis, 33 (5.2%) non-Aboriginal, 23 (3.6%) non-status and 8 (1.3%) not known. Similarly, the

Culturally Appropriate Authority for this population was 344 (53.8%) First Nations South, 192 (30.0%) First Nations North, 62 (9.7%) Métis, 33 (5.2%) General and 9 (1.4%) not known.

The reasons for children with FASD coming into care were predominately related to parents (61.9%) with 'Conduct parent' accounting for 275 (43.0%) and 'Conditions parent' reflected in 121 (18.9%). Reasons were related to the child's condition (26 or 4.1%) and child's conduct (14 or 2.2%) in only 6.3% of the FASD group. By comparison, in the non-FASD population 54.1% of children were in care for reasons related to parents and 17.9% were in care for reasons related to child conduct or conditions.

Children with an FASD diagnosis were placed in foster homes 88% of the time [foster home 77.8% (498), specialized foster home 8.3% (53), and staffed home 1.9% (12)]. In the non-FASD group, foster homes were the placement for 72.2% of children [foster home 59.4% (730), specialized foster home 10.3% (126), and staffed home 2.5% (3)].

Children with FASD had limited contact with parents. In this group 46.6% (298) had no contact with parents. For those maintaining contact with parents, 11.9% (76) had regular contact monthly or more, 4.2% (27) had regular contact though less than monthly, 17.0% (109) had irregular contact. By way of comparison, in the non-FASD group 24.4% (300) had no contact with parents and 24.4% (378) had regular monthly or more contact. Regular but less than monthly contact involved 4.0% (49) children in the non-FASD group and an additional 19.8% (243) had irregular contact.

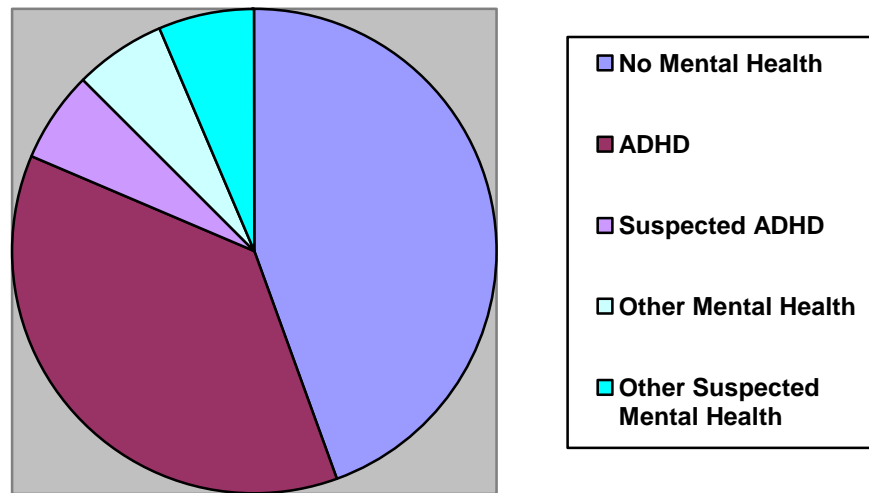
Disabilities.

Often children diagnosed with FASD had co-occurring disabilities. Mental health disabilities occurred in 291 (45.5%) children with an FASD diagnosis, 127 (19.8%) had a coincident medical condition, 107 (16.7%) had physical impairments, 21 (3.3%) were noted to also have a learning disability and 11 (1.7%) had a sensory disability.

As previously indicated, intellectual disabilities were often coincident with mental health disabilities. Children with intellectual disabilities numbered 1,403 (75.1%). Of those, 442 (31.5%) also had a diagnosed mental health disability, an additional 72 (5.1%) had both diagnosed and suspected disabilities and 132 (9.4%) had suspected mental health disabilities. As illustrated here (Figure 4.9), the FASD group was consistent with the intellectual disability group. The most commonly occurring combination of cognitive and mental health disabilities was FASD and ADHD.

As shown, of the 640 children with diagnosed FASD, 300 (46.0%) had no mental health disorder. Of the remaining 340 children, 250 (39.1%) had a diagnosis of ADHD and 40 (6.3%) children were suspected of having ADHD. An additional 41 (6.4%) children had a different mental health diagnosis and 44 (6.9%) were suspected of having a different mental health disorder. However, ADHD was outstandingly the most frequently noted diagnosis occurring in the FASD group. It was also frequently found in the suspected FASD group (N = 323) where it occurred in 61 (16.9%) children.

Figure 4.9
Co-occurrence of ADHD in Those with Diagnosed FASD (N = 640)



Origin of Disabilities

Data on the origin of disabilities was collected under seven main headings: congenital, medical, family history, injury, substance abuse, premature birth, and unknown. As many children had more than one disability, it was correspondingly possible to have more than one cause or origin for disability. General frequencies of the origin of disability will be presented and the origins of disability as they are found in different groups.

Frequency of Origin

The frequency of each of the origins of disability can be seen in Figure 4.10 and Table 4.4. For just over one half of the children in care (51%) no origin of disability could be found on the file. This information may have been missing or the origin of the child's disability may be undetermined.

The most frequently identified cause of disability was substance abuse affecting 34.3% of children in care. Prenatal substance abuse was the cause of disability in 640 children and personal substance abuse resulted in disability in one child. In addition to those children with diagnosed FASD as a result of prenatal substance abuse, there were 323 children with suspected FASD. All those with suspected FASD were coded as 'Origin of disability unknown'. If those suspected of having FASD were included with those diagnosed with FASD in substance abuse origin, the graph of origin of disability would appear as shown in Figure 4.11.

Figure 4.10
Frequency of the Origins of Disability (N = 1,869)

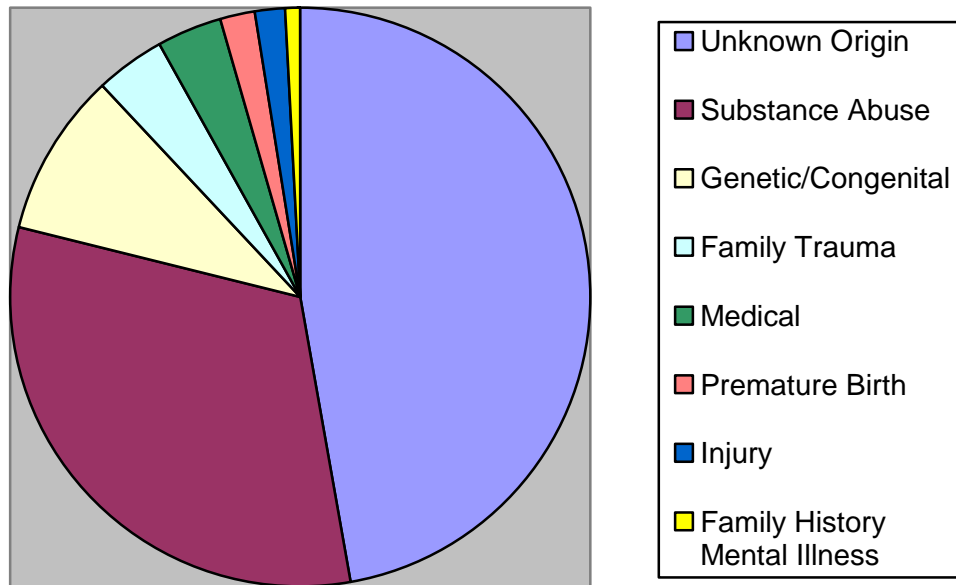
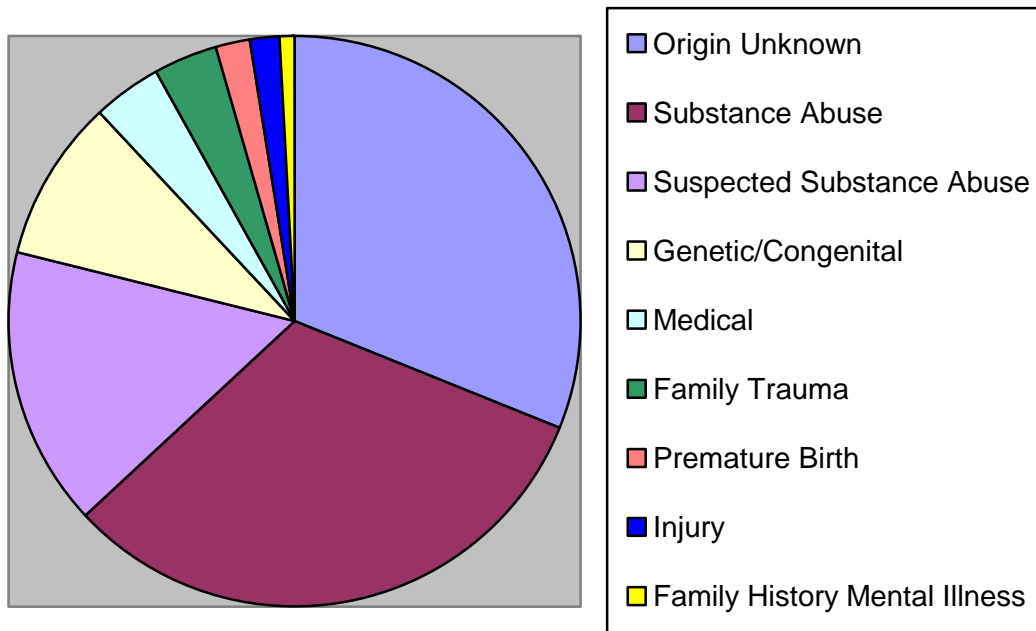


Table 4.4
Origin of Disabilities of Children in Care

| Origin | Number | Percent |
|----------------------------------|--------|---------|
| Unknown origin | 953 | 51.0 |
| Substance Abuse | 641 | 34.3 |
| Genetic/Congenital | 187 | 10.0 |
| Family Trauma | 76 | 4.1 |
| Medical | 74 | 4.0 |
| Premature Birth | 40 | 2.1 |
| Injury | 30 | 1.6 |
| Family History of Mental Illness | 19 | 1.0 |

For 10% of children in care, disabilities were present at birth. In the children reviewed, 187 children had congenital conditions and 58 different congenital conditions were noted as the cause of disability. The most frequently reported congenital condition was microcephaly which occurred in 39 children (20.9%). Thirty children (16%) experienced a condition from birth that was not described as a specific disorder or syndrome and therefore classified as ‘unknown’. Heart abnormalities affecting 14 (7.5%) children and brain abnormalities affecting 13 (7.0%) children were the next most frequently experienced conditions. Down Syndrome affected 11 children (5.9%), hydrocephaly

Figure 4.11
Origin of Disability Including Suspected FASD as Substance Abuse



affected 10 (5.3%) and 6 (3.2%) children were diagnosed with Fragile X. Other unspecified chromosomal abnormalities were noted in 5 (2.7%) children and Spina Bifida was also diagnosed in 5 or 2.7% of children. Other conditions occurred in 4 or fewer individuals.

Information related to the impact of the child’s family of origin on disability was gathered under two subheadings: ‘History of Mental Illness’ and ‘Family Trauma’. Where a physician or psychiatrist had identified either of these factors as being a contributor to the diagnosed disability, they were recorded as origins. It should be understood that there were many examples in the files of children in care where family history might be deemed to be a contributing factor to disability. However, our coding required that these be specifically identified by a physician or psychiatrist to be counted as origin of disability. ‘Family trauma’ referred to psychological trauma as a result of family violence, neglect and/or abuse. It was a genesis of disability in 76 (4.1%) of children in care. A family history of mental illness was recorded for 19 or 1% of children in care.

A medical origin was found for the disabilities of 74 (4.0%) of children. Disabilities that arose after birth, generally as the result of an internal disease process, were put in this category. Disease was defined as a disorder with a specific cause and recognizable symptoms or any bodily abnormality or failure to function properly except that resulting directly from physical injury. One exception to this was included as a medical origin and that was anoxia or oxygen deprivation at the time of birth.

The most frequent medical origin was related to disease processes occurring in 38 children (51.4%). Brain damage as a result of disease was found in 15 (20.3%) of the medical origin group. Lack of oxygen at birth affected 14 (18.9%). Eight children (10.8%) experienced neurological damage and 2 more (2.7%) had post birth brain damage from an unspecified cause. Juvenile arthritis was noted once (1.4%).

After premature births, which resulted in disabilities for 40 (2.1%) children, injury was the next most frequently noted cause of disability. Of those 29 (1.6%) children who were disabled as a result of injury, 16 (53.3%) experienced accidental injury, 9 (30%) were injured intentionally and 4 (13.3%) were injured as a result of neglect.

Origin and Gender

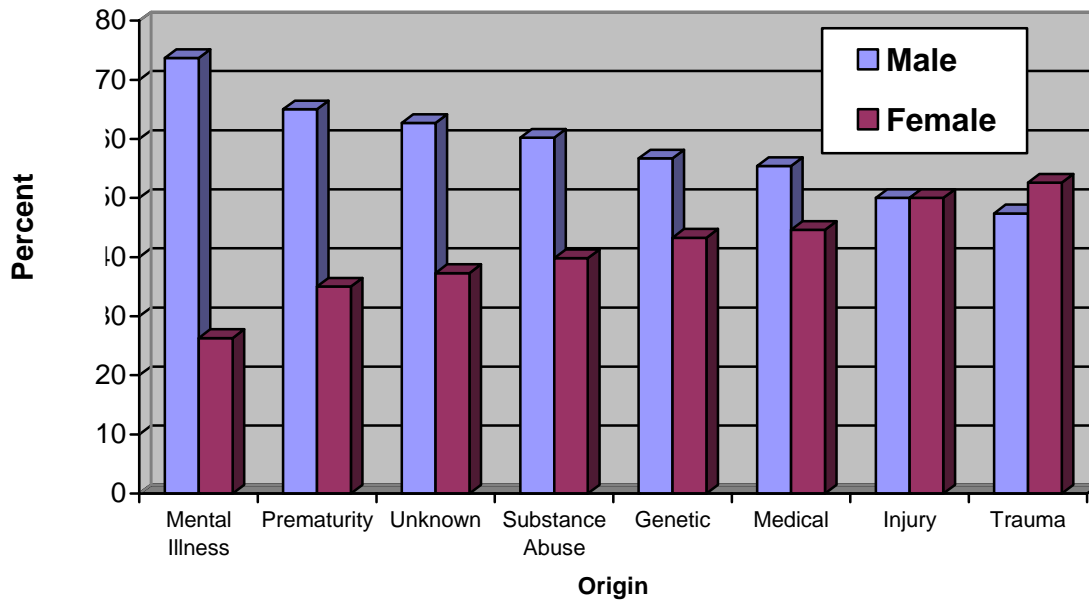
The pattern of origins of disability experienced by boys and girls in this population is generally the same. As shown in Table 4.5 the greatest differences were in the area of 'Genetic' origins and 'Family History of Trauma' where the proportion of girls was greater than that of boys. There was also a difference in proportion of girls and boys with an 'Unknown' origin of disability.

Table 4.5
Origin of Disability as a Proportion of Gender and Gender Proportion in Origin of Disability

| Origin of Disability | Male (N = 1126) | | | Female (N = 743) | | |
|----------------------|------------------|----------|----------|------------------|----------|----------|
| | N | % Gender | % Origin | N | % Gender | % Origin |
| Genetic | 106 | 9.4 | 56.7 | 81 | 10.9 | 43.3 |
| Medical | 41 | 3.6 | 55.4 | 33 | 4.4 | 44.6 |
| Fam Hist.Mental Ill. | 14 | 1.2 | 73.7 | 5 | .7 | 26.3 |
| Fam Hist Trauma | 36 | 3.2 | 47.4 | 40 | 5.4 | 52.6 |
| Injury | 15 | 1.3 | 50.0 | 15 | 2.0 | 50.0 |
| Substance Abuse | 386 | 34.3 | 60.2 | 255 | 34.3 | 39.8 |
| Prematurity | 26 | 2.3 | 65.0 | 14 | 1.9 | 35.0 |
| Unknown | 598 | 53.1 | 62.7 | 355 | 47.8 | 37.3 |

The gender proportion within the children with disability population is approximately 60:40 in favour of boys and that ratio would be expected to be repeated within specific origins of disability. The proportions here differ most markedly from the general proportions in the area of 'Family History of Mental Illness' where boys are far more often represented and in 'Family History of Trauma' where the proportion of girls is higher than expected (Figure 4.12). The proportion of substance abuse most closely approximates the general population ratio.

Figure 4.12
Gender Proportions in Origins of Disability



Functioning and Service Needs

Functioning

Information on the functioning of children with disabilities was gathered in the same categories that were used to describe the nature of disability. That is, the tool asked for information related to physical, medical, sensory, intellectual and mental health functioning. More specifically, it gathered information on the degree of physical impairment, the degree of medical support required and the degree of sensory impairment. In the area of intellectual development, it required estimation of whether the ability to communicate using language or an alternative mode of communication was age-appropriate. Likewise it asked whether or not the child's development of conceptual, abstract and practical skills, knowledge and abilities was age-appropriate. Mental health functioning of children was indicated by their need for intervention in the form of medication, or direct therapy. The presence of psychotic episodes was also noted.

In addition to functioning related to disabilities, behaviour was also described. Age-appropriate behaviour in the areas of interpersonal interaction, emotional control, dependability, and safety was noted. Information on the occurrence of problem behaviours was also recorded. Problem behaviours were related to aggression, sexually acting out and conflict with the law.

Physical functioning.

Physical functioning items assessed the child's ability to function in the areas of feeding, mobility, and the activities of daily living. Also included was an item reflecting the need for total physical care. For this study children who were totally dependent for toileting, bathing and grooming beyond age appropriate limits were considered to require total physical care. Of the total number of children with disabilities in care (1,869), 470 (25.1%) required assistance for activities of daily living, 116 (6.2%) required total physical care, 114 (6.1%) required mobility assistance, and 110 (5.9%) had a disability that prevented self-feeding.

Medical functioning.

The Unified Referral and Intake System (URIS) categories were used to define medical needs as outlined in Appendix B. Children requiring URIS C medical support were the largest group 793 or 42.2% of children with disabilities. URIS C includes all children who take medication. There were 156 (8.3%) children requiring medical intervention as outlined by URIS B. Only 19 (1.0%) children required the intensive medical intervention described by URIS A. In addition 4 (0.2%) children required dialysis.

Sensory impairment – vision.

The degree of visual impairment in children with disabilities was qualified in this item by the categories mild, moderate, severe and profound. For 1,147 (61.4%) of children, no visual impairment was noted. If a professional had quantified the degree of impairment, that descriptor was used. Without a professional description, visual acuity difficulties that were corrected by lenses were classified as mild. The vision of 385 (20.6%) children was described as mildly impaired. Those with vision loss in one eye were described as moderately impaired. This applied to 31 (1.7%) children. Children with mild or moderate impairment were not counted as having a sensory impairment. Those described as having severe visual impairment had vision loss in both eyes and this included 31 (1.7%) children. Profound vision loss, total blindness, occurred in 15 (0.8%) children.

Sensory impairment – hearing.

Like the vision item, hearing loss was qualified using mild, moderate, severe and profound descriptors. There was no hearing impairment in 1,147 (61.4%) children with disabilities in care. A mild impairment or some hearing loss was noted in 46 (2.5%) children. Moderate hearing loss impacted 22 (1.2%) children who had difficulty hearing but used hearing and speech to communicate without the use of a hearing aid. Children with a severe hearing impairment, those who could understand speech with a hearing aid, numbered 31 (1.7%). There were 15 (0.8%) children who were profoundly impaired or totally deaf. Again, only the severely and profoundly impaired were counted as having a sensory disability.

Intellectual functioning.

Intellectual functioning was described in two areas: age-appropriate use of language and communication skills and age-appropriate development of conceptual, abstract and practical skills knowledge and abilities. Language skills were felt to be age-appropriate in 628 (33.6%) children and not age-appropriate in 1,030 (55.1%) children. Learning was

considered age-appropriate for 472 (25.3%) children and not age-appropriate for 1,174 (62.8%) children. Because this information was not consistently available in the files, both of these categories note over 10% of children as 'no data'.

Mental health functioning.

In this review of mental health functioning, 727 (38.9%) children were prescribed medication. This item includes children who were prescribed medication but who refused to take it. Mental health was a diagnosed disability for 856 children. If we consider the number of children prescribed medication as a percentage of those with a mental health disability, then 84.8% have been prescribed medication for their condition. Direct therapy was a requirement for 335 (17.9%) children or 39.1% of those with a mental health disability. Children who received therapy for reasons other than mental health were not included in this number. There were 35 (1.9%) children who were subject to psychotic episodes.

Behaviour

Behaviour is an important element in creating an accurate profile of the kinds of needs children have and the kinds of services they require to adequately support their development. Consequently, we included items to assess the age-appropriate development of children with disabilities in the areas of interpersonal and emotional behaviour as well their dependability and awareness of risks. These items often required some interpretation of the behaviours described in the files and are therefore possibly more subjective than other more concrete items. Where information on children's behaviour was incomplete, unclear or contradictory, the items were scored as no data. For these items the no data count ranged from 5% for dependability to 15.5% for awareness of risks.

Interpersonal behaviour.

This item asked which children were able to interact with others in an age-appropriate way. In the disability population, 522 (27.9%) children were considered age-appropriate. The majority of children, 1,204 (64.4%), were not considered able to interact in an age-appropriate manner.

Emotional modulation.

To assess the ability of children to deal with their emotions, information was gathered on their ability to modulate behaviour associated with affective experience in an age-appropriate fashion. The number of children who were found to be age-appropriate was 364 (19.5%) and the total found not age-appropriate was 1,364 (72.0%).

Dependability.

Dependability was defined as an age-appropriate ability to adhere to structure and expectations within home and/or school environments. In this area, 342 (18.3%) children were found to be age-appropriate and 1,428 (76.4%) were considered not age-appropriate. This made dependability the most frequently reported developmental lag in children with disability.

Safety.

The ability of children to understand risks to the safety of themselves and others is of significant concern to caregivers. In our population of children with disabilities, 476 (25.5%) were deemed to have an age-appropriate understanding of safety issues. That left 1,095 (58.6%) children who might put themselves or others at risk more often than would be expected for children of their age.

Problem Behaviours

In addition to the rudimentary assessment of children's behavioural development, we included items related to particular problem behaviours. Problem behaviours that had occurred within one year of our data collection date (September 1, 2004) were included. Problem behaviours are summarized in Table 4.6.

Table 4.6
Frequency of Problem Behaviours in Children with Disabilities

| | Aggression | | Sexually Acting Out | | In Conflict with the Law | |
|-------|------------|-------|---------------------|-------|--------------------------|-------|
| | N | % | N | % | N | % |
| Yes | 803 | 43.0 | 294 | 15.7 | 212 | 11.3 |
| No | 952 | 50.9 | 1501 | 80.3 | 1612 | 86.2 |
| Other | 114 | 6.1 | 74 | 4.0 | 45 | 2.4 |
| Total | 1869 | 100.0 | 1869 | 100.0 | 1869 | 100.0 |

Problem behaviour – aggression.

Children were considered to have a problematic degree of aggression where the file showed that there were assaults on caregivers or peers, that there were school suspensions or behaviour plans to deal with aggressive episodes or, especially in young children, that workers described aggressive behaviour as problematic. Aggressive behaviour was a problem for 803 (43.0%) of children with disabilities.

Problem behaviour – sexually acting out.

Sexually inappropriate or sexually acting out behaviour included problematic sexualized behaviour in young children, promiscuity and prostitution in older children and youth as well as the sexual victimization of others. Children identified as sexually inappropriate numbered 294 (15.7%).

Problem behaviour – conflict with the law.

Children who were charged with offenses were counted as being in conflict with the law. The number of children found to be in conflict with the law was 212 (11.3%). Children who were committing illegal acts but had not been dealt with by the law were counted as not being age-appropriately dependable. Therefore these numbers do not reflect, for

example, children stealing or using illegal substances where it was being addressed within their residential or school setting. They do include youth who had been referred to community justice options by the police.

Problem behaviour demographics.

Problem behaviours were examined more closely. There were both gender and age differences in the problem behaviour group when compared to children with disabilities not evidencing problem behaviour.

Problem behaviours were more likely to be typical of male children. The ratio of male to female in the overall disability population was approximately 60% male and 40% female. Those in conflict with the law (212) were 71.2% (151) male. Those expressing aggressive behaviour (803) were 68.9% (553) male. Sexually inappropriate behaviour (294) followed the gender distribution of the general disability population. Males (176) accounted for 59.9% of the behaviour.

The age of children with problem behaviours was significantly greater than the age of children not exhibiting problem behaviours. Independent-samples t-tests were conducted to compare the age of children exhibiting particular problem behaviours with those not exhibiting those problem behaviours. There was a significant difference between the age of children with aggressive behaviour ($M = 11.35$, $SD = 3.89$) and the age of those with no aggressive behaviour ($M = 9.86$, $SD = 4.85$, $p = .000$). There was also a significant age difference between those children with sexually inappropriate behaviour ($M = 12.12$, $SD = 3.55$) and those not noted to be sexually inappropriate ($M = 10.15$, $SD = 4.61$, $p = .000$). Similarly, those in conflict with the law ($M = 14.83$, $SD = 2.11$) were significantly older than those without legal involvements ($M = 9.92$, $SD = 4.43$, $p = .000$). The effect size of the differences in each comparison was extremely small (eta squared = .0005). Age and gender statistics are detailed in Table A 4.11

Problem behaviours and disability groups.

Problem behaviour occurred with varying frequency within particular disability groups. Appendix Table A 4.12 shows the frequency of problem behaviours within a disability group as a percentage of the disability group. (Our categories of disability are not mutually exclusive and most children have multiple disabilities, consequently these percentages do not total 100%.) It is clear that aggressive behaviour was the most frequently encountered problem behaviour across disabilities. With the exception of learning disability which had a small number (47), children with a mental health disability (856) showed the greatest frequency of involvement in each of the problem behaviours. They were much more likely to be aggressive (59.8%) than the intellectual disability group (39.7%) or its subgroup those with FASD (41.4%). As might be expected, those with sensory, physical and medical disabilities were much less likely to be involved in problem behaviours.

Appendix Table A 4.13 indicates what percentage of a disability group was involved in particular problem behaviour. Using the information from both this and the previously cited table provides a perspective on problem behaviour that is not possible with either

table alone. For example, although children with a mental health disability were more likely to be aggressive than those with other disabilities, because of the preponderance of children with intellectual disabilities in the child in care population, children with intellectual disabilities were responsible for a slightly larger proportion of the aggressive behaviour. (Children with intellectual disabilities exhibited 69.4% of aggressive behaviour; children with mental health disabilities were involved in 63.8% of aggressive behaviour.) The same was true for sexually acting out behaviour (294) where children with intellectual disabilities were responsible for 72.1% of sexual behaviour and children with mental health disabilities produced 60.5% of sexual behaviour. The situation with children in conflict with the law was different. In that circumstance, 17.9% of the mental health disability group (153) accounted for 72.2 % of those in conflict with the law (212). Because this small group represented such a large proportion of the illegal problem behaviour, it was further analyzed to determine the nature of mental health disabilities occurring in the group. The most frequently occurring diagnoses were ADHD 104 (91.5%), Attachment Disorder 29 (19%), Conduct Disorder 24 (15.7%), Oppositional Defiant Disorder 24 (15.7%), Suicidal 23 (15%) and Depression 18 (11.8%). Again, note that children might have more than one mental health diagnosis.

The key findings in this rather difficult analysis were that children with mental health diagnoses were more likely to be acting out aggressively, sexually and illegally than the children in other disability groups. Because of the very large numbers of children with intellectual disabilities, the number of children with intellectual disabilities exhibiting aggressive or sexually inappropriate behaviour was greater than the actual number of children with mental health disabilities. This was not the case with illegal activity where a small number of children with mental health disabilities (153), less than 20% of the mental health disability group, accounted for almost three quarters (72.2%) of all the illegal activity in the entire population of children with disabilities. Almost all the children in this small group (91.5%) were diagnosed with ADHD.

Adaptive Services

Services

Children with disabilities by definition required adaptations to their environment to meet their special needs. As indicated in the study framework, four elements of adaptive intervention were analyzed: medical adaptations, mechanical adaptations, technical adaptations and personal supports.

Medical adaptations included special diet, provision of oxygen, medication, physiotherapy, occupational therapy, speech and language therapy, gastrostomy, and dialysis. Children might have more than one medical adaptation noted. Medical adaptations were provided to 1,234 or 66.0% of the total number of children with disabilities. As shown in Table 4.7, medication was the most frequently occurring medical adaptation.

Table 4.7
Adaptive Medical Services Provided to Children with Disabilities in Care

| Medical Adaptive Services* | N | Percent |
|-----------------------------------|----------|----------------|
| Medication | 893 | 72.4 |
| Speech and Language | 409 | 33.1 |
| Occupational Therapy | 312 | 25.3 |
| Physiotherapy | 203 | 16.5 |
| Diet | 63 | 5.1 |
| Gastrostomy | 61 | 4.9 |
| Oxygen | 20 | 1.6 |
| Dialysis | 3 | 0.2 |
| Total Population (N = 1869) | 1234 | 66.0 |

*Children may be receiving more than one medical adaptive service

Mechanical adaptive services were provided to 130 (7%) children with disabilities. Mechanical supports were primarily related to mobility and included wheelchair, lift, walker, cane, prostheses, and adaptations to seating, bed and/or bath. Also included was equipment related to recreational mobility, splints and braces, and weighted vests. Orthodontic services that were required for speech production or necessary for proper eating were also counted.

Technical supports were noted in the files of 74 (4%) children with disabilities. Hearing and communication devices, computers and computer software, sound systems, pacemakers and Braille equipment made up the technical adaptation category.

In addition to these concrete supports, children with disabilities and their caregivers had personal supports. Where children were receiving support for the activities of daily living and/or behavioural guidance and supervision that was beyond the support typically provided for same age children, it was counted as personal support. Other personal supports included respite, in-home support workers, 24-hour supervision and family preservation. Additional respite was respite provided in addition to what was automatically part of the childcare rate. Round the clock wakefulness in a caregiver or continuous daily visual supervision were considered 24-hour supervision. In-home support workers might be mentors for children in care; they might be family visit supervisors or extra support for a child in their placement. Family preservation was noted when families were involved with a Family Preservation Program. Personal supports were the most frequently provided adaptive support. Most children (1,521 or 81.4%) were receiving some form of personal support. The distribution of personal supports is illustrated in Table 4.8.

Many children received more than one type of personal support. No personal supports were noted as being provided to 348 (Female = 150, Male = 198) children and 797 children (Female = 310, Male = 487) received one personal support. Two types of

personal support were provided to 486 children (Female = 198, Male = 288) and 196 children (Female = 66, Male = 130) received three types of personal support. Four supports were noted for 39 children (Female = 17, Male = 22) and 3 children (Female = 2, Male = 1) received five types of personal support.

Table 4.8
Frequency of Personal Supports Provided to Children with Disabilities in Care

| Personal Supports | N | Percent |
|------------------------------------|----------|----------------|
| Behavioural Guidance | 810 | 43.3 |
| Respite | 805 | 43.1 |
| Assistance with Daily Living (ADL) | 469 | 25.1 |
| In-Home Support | 313 | 16.7 |
| 24-Hour Supervision | 100 | 5.4 |
| Family Preservation | 31 | 1.7 |

*Children may be receiving personal supports in more than one category.

Services by Disability

The proportion of children within each disability group receiving services varied considerably. Support for the activities of daily living (ADL) was most often provided to those with sensory disabilities (67.8%) as was respite (63.3%). Behavioural guidance and supervision was most frequently provided for children with a mental health disability (56.2%). Services by disability are completely reported in Appendix Table A 4.14. Although 67.8% of children with a sensory disability receive services for ADL, they receive only 13% of the total ADL services. The largest consumer group of services is the intellectual disability group, receiving for example 88.1% of ADL services, 68.7% of behavioural supervision and 80.3% of respite. It is important to note, however, that while those with an intellectual disability receive the largest share of services, the services are provided to a smaller proportion of the group (ADL 29.4%, behavioural supervision 39.6% and respite 46.0%). The proportion of services provided to each disability is reported in Table A 4.15.

In our examination of functioning, it was reported that 470 children required assistance for ADL. Of those, 404 (86%) were found to be receiving personal support for ADL. Further examination of the profiles of those 470 children, revealed that 399 (84.9%) were receiving adaptive medical services, 120 (25.5%) were receiving adaptive mechanical services and 48 (10.2%) were receiving adaptive technical services. The relationships between the need for support with the activities of daily living and adaptive medical, technical and mechanical services were tested using a chi square test of significance. In each case the relationships were found to be significant [Asymp. Sig. (two-sided) = .000].

This would indicate that those requiring assistance with activities of daily living were likely to receive medical, mechanical and/or technical services.

It was previously reported that multiple disabilities were common among children with disabilities. Service provision to children appears to be related to the number of their disabilities and consequent complexity of their care needs. Table 4.9 describes the proportion of children with a specific number of disabilities receiving each of the adaptive services. As the number of disabilities increases, the proportion of children receiving services also increases.

Table 4.9
Multiple Disabilities as a Factor in the Provision of Adaptive Services

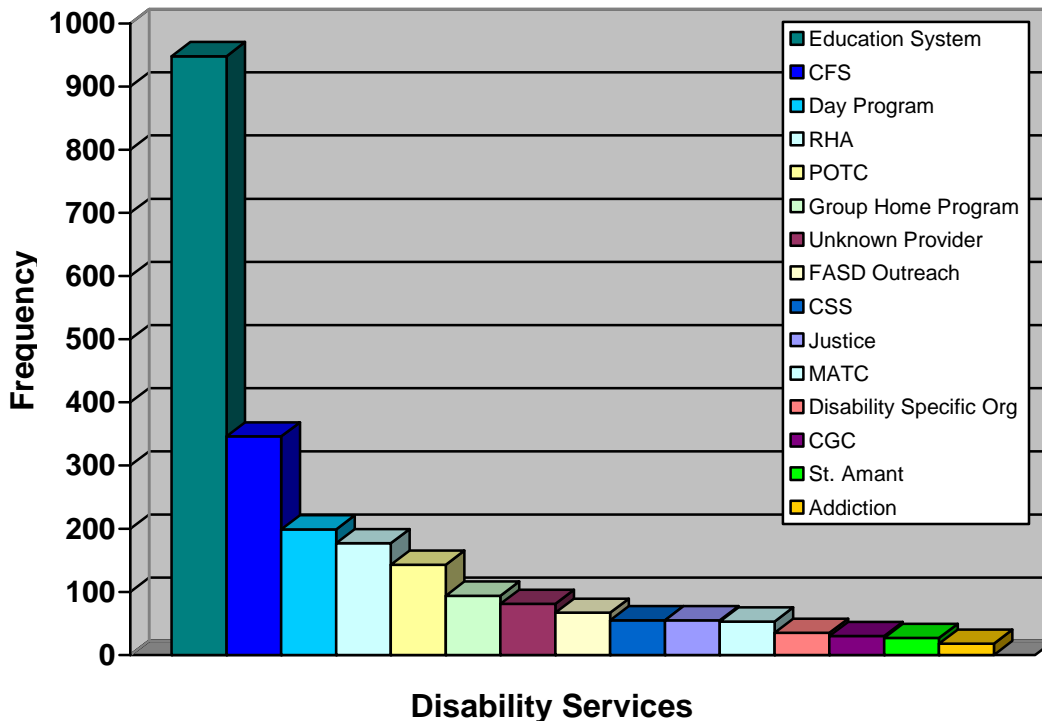
| Multiple Disabilities N = 1869 | Adaptations | | | | | | | |
|-----------------------------------|-------------|-------|---------|-------|------------|------|-----------|------|
| | Personal | | Medical | | Mechanical | | Technical | |
| | N | % | N | % | N | % | N | % |
| One Disability n = 784 | 596 | 76.2 | 373 | 47.6 | 11 | 1.4 | 14 | 1.8 |
| Two Disabilities n = 729 | 605 | 83.0 | 543 | 74.5 | 27 | 3.7 | 21 | 2.9 |
| Three Disabilities n = 274 | 241 | 88.0 | 239 | 87.2 | 50 | 18.2 | 25 | 9.1 |
| Four Disabilities n = 75 | 70 | 93.3 | 72 | 96.0 | 37 | 49.3 | 12 | 16.0 |
| Five Disabilities n = 7 | 7 | 100.0 | 7 | 100.0 | 5 | 71.4 | 2 | 28.6 |

Non-CFS Services

In addition to the services provided directly by the CFS social workers, foster care providers or placement staff, children with disabilities often received a variety of other services. As files were reviewed, external service providers were noted. As part of the data analysis, external sources of service provision were added to the database as they occurred in the population reviewed. From the resulting list, categories were created. Although these services are described as non-CFS services, one of the categories is CFS-funded services. This category includes all those services contracted and funded by CFS that are in addition to services typically provided by workers and caregivers. The frequency of non-CFS services is shown in Figure 4.13.

The education system is obviously the most frequent partner with child welfare agencies in addressing the needs of children in care with disabilities. Special programs or assistance at school were noted for 948, just over 50%, of those children. The second

Figure 4.13
Disability-Related Services Provided to Children in Care with Disabilities



largest service provider was CFS agencies who funded 346 additional services for 18.5% of the children in their care. Day care programs were noted in the files of 199 (10.6%) children. The remaining services were each noted in less than 10% of the disability population. The various provincial Regional Health Authorities (RHA) provided services to 177 children. Provincial Outreach Therapy for Children (POTC) was involved with 143 children. Group homes were noted as additional service providers for 94 children. The remaining service providers were noted in less than 4% of the files of children with disabilities: FASD Outreach 67, Children’s Special Services (CSS) 55, Justice 55, Manitoba Adolescent Treatment Centre (MATC) 53, disability specific organizations 35, Child Guidance Clinic (CGC) 27, St. Amant Centre 27, and addiction-focused organizations 18. The graph does not include those service providers that were noted less than 15 times (0.7%) in the database. Present in the database but not included here are: Healthy Child, Manitoba Youth Centre (MYC), Clinic for Alcohol and Drug Affected Children (CADEC), Alternative Justice, Special Olympics, Big Brothers Big Sisters, Families Affected by Sexual Assault (FASA), Nurse, Mount Carmel Clinic, Chiropractor, Manitoba Public Insurance (MPI), Dietician, and Family Support Programs.

The type of service being provided by the most frequent service providers is of interest. In education, teacher assistants were assigned to 488 children in care representing 26.1% of the support provided. The next most frequent educational service (14.2%) was provision of a modified or adapted program to 265 children. Special educational funding

(17.5%) was provided 327 times: 202 children qualifying for Level 2 and 125 qualifying for Level 3. Speech and language therapy (10.6%) was part of the program for 198 children. For a complete breakdown of services provided by the education system see Table A 4.16.

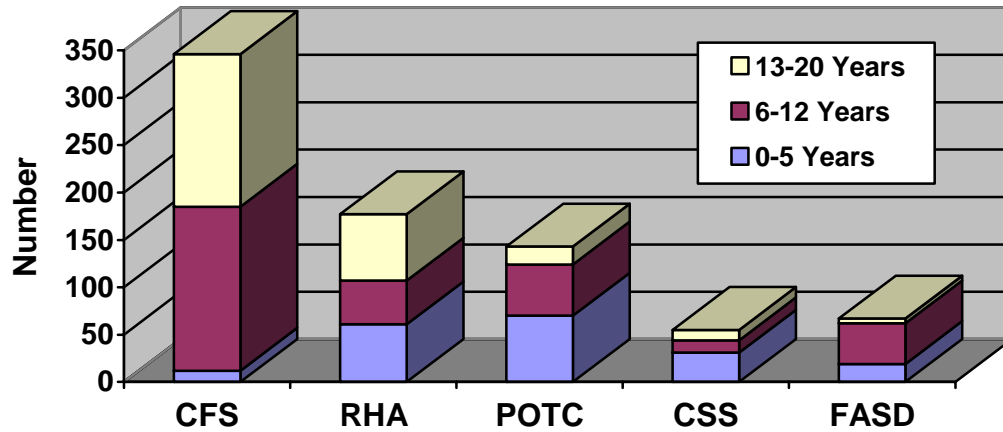
CFS agencies were a major source of additional service support (18.5%). Of the 346 children noted to receive additional support, 267 were receiving counselling. This counselling might have been related to or made necessary by their disability. For example, some children were receiving counselling in sign language which was not possible for workers or caregivers to provide. In other cases, the counselling was related to issues common among children in care such as abuse or attachment. In addition to counselling, 44 children were receiving art, play or music therapy. A tutor was provided for 20 children with disabilities. The complete list of CFS-funded services is available in Table A 4.17.

The most frequent services provided by Regional Health Authorities were mental health services for 76 children. RHAs also provided occupational therapy to 46 children, speech and language to 34 children, counselling to 33 children, physiotherapy to 32 children and feeding assistance to 10 children as noted in the files of children in care with disabilities. (Feeding assistance was related to overcoming feeding difficulties, monitoring intake and supervising tube feeding.)

Therapy provided by the Provincial Outreach Therapy for Children (POTC) included occupational therapy to 90 of the children in care with disabilities, speech and language to 71 and physiotherapy to 58. POTC also provided feeding assistance to 25 children, assistive technology to 11 children, general support to 8 and developmental programming to 4 children.

Service providers did not distribute services equally to all age groups. Figure 4.14 illustrates the proportion of services provided to age groups by some of the most common non-CFS service providers. POTC and CSS concentrate on the 0-5 age group with 49.0% (70) and 56.4% (31) respectively of their services directed to preschoolers. The FASD Outreach service is largely provided (64.2% or 43) to early years children ages 6-12 years. Services provided by RHAs are the most evenly divided among the age groups with 34.5% (61) of service for the 0-5 year group, 26.0% (46) for the 6-12 group and 39.5% (70) for the 13-20 group. CFS-funded services are definitely concentrated in the older age groups: 6-12 group 49.9% (173) of services and the 13-20 group 46.7% (161) of services. The full results are in table form in Table A 4.18. The largest proportion of any age group receiving services from a particular source is the 0-5 year group where 23% were receiving services from POTC. Groups are compared in Table A 4.19.

Figure 4.14
Service Providers Showing Proportion of Age Groups Served



Children Not in Care but Receiving Services

Demographics

The mean age of the children not in care but receiving services sample (N = 226) was 10.04 years, median 10 years and mode 9 years. The gender proportion was 32.3% (73) girls and 67.7% (153) boys. In terms of culture of origin, the group consisted of 52.2% (118) non-Aboriginal, 17.7% (40) not determined, 16.4% (37) Treaty, 10.6% (24) Métis, and 3.1% (7) Non-status. Their recorded Culturally Appropriate Authority was General 52.7% (119), First Nations South 11.9% (27), Métis 11.5% (26), First Nations North 6.2% (14). [CAA was not determined for 17.7% (40) of children not in care.] It must be remembered that this sample was gathered from a small number of agency sites and cannot be considered representative of the children receiving services in Manitoba.

Nature of Disability

The disability profile of this group was: intellectual 50.9% (115), mental health 50.0% (113), physical 19.9% (45), medical 17.7% (40), sensory 7.5% (17), and learning 3.1% (7).

Services

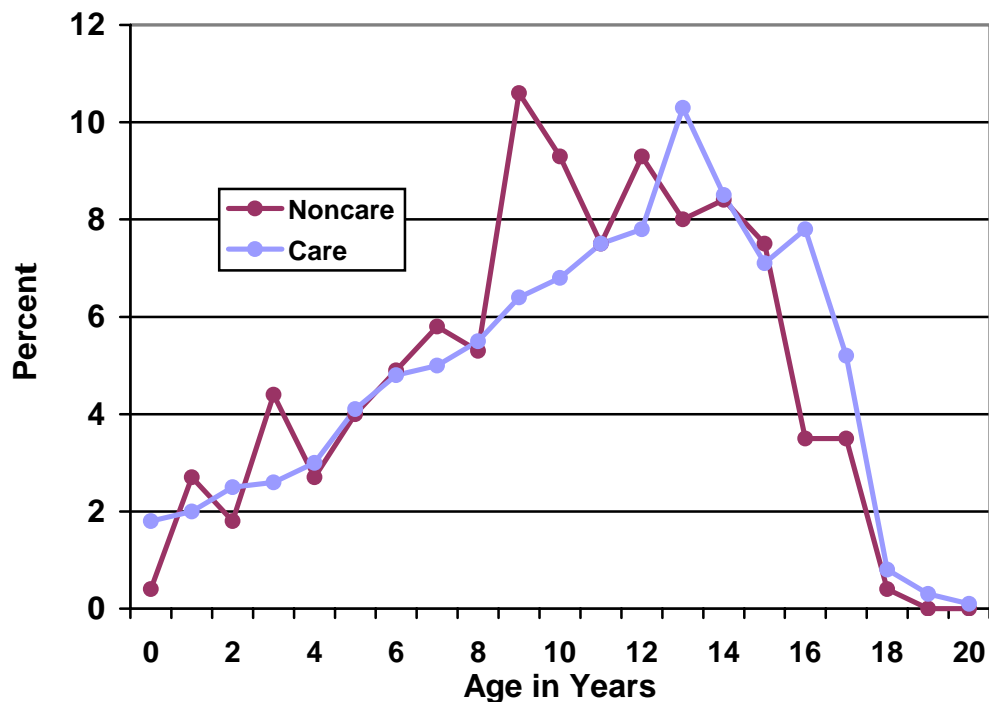
Services provided to children not in care included: in-home support 46.5% (105), respite 24.8% (56), behavioural guidance and supervision 19.5% (44), support for activities of daily living 15.0% (34), 24 hour supervision 3.5% (8) and Family Preservation 2.7% (6). Services by disability are outlined in the Appendix Table A 4.20. The most frequently provided service 46.5% (105) was in-home support workers. Twenty-five percent of the

group (56) was receiving respite. Although non-CFS services are not described here for this sample, the involvement of Children’s Special Services (CSS) with this group is of interest. CSS was noted to be providing services to 25.2% (57) of the children not in care.

Care / Non-care Comparison

With only a small convenience sample, comparisons are of limited usefulness. However, we cautiously offer a comparison of the ages of the care and non-care samples (Figure 4.15) to highlight the differences in the age profiles.

Figure 4.15
Age Comparison of Care and Non-Care Children



Summary

One third (33%) of the children in care in Manitoba on September 1, 2004 were found to have a disability. Boys accounted for 60% and girls for 40% of the children with disabilities in care. The higher proportion of boys was consistent across cultures of origin. The number of children in care increased with age until age 13 when the numbers of both boys and girls began to decline. Most children in care with disabilities were permanent wards. The proportion of permanent wards was somewhat greater among First Nations children. First Nations children comprised just over two thirds (68.7%) of

children with disabilities. Their representation in the disability population approximated their representation in the overall child in care population. The distribution of children with disabilities by Culturally Appropriate Authority was First Nations Southern Authority 45.9% (857), First Nations Northern Authority 22.2% (415), General Authority 20.0% (374) and Métis Authority 10.7% (200). The most frequently cited reasons for children with disabilities coming into care were related to the conduct and condition of their parents. The great majority of children with disabilities (approximately 80%) were placed in foster homes. There was ongoing regular family involvement for 53% of children in care under a VPA and 15.4% of permanent wards.

The most common disabilities were intellectual which affected 75.1% of the children with disabilities and mental health which impacted 45.8% of children. More than half the children had more than one type of disability (58.1%) and the most common combination of disabilities was again intellectual and mental health. FASD was diagnosed in one third of children with disabilities (34.2%) and close to half (45.6%) of children with an intellectual disability. The most frequently diagnosed mental health condition was ADHD. FASD and ADHD were coincident in 39.1% of children with an FASD diagnosis.

The majority of disabilities resulted from an unknown cause. Substance abuse was the origin of disability for 34.3% of the disability population and was a suspected cause for an additional 17.3% of those children.

To support functioning, 25.1% children needed assistance with the activities of daily living and 42.2% required medical support as described by URIS C. The majority of children were not age-appropriate in language (55.1%) or learning (62.8%). Of those with mental health disabilities, 84.4% required medication. Most children with disabilities were not able to achieve age-appropriate behaviour in dependability (76.4%), emotional modulation (72.0%), interpersonal interaction (64.4%), or awareness of risk (58.6%). Aggressive behaviour was problematic for 43% of children with disabilities. Other problem behaviours included sexually inappropriate behaviour involving 15.7% (294) and conflict with the law 11.3% (212).

The most frequently noted adaptive service was medication provided for 47.8% of children. Children with multiple disabilities were the most frequent recipients of services. Many organizations and agencies outside of CFS assisted in supporting children with disabilities. The greatest contributor was the education system which provided some form of additional support to more than 50% of children. By purchasing extra services for 18.5% of children with disabilities, CFS became the second most frequent additional service provider.

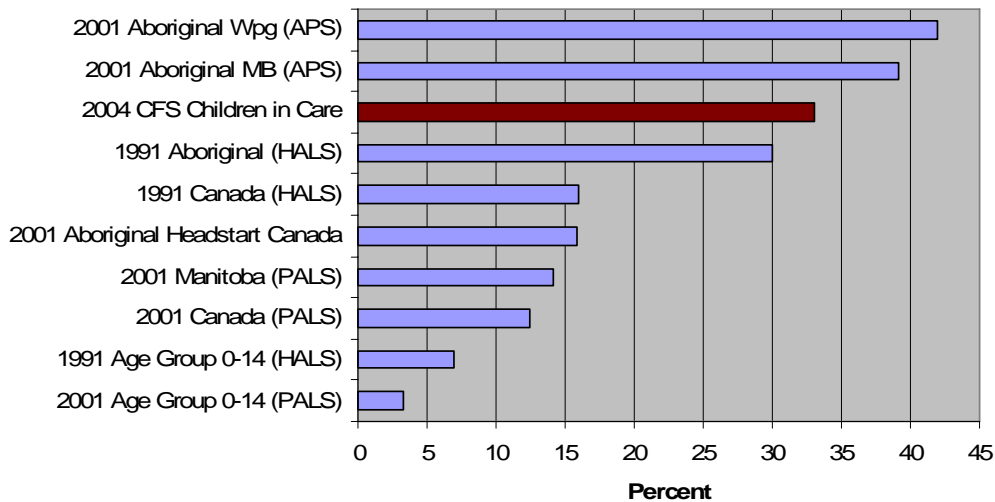
V. Discussion of the Nature, Needs and Resources of Children with Disabilities involved with the Child Welfare System

The purpose of this research was first to determine the number and proportion of children in care in Manitoba with disabilities and then to create a profile of those children, outlining the nature of their disability, their functioning and the services they receive. The previous chapter presented the profile of children with disabilities in care on September 1, 2004. The focus of this chapter will be to expand on the meaning of some of the major findings reported in Chapter IV and attempt to tease out factors associated with children with disabilities (CWD) coming into the care of a child welfare agency. The prevalence of children with disabilities in the child in care population will be considered. Some of the demographics of the CWD population, including gender, age, legal status and placement, will be more closely examined. The connection of services to needs will be reviewed.

Prevalence

One in three children in care in Manitoba has a diagnosed disability. This rate of disability is much higher than the rate for Manitoba as a whole (14.2%) published by PALS and even more disparate from the PALS rate for children which varied between 1.6% and 4% depending on the age group (Statistics Canada, 2002). It is well above the rate of 7.6% found in Australian children aged 0-14 (Australian Institute of Health and Welfare, 2004). As shown in Figure 5.1 the rate in this population exceeds all the published rates for Manitoba except those reported for Aboriginal populations.

Figure 5.1
Comparison of Child in Care Rate of Disability with Published Rates of Disability



The high rate of disability found in this group of children, compared to other prevalence rates, may be the result of a number of factors. PALS excluded people in institutions and those living on reserve, so there were differences in the samples. Because 70% of the children in care in Manitoba are First Nations children, the high rate may be a confirmation of the rates of disability published by the Aboriginal Peoples Survey. The Aboriginal Peoples Survey (APS) reported in 2001 the rate of diagnosed medical conditions in Aboriginal children in Manitoba was 39.1% and in Winnipeg 42.0% (Statistics Canada, 2001). However, there was a slightly higher proportion of non-Aboriginal children in the children with disabilities (CWD) population (19.7%) than was found in the total child in care (CIC) population (17.5%). Therefore in this sample, the rate of disability in First Nations children was not higher than the rate in non-Aboriginal children. The high rate of disability may reflect an increase in maltreatment experienced by children with disabilities. Children with disabilities have been reported to suffer maltreatment at a rate 3 times the rate of children with no disability (Sullivan & Knutson, 2000). This would result in a concentration of children with disabilities in care. Most children described in this profile came into care as a result of their parents' conduct.

Demographic Profile

Children in care with disabilities were most often First Nations middle-years boys with intellectual disabilities placed as permanent wards in foster homes.

Boys with disabilities outnumbered girls in the CWD population as a whole and in each culture of origin group. The proportion of boys with disabilities was greater than the overall proportion of boys in care. The difference between the populations would be even more striking if we had the statistical capability to remove our sample from the CIC population for comparison. Our review of the literature would indicate that this finding is to be expected. Although there are more CWD boys in each culture of origin when compared to the overall CIC population, the difference in the proportion of boys to girls is most pronounced in the non-Aboriginal population. For First Nations Authority groups the approximate proportion was 58.5% boys to 41.5% girl; for the Métis Authority the proportion was 63.3% boys and 36.7% girls and for General Authority children the proportion was 66% boys and 33% girls. The one-third girls/two-thirds boys ratio among non-Aboriginal children with disabilities in care was unexpected. Differences between gender groups also occurred in the area of mental health disabilities, where 60% of boys were affected but less than 50% of girls were affected.

The mean age of children with disabilities was 10.52 years. The largest number of children with disabilities was in the 6-12 year group (820 children). The age comparison of those in the CWD group and all CIC shows the greatest difference between the proportions of pre-schoolers. The CWD group had 16.1% in the 0-5 year old age bracket and the CIC group had 24.6% in that age category. There are two possible interpretations of this result. Young children may not be typically identified as having a disability or young children with disabilities may not be coming into care as frequently as others. The former possibility has been suggested in the literature. For example Boyle, Doernberg, Holmgren, Murphy and Schendel (1996) indicated that the rate of

occurrence of mental retardation increased with age in those diagnosed with mild or moderate retardation.

Most children with disabilities were permanent wards (68.7%). Typically, children became permanent wards because of the conduct (42.3%) or condition (18.9%) of their parents rather than for reasons associated with child conduct or condition.

The legal status of children varied by their culture of origin group. Three quarters (75.4%) of First Nations children were in care as permanent wards, two thirds of Métis children (67.6%) and less than half of non-Aboriginal (48.4%) children with disabilities were permanent wards. The difference in the proportion of VPA users in First Nations and non-Aboriginal groups was large and significant (non-Aboriginal 30.7%, Métis 14.5%, First Nations 7.5%).

Although The Child and Family Services Act (1985) makes provision for parents to sign an ongoing agreement with an agency to provide for their child with a disability (VPA), the proportion of children with disabilities in care under the provisions of a VPA (12.6%) was not notably greater than the proportion of children without disabilities in care under a VPA (12.3%). There was a difference in the proportion of level 5 children under a VPA. In this group of more severely compromised children, 30.4% (34) of children were under a VPA. The increased use of VPAs in level 5 children suggests that VPAs are sometimes being used as a means of obtaining additional resources for children with disabilities while maintaining parental guardianship. However, the similarity in rates of VPA use between the disability and non-disability groups of children in care would indicate that the VPA provision for disability is not being used generally to maintain the connection between parents and children with disability.

Voluntary Placement Agreements, used for 236 children (12.6% of legal status), were associated with older children (M = 11.79 years). For 49.6% (117) of children in care under VPAs, reasons for care were related to the conduct of the child (29.7%) or the conditions of the child (19.9%). In contrast, reasons related to children were associated with only 6.5% (84) of permanent wards.

Most children with disabilities in care were placed in foster homes (65.7%). It might be assumed that the care needs of children with disabilities would be greater than could be readily met in a family home setting. This was not the case. A few children were in specialized, group or staffed homes (11.9%) and a few were in residential or institutional placements (2.1%). This latter 14% of children required more care than could be reasonably provided in a regular family home. However, the large proportion of children was cared for in family settings with various levels of additional support. This was true even for the level five children where 55.4% (62) were in regular foster care. The profile of placement found for children under VPAs was somewhat different. Only 40.7% (96) of those children were placed in foster homes. An almost equal percentage, 39.8% were placed in more intensive care facilities: 12.7% (30) in specialized foster homes, 13.1% (31) in group homes, 6.4% (15) in staffed homes, and 7.6% (18) in health or mental health facilities.

Nature of Disability

Intellectual disability was the most frequently occurring disability in children in care with disabilities. Although our finding of 75.1% intellectual disability was a higher proportion than reported elsewhere, our intellectual category included developmental delays, cognitive impairments and FASD. Our finding was similar to the PALS finding of 68% developmental delay in children 0-4 years with a disability. The incidence of mental health diagnoses (45.8%) was also somewhat greater than reported for general populations. As cited earlier, PALS reported 31.8% of children with a disability having a psychological disorder. ADHD was our most common diagnosis and affected 72.4% of those with a mental health diagnosis. A high percentage of ADHD could be expected given the report of the Manitoba Centre for Health Policy (Martens et al., 2004) indicating three times the prevalence of this disorder in children who were wards of child and family services agencies. The diagnosis was more common in males and our findings also support that conclusion. The incidence reported by the Manitoba Centre for Health Policy of 13.6% male and 4.8% female approximates our finding of 10.9% (620) of all children in care.

The distribution of disabilities within cultures of origin showed that the non-Aboriginal group had the highest proportion of mental health, medical, physical, and sensory disabilities. The First Nations group had the highest percentage of children affected by intellectual disabilities (80.5%) and the lowest percentage of children affected by mental health disabilities (50.5%). In the non-Aboriginal group, 71.2% of children had mental health disabilities and 58.5% had intellectual disabilities. Given the proportion of First Nations children within the disabilities population, there are substantially large numbers of children who need culturally relevant services across health and social service sectors.

Multiple disabilities impacted the functioning of more than half (58.1%) of the children with disabilities. In the PALS survey, 49.1% of preschoolers and 71.8% of school-aged children with a disability had multiple disabilities. Our finding is therefore entirely consistent with previously published reports.

Slightly more than one third (34.2%) of children with disabilities had FASD. If children with suspected FASD were included, then FASD impacted more than half (51.5%) of the children with a disability. Diagnosed FASD was a factor in the lives 11.3% of the children in care. That percentage rises to 17% if those with suspected FASD are included.

Close to half (45.6%) of the children with an intellectual disability were diagnosed with FASD. Reports of the prevalence of FASD in the general population range from 7.2 to 101 per 1,000 live births (Square, 1997; Williams, Odaibo & McGee, 1999). Our incidence of 640 in a population of 5,664 would be the equivalent of 109 per 1,000. Although this is close to the upper reported range, the prevalence of FASD among children in care may not be reflective of the prevalence in the general population. A number of factors may contribute to concentrating children with FASD in the child in care population.

Most children with FASD have come into care as permanent wards (86.9% compared to 59.2% for non diagnosed children). In fact, 62.3% of all permanent wards are diagnosed with or suspected of having FASD.

Origin

In this group of children in care, substance abuse was responsible for the disability of 34.3% (640) of the children. If suspected FASD (323) is added to that total then 51.5% of children with disabilities are disabled as a result of substance abuse. Prenatal substance abuse is a totally preventable origin of disability. Prevention of FASD would have a significant impact on the number of children in care with disabilities.

Functioning and Services

One quarter (470) of children with disabilities needed support or adaptation to carry out the activities of daily living (ADL). It was reassuring to note that 404 (86%) of those children were receiving personal support for ADL. In addition, 399 (84.9%) were receiving adaptive medical services, 120 (25.5%) were receiving adaptive mechanical services and 48 (10.2%) were receiving adaptive technical services.

Medically related supports as categorized by URIS were needed by 51.7% (968) of children. Medication was the most frequently provided medical service with 47.8% (893) children receiving some form of prescribed medication.

A lack of age-appropriate facility with language presented a need for 55.1% (1,030) of children. The file review found 409 children were receiving speech and language therapy. Speech and language therapy providers included POTC, the school, the RHA, and private therapists funded by CFS. In addition, the development of conceptual, abstract and practical knowledge and skills required support for 62.8% (1,174) of children. The education system provided additional support to 948 children in this group.

Children with mental health disabilities (856) were most often prescribed medication (84.8%) as a means of support. In addition 335 (39.1%) children received direct therapy. The Regional Health Authorities were the most frequent mental health service providers and were noted to be providing assistance to 76 children.

Assessments of the personal and social behaviour of children with disabilities found that the majority were not age-appropriate in any of the areas examined. Difficulties with behaviour ranged from 76.4% (1,428) of children not age-appropriate in dependability to 58.6% (1,095) of children unable to age-appropriately assess risks to personal safety. The review of files showed 43.3% (810) of children with disabilities were receiving additional support and/or guidance for their behaviour. Although children might not have been receiving support obviously directed at their behaviour, other personal supports such as a mentor or in-home support worker might have been part of the child in care plan.

Additional respite for caregivers (43.1% or 805) should be noted as the second most frequently provided personal support.

In addition to the assessment of social behaviour, three areas of problem behaviour were examined. Aggressive behaviour was problematic for 43% (803) of children with disabilities. Other problem behaviours included sexually inappropriate behaviour involving 15.7% (294) and conflict with the law involving 11.3% (212). Children presenting these problem behaviours were all significantly older than those not presenting problem behaviour. The proportion of boys exhibiting problem aggressive behaviours (68.9%) and being in conflict with the law (71.2%) was greater than the proportion of girls. In fact 49.1% of boys were noted to have problem aggressive behaviour. There was a higher proportion of problem aggressive behaviour in children in care under a VPA than in children who were permanent wards: 55.1% (130) of those under a VPA (236) and 40.7% (523) of permanent wards (1,284) had problem aggressive behaviour. Children with mental health disabilities were the most likely to exhibit problem aggressive behaviour. They were much more likely to be aggressive (59.8%) than the intellectual disability group (39.7%) or its subgroup those with FASD (41.4%). It should be noted that while this research can comment on the relationship between particular types of disability and problem behaviour, it does not provide any evidence to indicate that problem behaviour is linked to disability in general.

The proportion of children receiving services varied considerably across disabilities. Of children with a sensory disability, 67.8% were receiving support for ADL and 63.3% had caregivers receiving additional respite. The greatest proportion of children receiving behavioural guidance and supervision was 56.2% of children with a mental health disability. The largest consumer group of services was the intellectual disability group, receiving for example 88.1% of ADL services, 68.7% of behavioural supervision and 80.3% of respite. Although they received the largest share of services, services were provided to a smaller proportion of the group (ADL = 29.4%, behavioural supervision 39.6% and respite 46.0%). Service provision to children appeared to be related to the number of their disabilities and consequent complexity of their care needs. As the number of disabilities increased, the proportion of children receiving services also increased. So that while three quarters (76.2%) of children with one disability received some form of adaptive personal service, every child (100%) with 5 disabilities received personal service. The distribution of services left many children without any apparent additional supports and others without support specific to their needs. This raises questions about the availability of services and access to support for children in care.

The children in care with disabilities presented a wide range of disabilities and multiple disabilities that require adaptation, support and/or treatment. Many had complex health needs and the great majority required behavioural supervision. In addition to the expertise of caseworkers and care providers, a range of disability and disability related services would be beneficial in meeting the needs of children in care. The list of additional service providers involved with this group of children is extensive. However, the files record small numbers of children receiving the benefit of the specialized expertise available from sources external to CFS. For example, of 300 pre-schoolers

with disability, POTC was assisting 143. Of 640 children diagnosed with FASD, 67 were receiving assistance from FASD Outreach. Children's Special Services was providing support to 55 children. The Manitoba Adolescent Treatment Centre was involved with 53 children. Disability specific organizations were connected to 34 children. The Child Guidance Clinic worked with 27. If the files are an accurate reflection of the support provided to children, then caseworkers and care providers shoulder a very heavy load.

Summary

In summation, we might add to our original description of the typical child in care with a disability. As a 13-year-old, he has been diagnosed with multiple disabilities and his aggressive behaviour is problematic. He has difficulty controlling impulses. This results in problems at school where he struggles to adhere to structure and expectations. He has been prescribed medication to assist with modulating his activity level and concentration. Academically, he is challenged and he has been provided a part-time teacher aid. He has no real friends his own age but does spend time with neighbourhood children several years his junior. He needs ongoing behavioural guidance and supervision.

VI. Implications

The research on disabilities completed by this project provides a unique contribution to knowledge in an underdeveloped area of child welfare research. It contributes significantly to the understanding of the needs and services available to children with disabilities and their families. Consequently it offers a great deal of insight for practitioners and policy makers in the fields of child welfare, health, disability and education. This chapter discusses the implications for practice/service delivery and policy as well as implications for future research.

Implications for Practice/Service Delivery

Expertise of Social Workers in Child Welfare

With the large number of children with disabilities emerging, social workers in child welfare need to be aware of more than just child welfare issues such as maltreatment, neglect and family functioning. They also need to have knowledge of disabilities and the services available. It is necessary to create training programs for staff members on the definition of disability and types of disability. There is also a need for workers to become more knowledgeable about the importance of and process for recording information in paper files and on CFSIS. The child's disability, how the disability affects the child's functioning, service needs, as well as adaptive services and personal supports received, should all be recorded. In addition, workers should be trained to recognize the additional stressors faced by families caring for a child with a disability. Child and family service workers' awareness of services and supports available to children with disabilities, their families, and foster parents is essential.

Training of Foster Parents and Other Direct Care Providers

Children in care with a disability have unique care needs that require adaptations, personal supports and special services. One way to ensure these needs are met is to provide training to foster parents and other direct care providers on the unique needs of these children. A training program needs to be developed and implemented to provide general information on disabilities as well as specific information on their foster child's disability and how this disability affects the child. This may include information and training on multiple disabilities, immature functioning in one or more areas, problem behaviour, inability to foresee consequences, inability to learn from previous experience, as well as poor impulse control.

Whenever possible, child care workers and other professionals should work together with foster parents and other caregivers to develop and implement an individualized program for the child. Additional training programs on implementing behaviour management strategies and behaviour interventions should be developed and provided. In addition, education on reasonable expectations consistent with the abilities of children who may have compromised intellectual and/or biological functioning is important. Typical behaviour interventions may need to be adapted for children who have difficulty

understanding or remembering the rules. Such difficulties may be shown through challenging behaviours which present a further need for expertise.

Training foster parents on these issues and accessing family support resources will help to decrease the stress and burnout of foster parents. This will hopefully allow foster parents to better understand the reasons why a child behaves or functions in a certain way and reduce placement changes for the child.

Placement Resources

As the number of children with disabilities increases, so will the importance of placement resources. Quality placements that can adequately meet the unique needs of children with disabilities are required. Recruitment and training of foster parents and group home staff is crucial. Adequate resources need to be available within the placement to provide additional support to decrease the possibilities of burnout. Respite providers are only one type of support that should be available. A training and recruitment program for respite providers also needs to be in place so they adequately understand the child's disability, any limitations the child may have, and behaviour intervention techniques used.

To ensure the needs of these children are met when they reach the age of majority a clearly defined protocol needs to be in place. Resources such as adult placements and supports need to be increased. Currently there is no connection between the per diems for caregivers in the child welfare system and the adult disability system. A foster parent may face a dramatic reduction in per diem to care for the same individual once they reach the age of majority even though the needs of the individual have changed little. In addition, some children do not meet the criteria to qualify for adult services yet they are unable to function adequately on their own. These issues make it important to strengthen the connection between the services provided to children with a disability and those for adults.

Child and family services staff need to plan ahead to ensure adequate supports are in place so that children make a successful transition into adult society. This would include making sure that children receive training in practical life skills such as cooking, cleaning, finding a job, and budgeting based on their abilities.

Connections to Disability Resources and Other Service Systems

To ensure the needs of the children are met it is necessary to create a clearly defined protocol to promote better communication between child protection workers and child disability workers. There needs to be a collaborative intersectoral team approach to ensure each child is receiving all the necessary services to best meet their needs. This will allow the different services sectors to work together as one united team for the best interest of the child.

Our study found that in some cases access to services was denied to the child based on legal status, age, budget restraints or because the child was in care. In other cases a child

could only receive services if they were brought into care. Services may also be unavailable due to the physical location of the child's community, such as on reserves in remote parts of the province. Better intersectoral communication between child welfare workers and disability workers would lead to a better integration of services. Child welfare workers also need to become more aware of what resources and services are available for children with disabilities so that they can make the appropriate referrals and connections.

Integration of Services

Without a profile of the children, a profile of the resources required to meet the needs of children with disabilities was impossible. Information was gathered on the type of services and adaptations children were receiving and which agencies were providing them. While the intention was to collect data on the financial resources used by this population of children, it was not possible due to database limitations.

As the Manitoba Family Services continues with the implementation of the Aboriginal Justice Inquiry - Child Welfare Initiative (2004) process, it will remain important to maintain consistency in the availability of resources and in service delivery to children with disabilities. A review of Manitoba services to children will highlight strengths and gaps that exist.

Manitoba is currently in the process of establishing an integrated service delivery system, intended to coordinate services from a multitude of areas. In keeping with the Integrated Service Delivery initiative, the integration of services for children with disabilities is currently under review. Services to children with disabilities exist outside the child protection system. However, knowledge of service needs in the "in care" population and clarification of present service delivery systems will facilitate further service integration.

A clearer understanding of what resources are presently being used and how and where they are being used will be of fundamental assistance to program planners. Armed with this information, program and policy analysts can evaluate the efficiency and effectiveness of existing services. Perhaps even more importantly, they will have the information necessary to consider the appropriateness of service delivery. What is the most effective way to support families? Are children being channeled into the protection system simply because they have a disability? This may lead, for example, to strengthening disability services rather than child protection services.

Implications for Policy

Information Database CFSIS

The results of this project highlight the importance of specific information gathering systems to collect information related to disability as part of the provincial administrative data base, the Child and Family Services Information System (CFSIS). Using a computer system which can effectively extract statistical information on abused disabled children is

necessary. The CFSIS system has been updated to include the information on children with disabilities so that subsequent reporting on this population can be done with ease. These reports will allow further exploration of this population, including answering questions on the duration of time which children are in care or prior contact history with the child welfare system, which this project was unable to determine.

Additionally, training on file recording and use of the new Wellness windows in CFSIS should be implemented. Use of the recently enhanced CFSIS system will ensure that children with disabilities are identified as they enter the system. Early identification will make it possible to more effectively address the specific needs of each child.

Availability of Support Services

The study clearly identified unmet needs for support services available to children with disabilities and their families. There may be many reasons why children are not receiving these services. It could be a result of problems in documenting needs or communication gaps between child welfare workers and children with disability workers, budget restraints or a lack of qualified support providers. The first two possibilities were previously discussed under implications for practice/service delivery. Additionally, support services may not be available in the child's community.

To ensure that adequate support services are in place for the growing number of children with complex and multiple disabilities, there will need to be additional resources allocated to ensure the availability of support resources and the development of new training programs.

Culturally Appropriate Intervention and Prevention Models

Culturally appropriate interventions and prevention models reflecting Manitoba's culturally diverse population are essential. This is particularly important in terms of First Nations people, who make up the largest percentage of children in care with a disability. Cultural effects may be further compounded by significant family problems such as poverty and domestic violence.

Programs need to be developed that respect Aboriginal cultures and are structured in a way that will promote accessibility and participation. Such programs would need to address issues related to understanding disabilities and the additional stress placed on families caring for children with disabilities as well as resources available to families.

This study found that substance abuse was a major factor in the origin of disability in many children. This suggests there is a particularly strong need for culturally appropriate FASD prevention programs and culturally relevant services for children with FASD related disabilities.

Intersectoral Links and Service Structures

In this study, a high proportion of children in care were not receiving services from other intersectoral links. For example, there were only 55 children in care with disabilities who were also involved with CSS and 57 children with disabilities receiving child welfare services who were also involved with CSS. Before any conclusions can be drawn, there needs to be some consultation with CSS and other intersectoral programs regarding their database of children receiving their services. It is possible that the child and family service files did not include notations regarding the involvement of CSS or other service providers.

However, it would be important to create a policy to ensure a better working relationship between the child protection teams and other intersectoral program teams. Areas that should be examined include the following:

- The eligibility criteria for CSS and other intersectoral services
- The kind of information that can be generated from other services' databases with regard to types of disability, frequencies, ages of children, services needs, etc.
- Ways to better identify children who are involved with both intersectoral links and the child and family services system
- The kinds of services that each system provides including any gaps or overlaps
- The types of policies and/or funding arrangements that cause constraints for the two systems and impact service delivery to children with disabilities
- How the systems currently work together, and how communication, collaboration, and service delivery between the two systems be enhanced

The Child and Family Services Act

The Child and Family Services Act makes provision for children to be placed in care based on having a disability. This is a problem for families wanting to access services for their child from places such as St. Amant Centre. The parent is required to sign a VPA and allow their child to come into care of the child welfare system before the child can be admitted to the facility. Is bringing a child into care for the sole purpose of accessing disability services appropriate or necessary? Does this fit with the role of the child welfare system? Our research would indicate that these questions need to be examined by policy makers.

Implications for Future Research

While this disabilities project has provided invaluable information regarding the Manitoba population of children in care with disabilities, it also raises a number of areas meriting further research. The following is an overview of some of the themes that could be prioritized as future research projects.

CFSIS

When this project began, the only way to create a profile of children in care with disabilities was to do a manual file review. Based on the research completed and updates made to CFSIS, it has been possible to have all of the data collected from the current research project entered into CFSIS. This will allow future profiles and research to be done by creating reports directly from CFSIS. Child welfare agencies will now be able to trace the number of children within their agency who have a disability, services they require, as well as services and adaptations they receive.

Determinants of Care

There are a number of critical questions concerning the relationship between disability and maltreatment. Are they coincident in this population? Are maltreatment and/or neglect primary reasons for children with disabilities coming into care in Manitoba? This information is critical to strengthening and supporting families and will inform efforts to prevent children coming into care. Better knowledge of the characteristics of permanent wards with disabilities and children with disabilities who are voluntarily placed leads to the need to understand how and why these children come into care. Our results indicated permanent wards were more likely to come into care due to reasons associated with the conduct of the parent or conditions of the parent and children in care under voluntary placement agreements were more likely to be in care as a result of the conduct or condition of the child. The limitations of CFSIS however, prevented exploring the reasons in detail. The categories 'Conduct parent', 'Conditions parent', 'Conduct child' and 'Conditions child' reflect in only the broadest terms reasons why children become involved with child welfare agencies. A more detailed examination of these determinants of care is required. This type of research could involve surveys or interviews with case managers, surveys or interviews with parents (particularly those parents who placed their child under a voluntary placement agreement), and/or case studies/file reviews.

FASD

There have been numerous studies done on FASD however few focus on helping children, families and service providers deal with the stress and difficulties that arise. Given the significant number of children with FASD in Manitoba and both their service and placement needs, this is an area that warrants further attention. There are many potential research areas that include:

- Diagnosis of FASD
- Services for children with FASD
- Services to biological parents caring for children with FASD
- Services to foster parents caring for children with FASD
- Characteristics of effective placement settings for children with FASD
- Training of foster parents
- Training of child and family services staff
- Transition of children with FASD to age of majority

- FASD services, policies, standards and funding in other jurisdictions

Joint Research – Children with FASD

Given the prevalence of FASD in Manitoba, it would be useful to compare our experience with the situation in another jurisdiction. For example, New Zealand has a similar Aboriginal population and a high incidence of FASD. A joint research initiative could be created to explore the following questions:

- What is the incidence of FASD in the two jurisdictions in the general population and in children involved with the child welfare system?
- How is FASD diagnosed in the two jurisdictions? Who conducts the diagnosis process? How old are children at the point of diagnosis?
- Who identifies children for assessment of possible FASD? How accessible are assessment/diagnosis services?
- What kinds of services are available for children with FASD in the two jurisdictions? What services are available for their parents? For their caregivers?
- What kinds of prevention strategies are in place in the two jurisdictions?

This comparative research would be of benefit to both Manitoba and a comparative jurisdiction, providing an opportunity to explore similarities and differences in populations, needs, services, and policies.

Services to Children with Disabilities

This project was able to determine some of the service systems that are currently involved with children with disabilities. However, there was not always clear documentation in files to identify service providers, so it is likely that our data in this area is incomplete.

It is interesting that child and family service agencies provide a significant proportion of non-CFS services, suggesting that the child welfare system provides for or pays for services related to the child's disability. It would be useful to have a better understanding of the services that children with disabilities receive, as well as the services that children require, and the costs that are associated with these services. Further, it would be important to determine the geographical locations where children live and whether services are accessible in their home communities.

Children with Disabilities Receiving Services

This disabilities project identified 226 children with disabilities who were not in care but were receiving services from a child and family services agency. This is a very small proportion of the children receiving services. Given that 33% of all children in care have some type of disability, it raises some questions about the low number of children receiving services who have a disability. Certainly, it was children receiving services in the data collection process than it was to identify children in care. As workers begin to

use the new CFSIS windows, there will be more information about children involved with the child welfare system, which will allow us to better identify and analyze the population of children with disabilities receiving services.

Comparison of the ages of children with disabilities receiving services and children with disabilities in care raises questions. The percentage of children in care peaks at age 13 while the percentage of children receiving services peaks at age 9. Subsequent analyses of CFSIS data may provide answers to questions raised here:

- Do children with disabilities receiving services become children in care as they age?
- How long and how often have the children in care been in care?
- At what ages did the children in care come into care for the first time and come into care permanently?
- In addition to child welfare support services, what other kinds of services are non-care children receiving?
- In particular, do the legal status proportions for children in care differ for children around age 13 as compared to younger children?
- What types of disability are represented at different age groups? Are there certain disabilities more common at certain ages?

With the data entered into CFSIS, an examination of these questions is possible within the parameters of a new research project.

Summary

The findings of this study have significant implications for policy, program and practice relating to children with disabilities in contact with the child welfare system. The study has shown the number of children with disabilities involved with the child welfare system is increasing and there are a growing number of children with complex disabilities receiving services in and through the child welfare system. There is a great need to include knowledge relating to these needs in policy, planning, program development and service provision. It will involve developing new training programs and mechanisms for intersectoral collaboration between service sectors in the provision of services. In addition, it will involve the continued systematic gathering of specific information on the needs of these children.

VII. Recommendations and Conclusion

Findings and Discussion Summary

This study found that approximately one third of Manitoba's children in care have a disability and most of these children have multiple disabilities. Children tended to be in the middle years with males more likely than females to have a disability. The culture of origin of children with disabilities was reflective of the general population of children in care where children of Aboriginal ancestry are over-represented. Most children were permanent wards and the majority of children in care with a disability were placed in foster homes.

Intellectual disabilities were the most frequently found disability followed by mental health disabilities. The highest proportion of mental health, medical, physical, and sensory disabilities was in the non-Aboriginal population. However, it is important to note there were substantially higher numbers of Aboriginal children with all types of disabilities in care. The First Nations group had the highest percentage of children with intellectual disabilities and the lowest percentage of children affected by mental health disabilities. In the non-Aboriginal group, the opposite was true. Slightly more than one third of children with disabilities had FASD; this rose to slightly more than half when suspected FASD was included. In most cases children had co-occurring disabilities with intellectual and mental health being the most frequently noted combination for example FASD and ADHD.

Substance abuse was responsible for disabilities in approximately one third of the children. If suspected FASD was included, then just over half of the children had a disability as a result of substance abuse. Prenatal substance abuse is a totally preventable origin of disability. If FASD could be prevented, then the number of children in care with disabilities would shrink by one third to one half.

Adaptations and supports were received by a large number of children with medical adaptations and personal supports being most common. Prescribed medication was the most frequently noted adaptation. Most children were not functioning at an age-appropriate level in terms of personal and social behaviour.

Implications Summary

The findings of this study have significant implications for policy makers and practitioners who are in contact with children with disabilities in the child welfare system.

This study has demonstrated that children with disabilities are a significant proportion of the children in care in this province. Children with disabilities in care receive services in and through the child welfare system. The child welfare system is not currently structured in a manner to serve children with disabilities and their families. The data indicates that many children with disabilities and their families are not receiving, from the child welfare system or from other service sectors, the services necessary to meet

their needs. To ensure that these children and their families receive the services they require, awareness of their needs and knowledge of how to address those needs must be the foundation of policy, program planning, staff training and service provision.

With the large number of families and children with disabilities coming to the child welfare system, increasing social and economic costs must be addressed. Greater understanding, sensitivity and awareness within the child welfare system are required to more effectively address the issues and needs of families and children with disabilities.

Recommendations

This project has demonstrated through its findings and implications the importance of research in the area of children with disabilities. It has led to several recommendations for the child welfare, education, disability and health care sectors:

1. Develop policy to ensure intersectoral collaboration occurs between service sectors in the provision of services.
2. Develop and implement collaborative models with intersectoral teams of service providers to provide the necessary services to children with disabilities and their families.
3. Develop training programs on disabilities, including information on how intellectual and biological limitations affect functioning and how to deal with problem behaviour. This training should be available for all child welfare workers, foster parents and other direct care providers.
4. Develop and implement culturally appropriate prevention and service delivery programs. This would include: strengthening programs on prevention of FASD; providing services to families with children with FASD; understanding issues relating to disabilities; supporting families in dealing with the additional stress of caring for children with a disability; and linking available resources to families.
5. Continue the development of the information database on the needs of children with disabilities, specifically those involved with the child welfare system, and the development of a mechanism to ensure the information is integrated into the annual planning of agencies and departments.

Conclusion

The importance of research in the area of disability and the prevention of maltreatment of children with disabilities is evident. There is a great need for more research in this area to inform policy makers, planners and service providers. Ensuring professionals are knowledgeable in these areas and that services are available is of most importance for the promotion of the increased accessibility and greater social inclusion of families and children with disabilities in society.

References

- Aboriginal Justice Inquiry - Child Welfare Initiative. (2004). *General Background*. Retrieved February 2, 2004, from <http://www.AJI-CWI.mb.ca>
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.
- Australian Institute of Health and Welfare. (2004). *Children with disabilities in Australia*. Retrieved June 10, 2005, from <http://www.aihw.gov.au/publications/dis/cda.pdf>
- Bertrand, J., Mars, A., Boyle, C., Bove, F., Yeargin-Allsopp, M., & Decoufle, P. (2001). Prevalence of Autism in a United States population: The Brick Township, New Jersey, investigation. *Pediatrics*, *108*, 1155-1161.
- Betz, C., Baer, M., Poulsen, M., Vahanvaty, U., Bare, M., Haddad, Y., & Nwachukwu, G. (2004). Secondary analysis of primary and preventive services accessed and perceived service barriers by children with developmental disabilities and their families. *Issues in Comprehensive Pediatric Nursing* *27* (2), 83-106.
- Blackstock, C., Trocmé, N., & Bennett, M. (2004). Child welfare response to Aboriginal and Caucasian children in Canada: A comparative analysis. *Violence against Women*, *10*(8), 901-916.
- Boyle, C. A., Decoufle, P., & Yeargin-Allsopp, M. (1994). Prevalence and health impact of developmental disabilities in US children. *Pediatrics*, *93*, 399-403.
- Boyle, C. A., Doernberg, N. S., Holmgren, P., Murphy, C., & Schendel, D. E. (1996). Prevalence of selected developmental disabilities in children 3 to 19 years of age: The metropolitan Atlanta developmental disabilities surveillance program, 1991. *Morbidity and Mortality Weekly Report*, *45*(SS-2), 1-14.
- Brett, J. (2004). The journey to accepting support: How parents of profoundly disabled children experience support in their lives. *Paediatric Nursing*, *16*, 14-18.
- Brown, J., Moraes, S., Bednar, L., & Mayhew, J. (2004). *Promoting successful foster placement for children with disabilities*. Unpublished report to the Winnipeg Regional Health Authority.
- Burgess, D. M. (1994). Helping prepare children with FAS or FAE for school and beyond. *Alcohol Health and World Research*, *18*(1). Retrieved September 6, 2005, from <http://web12.epnet.com.proxy1.lib.umanitoba.ca/>

- Cass, H., Price, K., Reilly, S., Wisbeach, A., & McConachie, H. (1999). A model for the assessment and management of children with multiple disabilities. *Child: Care, Health and Development*, 25(3), 191-211.
- Chudley, A. E., Conry, J., Cook, J. L., Looock, C., Rosales, T., & LeBlanc, N. (2005). Fetal Alcohol Spectrum Disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal*, 172(5 suppl), S1-S21.
- Cooke, P., & Standen, P. J. (2002). Abuse and disabled children: Hidden needs...? *Child Abuse Review*, 11, 1-18.
- Crosse, S. B., Kaye, E., & Ratnofsky, A. C. (1993). *A report on the maltreatment of children with disabilities*. Washington, DC: National Center on Child Abuse and Neglect, Administration on Children, Youth and Families, Administration for Children and Families, US Department of Health and Human Services.
- Erevelles, N. (1996). Disability and the dialectic of difference. *Disability & Society*, 11 (4), 519-537.
- Federal/Provincial/Territorial Ministers Responsible for Social Services. (1998). *In unison: A Canadian approach to disability issues, A vision paper*. Ottawa, ON: Human Resources Development Canada.
- First Nations Child and Family Caring Society of Canada. (2005). *Wen: De. We are coming to the light of day*. Ottawa, ON: Author. Retrieved October 23, 2005, from <http://www.fncfcs.com/docs/WendeReport.pdf>
- Flynn, R. & Ghazal, H. (2002). *Looking after children (CanLAC) project*. Ottawa, ON: University of Ottawa, Center for Research on Community Services (CRCS).
- Friendly, M., & Beach, J. (2005). *Early childhood education and care in Canada 2004*. Toronto, ON: University of Toronto, Childcare Resource and Research Unit.
- Human Resources Development Canada. (2001). *Disability in Canada: A 2001 Profile*. Gatineau, QC: Government of Canada.
- Jacobson, S. W., Jacobson, J. L., Sokol, R. J., Chiodo, 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.
- Kendall-Tackett, K., Lyon, T., Taliaferro, G., & Little, L. (2005). Why child maltreatment researchers should include children's disability status in their maltreatment studies. *Child Abuse and Neglect*, 29, 147-151.

- Koren, G., & Nulman, I. (2002). *The motherisk guide to diagnosing Fetal Alcohol Spectrum Disorder*. Toronto, ON: The Hospital for Sick Children.
- Krahn, G. L., Thom, V. A., Sokoloff, K., Hylton, J., & Steinberg, M. (2000). *Every child special, every child safe: Protecting children with disabilities from maltreatment*. Portland, OR: Oregon Health Sciences University. Retrieved September 15, 2005, from <http://www.ohsu.edu/oidd/pdfs/OAKSProjectbw.pdf>
- Lewis, A. C. (1994). Fetal alcohol syndrome. *Education Digest*, 60(2), 72-75.
- Llewellyn, G., Dunn, P., Fante, M., Turnbull, L., & Grace, R. (1999). Family factors influencing out-of-home placement decisions. *Journal of Intellectual Disability Research*, 43, 219-233.
- Manitoba Family Services and Housing, Manitoba Education and Training & Manitoba Health. (1999). *Unified Referral and Intake System (URIS), Policy and procedure manual*. Winnipeg: Government of Manitoba.
- Martens, P., Burchill, C., Fransoo, R., De Coster, C., McKeen, N., Ekuma, O., et al. (2004). *Patterns of regional mental illness disorder diagnoses and service use in Manitoba: A population-based study*. Winnipeg: University of Manitoba, Manitoba Centre for Health Policy.
- Matheson, L. (2001). Disability methodology redesign: Considerations for a new approach to disability determination. *Journal of Occupational Rehabilitation*, 11(3), 135-142.
- McKenzie, B., & Morrissette, V. (2003). Social work practice with Canadians of Aboriginal background: Guidelines for respectful social work. In A. Al-Krenawi & J. R. Graham (Eds.) *Multicultural social work in Canada: Working with diverse ethno-racial communities*. Don Mills, ON: Oxford University Press Canada.
- Morris, J. (1999). Disabled children, child protection systems and the Children Act 1989. *Child Abuse Review*, 8, 91-108.
- Office for Disability Issues. (2003). *Disability in Canada: A 2001 Profile*. Human Resources Development Canada, SDDP-048-12-03.
- Province of Manitoba. (2001). Aboriginal People with Disabilities. *Full citizenship: A Manitoba strategy on disability*. Retrieved July 29, 2005, from <http://www.gov.mb.ca/access/abor.html>
- Province of Manitoba. (2005). *Full citizenship: A Manitoba strategy on disability*. Retrieved September 29, 2005, from <http://www.gov.mb.ca/access/append.html>

- Public Health Agency of Canada. (2001). *Aboriginal Head start in Urban and Northern Communities: Program and participants 2001*. Retrieved August 2, 2005, from http://www.phac-aspc.gc.ca/dca-dea/publications/ahs_program2001_e.html
- Simeonsson, R. J., Leonardi, M., Lollars, D., Bjorck-Akesson, E., Hollenweger, J., & Martinuzzi, A. (2003). Applying the International Classification of Functioning, Disability and Health (ICF) to measure childhood disability. *Disability and Rehabilitation*, 25(11-12), 602-610.
- Social Development Canada. (2004). *Defining Disability*. Retrieved June 22, 2005, from <http://www.sdc.gc.ca/en/hip/odi/documents/Definitions/Definitions002.shtml>
- Sokol, R.J., Martier, S., & Ager, J. (1989). The T-ACE questions: Practical prenatal detection or risk-drinking. *American Journal of Obstetrics and Gynecology*, 160, 863-868.
- Square, D. (1997). Fetal Alcohol Syndrome epidemic on Manitoba reserve. *Canadian Medical Association Journal*, 157(1), 59-60.
- 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-e.htm>
- Statistics Canada. (1991). Health and Activity Limitations Survey 1991 (HALS). Ottawa, ON: Author.
- Statistics Canada. (2001). Aboriginal Peoples Survey Community Profile. Retrieved July 25, 2005, from <http://www12.statcan.ca/english/profil01aps/statistics.cfm?component=2&community>
- Statistics Canada. (2002). *A profile of disability in Canada, 2001*. Catalogue no. 89-577-XIE. Ottawa, ON: Author.
- Sullivan, P. M., & Knutson, J. F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*, 24, 1257-1274.
- Taylor, E., & Rogers, J. W. (2005). Practitioner review: Early adversity and developmental disorders. *Journal of Child Psychology and Psychiatry*, 46(5), 451-467.
- The Child and Family Services Act. (1985). Government of Manitoba. Available at: <http://web2.gov.mb.ca/laws/statutes/ccsm/c080e.php>
- The Child Welfare Act. (1974). Government of Manitoba, c30 – Cap. C80.

- The Vulnerable Persons Living with a Mental Disability Act. (1993). Government of Manitoba. Available at: <http://web2.gov.mb.ca/laws/statutes/ccsm/v90e.php>
- Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., et al. (2005). *Canadian incidence study of reported child abuse and neglect – 2003*. Ottawa, ON: Health Canada.
- Trocmé, N., Knoke, D., & Blackstock, C. (2004). Pathways to the overrepresentation of Aboriginal children in Canada's child welfare system. *Social Service Review*, 75(4), 577-600.
- Umlah, C., & Grant, T. (2003). Intervening to prevent prenatal alcohol and drug exposure: The Manitoba experience in replicating a paraprofessional model. *Envision: The Manitoba Journal of Child Welfare*, 2(1). Retrieved September 6, 2005, from <http://www.envisionjournal.com>
- United Nations. (2003-2004). *UN Enable – The United Nations and persons with disabilities*. Retrieved September 6, 2005, from <http://www.un.org/esa/socdev/enable/disun.htm>
- Wiener, J., & Siegel, L. (1992). A Canadian perspective on learning disabilities. *Journal of Learning Disabilities*, 25(6), 340-350, 371.
- Williams, R. J., Odaibo, F. S., & McGee, J. M. (1999). Incidence of Fetal Alcohol Syndrome in northeastern Manitoba. *Canadian Journal of Public Health*, 90(3), 192-4.
- World Health Organization. (2001). *ICF Checklist, for international classification of functioning, disability and health*. Geneva: Author.
- World Health Organization. (2002). *Towards a common language for functioning, disability and health, ICF*. Geneva: author.
- World Health Organization. (2003). *Development of the ICF for children and youth – Status report*. (WHO/HFS/CAS/C/03.63) Geneva: Author
- Yeargin-Allsopp, M., Rice, C., Karapurkar, J., Doernberg, N., Boyle, C., & Murphy, C. (2003). Prevalence of autism in a US metropolitan area. *Journal of American Medical Association*, 289(1), 49-55.

Appendix A Children with Disabilities Information Profile

Name: _____

Date: _____

1. Gender: Male Female

2. Date of Birth: _____
day / month / year

3. Aboriginal Status: (check one)

- 1=Not determined
- 2=Not Aboriginal
- 3=Treaty (Status)
- 4=Metis
- 5=Non-status
- 6=Inuit

4. Culturally Appropriate Authority:

- 1=First Nations North
- 2=First Nations South
- 3=General
- 4=Metis
- 5=Not determined

5. Legal Status: (check one)

- 1=Not in care
- 3=Apprehension
- 5=Permanent Ward – court
- 7 = VPA
- 9=Unknown

- 2=Petition filed for further order
- 4=Temporary Ward
- 6=Permanent Ward - VSG
- 8=Transitional planning
- 10=Waiting closure

Effective: _____
day / month / year

6. Guardian Agency _____

7. Supervising Agency _____

8. Primary reason for coming into care: (check one)

- | | |
|---|---|
| <input type="checkbox"/> 1=Abandonment | <input type="checkbox"/> 2=Desertion |
| <input type="checkbox"/> 3=Conditions/Child | <input type="checkbox"/> 4=Conditions/Parent |
| <input type="checkbox"/> 5=Conduct/Child | <input type="checkbox"/> 6=Voluntary Relinquishment |
| <input type="checkbox"/> 7=Conduct/Parent/Medical refusal | <input type="checkbox"/> 8=Conduct/Parent/Other (unspecified) |
| <input type="checkbox"/> 9=Other | <input type="checkbox"/> 10 = Not in care |
| <input type="checkbox"/> 11=Transfer in from MB agency | <input type="checkbox"/> 12=Transfer in from out of province |
| <input type="checkbox"/> 13=Unknown | |

9. Level of Care

- | | | | |
|-------------------------------------|-------------------------------------|---|--|
| <input type="checkbox"/> 1=Level I | <input type="checkbox"/> 2=Level II | <input type="checkbox"/> 3=Level III | <input type="checkbox"/> 7 = Not in Care |
| <input type="checkbox"/> 4=Level IV | <input type="checkbox"/> 5=Level V | <input type="checkbox"/> 6=Undetermined | |

10. Placement: (check one)

- | | |
|---|---|
| <input type="checkbox"/> 1=Non-care | <input type="checkbox"/> 2=Foster home |
| <input type="checkbox"/> 3=Foster home – staffed | <input type="checkbox"/> 4=Foster home – specialized |
| <input type="checkbox"/> 5=Residential care | <input type="checkbox"/> 6=Group Home |
| <input type="checkbox"/> 7=Independent living | <input type="checkbox"/> 8=Place of Safety |
| <input type="checkbox"/> 9=Hotel | <input type="checkbox"/> 10=Correctional Facility |
| <input type="checkbox"/> 11=Health / Mental Health | <input type="checkbox"/> 12=Own home/Relative (non-pay) |
| <input type="checkbox"/> 13=Shelter | <input type="checkbox"/> 14=Home+placement combo |
| <input type="checkbox"/> 15=Placement not known | <input type="checkbox"/> 16=Out-of-province |
| <input type="checkbox"/> 17=Foster home/institution combo | |

11. Family of Origin involvement:

- | | |
|--|---|
| <input type="checkbox"/> 1=Regular monthly or more | <input type="checkbox"/> 2=Regular less than monthly |
| <input type="checkbox"/> 3=Irregular | <input type="checkbox"/> 4=No contact |
| <input type="checkbox"/> 5=Not known | <input type="checkbox"/> 6=Does not apply (child at home) |

Nature of Disability. Please indicate area(s) of disability and associated details. If a disability is not noted on this list, please add it at "Other".

12. Physical disability
- | | |
|--|---|
| <input type="checkbox"/> 1=Cerebral palsy | <input type="checkbox"/> 2=Hypotonia |
| <input type="checkbox"/> 3=Scoliosis | <input type="checkbox"/> 4=Motor Delay |
| <input type="checkbox"/> 5=General physical disability | <input type="checkbox"/> 6=Cleft palate |
| <input type="checkbox"/> 7=Club foot | <input type="checkbox"/> 9=Hemiparesis |
| <input type="checkbox"/> Other (describe) _____ | |
-
13. Medical (chronic health problems)
- | | | |
|---|---|--|
| <input type="checkbox"/> 1=Seizures | <input type="checkbox"/> 2=Feeding difficulties | <input type="checkbox"/> 3=Resp/Oxy |
| <input type="checkbox"/> 4=Heart | <input type="checkbox"/> 5=Diabetes | <input type="checkbox"/> 6=Asthma |
| <input type="checkbox"/> 7=Life threatening allergies | <input type="checkbox"/> 8=HIV/AIDS | <input type="checkbox"/> 9=Kidney |
| <input type="checkbox"/> 10=STD's | <input type="checkbox"/> 11=Hep C | <input type="checkbox"/> 12=Metabolic |
| <input type="checkbox"/> 13=Endocrine | <input type="checkbox"/> 14=Burns | <input type="checkbox"/> 15= Digestive |
| <input type="checkbox"/> 16=Liver | <input type="checkbox"/> 17=Skin | |
| <input type="checkbox"/> Other (describe) _____ | | |
-
14. Sensory perception
- | | | |
|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> 1=Vision | <input type="checkbox"/> 2=Hearing | <input type="checkbox"/> 3=Both V&H |
|-----------------------------------|------------------------------------|-------------------------------------|
15. Cognitive/Intellectual
- | | |
|--|---|
| <input type="checkbox"/> 1=Developmental delay | <input type="checkbox"/> 2=Cognitive impairment |
| <input type="checkbox"/> 3=FASD (diagnosed) | <input type="checkbox"/> 4=FASD (suspected) |
| <input type="checkbox"/> 5=Neurological behaviour disorder | <input type="checkbox"/> 6=FASD50 |
16. Learning Disability
- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> 1=Diagnosed | <input type="checkbox"/> 2 = Suspected | <input type="checkbox"/> 3 = No learning disability |
|--------------------------------------|--|---|

17.

Mental health Disorder

1=Diagnosed 2 = Suspected 3= No mental health disorder

Specify **Diagnosed** Disorders:

- | | | |
|--|---|--|
| <input type="checkbox"/> 1=Autistic Spectrum disorder (Autism, PDD, Aspergers) | <input type="checkbox"/> 3=Anxiety | <input type="checkbox"/> 4=Attachment |
| <input type="checkbox"/> 2=ADHD, ADD | <input type="checkbox"/> 6=Avoidant personality | <input type="checkbox"/> 7=Bipolar |
| <input type="checkbox"/> 5=Anti-social | <input type="checkbox"/> 9=Borderline personality | <input type="checkbox"/> 10=Dependent |
| <input type="checkbox"/> 8=Depression | <input type="checkbox"/> 12=Histrionic | <input type="checkbox"/> 13=Intimacy Deficit |
| <input type="checkbox"/> 11=Dysthymic | <input type="checkbox"/> 15=Oppositional defiant | <input type="checkbox"/> 16=Obsessive Compulsive |
| <input type="checkbox"/> 14=Narcissistic | <input type="checkbox"/> 18=Paranoid | <input type="checkbox"/> 19=Paraphilia |
| <input type="checkbox"/> 17=Organic Psychotic | <input type="checkbox"/> 21=Post-traumatic Stress | <input type="checkbox"/> 22=Schizoid |
| <input type="checkbox"/> 20=Pedophilia | <input type="checkbox"/> 24=Tourette's | <input type="checkbox"/> 25= Parent/child |
| <input type="checkbox"/> 23=Suicidal | <input type="checkbox"/> 27=Conduct disorder | <input type="checkbox"/> 28= Pica |
| <input type="checkbox"/> 26=Substance abuse | <input type="checkbox"/> 30=Social phobia | <input type="checkbox"/> 31=Disruptive behavior |
| <input type="checkbox"/> 29=Eating disorder | <input type="checkbox"/> 33=Sleep disorder | <input type="checkbox"/> 34=Adjustment |
| <input type="checkbox"/> 32=Mood disorder | <input type="checkbox"/> 36=Behaviour disorder | <input type="checkbox"/> 37=Impulse control |
| <input type="checkbox"/> 35=Dissociative | <input type="checkbox"/> 39=Pyschotic disorder | <input type="checkbox"/> 40=Intermittent explosive |
| <input type="checkbox"/> 38=Severe emotional | <input type="checkbox"/> 42=Abuse victim | <input type="checkbox"/> 43=Trichotillomania |
| <input type="checkbox"/> 41=Sexual deviance | <input type="checkbox"/> 45=Social emotional | |
| <input type="checkbox"/> 44=Gender identity | | |
| <input type="checkbox"/> Other (describe) _____ | | |

Specify **Suspected** Disorders:

- | | | |
|--|---|--|
| <input type="checkbox"/> 1=Autistic Spectrum disorder (Autism, PDD, Aspergers) | <input type="checkbox"/> 3=Anxiety | <input type="checkbox"/> 4=Attachment |
| <input type="checkbox"/> 2=ADHD, ADD | <input type="checkbox"/> 6=Avoidant personality | <input type="checkbox"/> 7=Bipolar |
| <input type="checkbox"/> 5=Anti-social | <input type="checkbox"/> 9=Borderline personality | <input type="checkbox"/> 10=Dependent |
| <input type="checkbox"/> 8=Depression | <input type="checkbox"/> 12=Histrionic | <input type="checkbox"/> 13=Intimacy Deficit |
| <input type="checkbox"/> 11=Dysthymic | <input type="checkbox"/> 15=Oppositional defiant | <input type="checkbox"/> 16=Obsessive Compulsive |
| <input type="checkbox"/> 14=Narcissistic | <input type="checkbox"/> 18=Paranoid | <input type="checkbox"/> 19=Paraphilia |
| <input type="checkbox"/> 17=Organic Psychotic | <input type="checkbox"/> 21=Post-traumatic Stress | <input type="checkbox"/> 22=Schizoid |
| <input type="checkbox"/> 20=Pedophilia | <input type="checkbox"/> 24=Tourette's | <input type="checkbox"/> 25= Parent/child |
| <input type="checkbox"/> 23=Suicidal | <input type="checkbox"/> 27=Conduct disorder | <input type="checkbox"/> 28= Pica |
| <input type="checkbox"/> 26=Substance abuse | <input type="checkbox"/> 30=Social phobia | <input type="checkbox"/> 31=Disruptive behavior |
| <input type="checkbox"/> 29=Eating disorder | <input type="checkbox"/> 33=Sleep disorder | <input type="checkbox"/> 34=Adjustment |
| <input type="checkbox"/> 32=Mood disorder | <input type="checkbox"/> 36=Behaviour disorder | <input type="checkbox"/> 37=Impulse control |
| <input type="checkbox"/> 35=Dissociative | <input type="checkbox"/> 39=Pyschotic disorder | <input type="checkbox"/> 40=Intermittent explosive |
| <input type="checkbox"/> 38=Severe emotional | <input type="checkbox"/> 42=Abuse victim | <input type="checkbox"/> 43=Trichotillomania |
| <input type="checkbox"/> 41=Sexual deviance | <input type="checkbox"/> 45=Social emotional | |
| <input type="checkbox"/> 44=Gender identity | | |
| <input type="checkbox"/> Other (describe) _____ | | |

Origin of Primary Disability

18. Genetic or congenital (from birth)

- | | | |
|---|---|--|
| <input type="checkbox"/> 1=Angelman | <input type="checkbox"/> 2=Cystic Fibrosis | <input type="checkbox"/> 3=Down Syndrome |
| <input type="checkbox"/> 4=Fragile X | <input type="checkbox"/> 5=Hydrocephaly | <input type="checkbox"/> 6=Klinefelter |
| <input type="checkbox"/> 7=Microcephaly | <input type="checkbox"/> 8=Muscular Dystrophy | <input type="checkbox"/> 9=Prader-Willie |
| <input type="checkbox"/> 10=Rhetts (Rett's) | <input type="checkbox"/> 11=Spina Bifida | <input type="checkbox"/> 12=Williams |
| <input type="checkbox"/> 13=Brain abnormality | <input type="checkbox"/> 14=Birth, origin unknown | <input type="checkbox"/> 15=Lissencephaly |
| <input type="checkbox"/> 16=Organice brain damage | <input type="checkbox"/> 17=Gloutaric acidemia | <input type="checkbox"/> 18=Rh factor |
| <input type="checkbox"/> 19=Noonan's syndrome | <input type="checkbox"/> 20=Prune belly | <input type="checkbox"/> 21=Willebrand's disease |
| <input type="checkbox"/> 22=Heart abnormality | <input type="checkbox"/> 23=Dwarfism | <input type="checkbox"/> 24=Cystic hygroma |
| <input type="checkbox"/> 25=Turner's syndrome | <input type="checkbox"/> 26=Macrocephaly | <input type="checkbox"/> 27=Bone disease |
| <input type="checkbox"/> 28=Chromosome abnormal | <input type="checkbox"/> 29=Dubourtz syndrome | <input type="checkbox"/> 30=Congenital lactic acidosis |
| <input type="checkbox"/> 31=Opitz syndrome | <input type="checkbox"/> 32=Neurofibromatosis | <input type="checkbox"/> 33=Cornelia de Lange |
| <input type="checkbox"/> 34=Pierre Robin syndrome | <input type="checkbox"/> 35=Marfan's syndrome | <input type="checkbox"/> 36=Perthes disorder |
| <input type="checkbox"/> 37=Tuberous sclerosis | | |
| <input type="checkbox"/> Other (describe) _____ | | |

19. Medical

- | | |
|--|---|
| <input type="checkbox"/> 1=Lack of oxygen at birth | <input type="checkbox"/> 2=Brain damage (result of a disease) |
| <input type="checkbox"/> 3=Disease-related | <input type="checkbox"/> 4=Neurological |
| <input type="checkbox"/> 5=Juvenile arthritis | |
| <input type="checkbox"/> Other(specify) _____ | |

20. Family History

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> 1=Mental illness | <input type="checkbox"/> 2=Family trauma | <input type="checkbox"/> 3=None noted |
|---|--|---------------------------------------|

21. Injury, as a result of:

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> 1=Accident | <input type="checkbox"/> 2=Inflicted/other | <input type="checkbox"/> 3=Inflicted/self |
| <input type="checkbox"/> 4=Neglect | | |

22. Substance abuse:

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> 1=Prenatal | <input type="checkbox"/> 2=Personal | |
| Substance type: | | |
| <input type="checkbox"/> 1=Alcohol | <input type="checkbox"/> 2=Solvents | <input type="checkbox"/> 3=Drugs |
| <input type="checkbox"/> 5=Not specified | <input type="checkbox"/> 4=Multiple substances | |

23. Prematurity

24. Origin unknown

Functioning

25. Physical

- Disability prevents self-feeding Yes No No data
- Child requires assistance with activities of daily living Yes No No data
- Child requires mobility assistance Yes No No data
- Child requires total physical care Yes No No data

26. Medical

- Complex medical needs requiring URIS A procedures Yes No No data
- Health care routines defined as URIS B procedures Yes No No data
- Assistance with medically related equipment/
medications URIS C Yes No No data
- Dialysis Yes No No data

27. Sensory perceptual

- Vision loss: none mild moderate severe profound N/K
- Hearing loss: none mild moderate severe profound N/K

28. Cognitive/intellectual

- Language: Age-appropriate ability to communicate
using language and/or alternative mode Yes No No data
- Learning: Age-appropriate development of conceptual,
abstract and practical skills, knowledge and abilities Yes No No data

29. Mental health

- Medication prescribed Yes No No data
- Receives direct therapy Yes No No data
- Subject to psychotic episodes Yes No No data

30. Behaviour

- Interpersonal: Age-appropriate ability to interact
constructively with others Yes No No data
- Behaviour modulation: Age-appropriate ability to
modulate behaviour associated with affective experience Yes No No data
- Dependability: Age-appropriate ability to adhere to
structure and expectations within home and/or school Yes No No data
- Safety: Age-appropriate awareness of risks to self
and others Yes No No data
- Sexually inappropriate/acting out Yes No No data
- Behaviour problems – aggression Yes No No data
- Behaviour problems – illegal Yes No No data
- Behaviour problems – Other (specify) _____

Adaptive Services

31. Medical

- | | | |
|--|---|--|
| <input type="checkbox"/> 1=Diet | <input type="checkbox"/> 2=Oxygen/Respiratory | <input type="checkbox"/> 3=Medication |
| <input type="checkbox"/> 4=Physiotherapy | <input type="checkbox"/> 5=Occupational therapy | <input type="checkbox"/> 6=Speech & Language |
| <input type="checkbox"/> 7=Gastrostomy | <input type="checkbox"/> 8 = Dialysis | <input type="checkbox"/> 77=None noted |
| <input type="checkbox"/> Other (specify) _____ | | |

32. Mechanical

- | | | |
|--|---|---|
| <input type="checkbox"/> 1=Wheelchair | <input type="checkbox"/> 2=Motorized wheelchair | <input type="checkbox"/> 3=Lift |
| <input type="checkbox"/> 4=Walker/Standing frame | <input type="checkbox"/> 5=Cane | <input type="checkbox"/> 6= Bed/bath |
| <input type="checkbox"/> 7= Recreation & other | <input type="checkbox"/> 8= Adaptive seating | <input type="checkbox"/> 9=Splints/braces |
| <input type="checkbox"/> 10=Orthodontics | <input type="checkbox"/> 11=Prosthesis | <input type="checkbox"/> 77=None noted |
| <input type="checkbox"/> Other (specify) _____ | | |

33. Technical

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> 1=Hearing aid | <input type="checkbox"/> 2=Communcation device | <input type="checkbox"/> 3=Computer |
| <input type="checkbox"/> 4=Computer software | <input type="checkbox"/> 5=Sound system | <input type="checkbox"/> 6=Pacemaker |
| <input type="checkbox"/> 77=None noted | <input type="checkbox"/> Other (specify) _____ | |

34. Personal Support

- Assistance for activities of daily living
- Behavioural guidance and supervision
- Caregiver respite
- 24-hour supervision
- In-home support worker
- Family Preservation
- None noted
- Other (specify) _____

Non CFS Service Providers

| Type of service provided | Direct Service Provider (Organization, Individual) | Funder (CFS, CSS, RHA, etc.) | Target/Focus (Child or Family) |
|--------------------------|---|---------------------------------|-----------------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Appendix B

UNIFIED REFERRAL AND INTAKE SYSTEM (URIS)
 URIS POLICY – A FOUNDATION FOR SERVICE DELIVERY

The chart below identifies the Group A and Group B health care procedures which are eligible for URIS support.

| | |
|---|--|
| <p>Complex Health Care Procedures (Group A)</p> <ul style="list-style-type: none"> ■ Complex health care procedures requiring the clinical skill and judgment of a registered nurse. <p>Procedures (Group A)</p> <ul style="list-style-type: none"> ■ Ventilator care ■ Tracheostomy care ■ Suctioning (tracheal/pharyngeal) ■ Nasogastric tube care and/or feeding ■ Complex administration of medication - i.e., via infusion pump, nasogastric tube, or injection (other than Auto-injector) ■ Central or peripheral venous line intervention ■ Other clinical interventions requiring judgments and decision making by a medical or nursing professional. | <p>Health Care Routines (Group B)</p> <ul style="list-style-type: none"> ■ Health care routines that may be safely delegated to non-health-care personnel who receive training and ongoing monitoring by a registered nurse. <p>Procedures (Group B)</p> <ul style="list-style-type: none"> ■ Clean intermittent catheterization ■ Condom application for urinary drainage ■ Gastrostomy care and feeding ■ Emptying an ostomy bag and/or changing an established appliance ■ Administration of medications by: <ul style="list-style-type: none"> ■ oral route (requiring measurement) ■ instillation (i.e., eye/ear drops) ■ topical (i.e., ointment, therapeutic dressing) ■ inhalation (i.e., bronchodilators) ■ gastrostomy ■ Suctioning (oral or nasal) ■ Responding to seizures when specific skills are required ■ Administration of sublingual lorazepam ■ Assistance with blood glucose monitoring requiring specific action based on results ■ Responding to low blood sugar emergencies ■ Administration of pre-set oxygen ■ Administration of adrenaline auto-injector ■ Other health care routines as approved by URIS |
|---|--|

Group A and Group B health care procedures are reviewed annually by the URIS Committee and the Manitoba Association of Registered Nurses.

EFFECTIVE JUNE 1999



The Group C activities of daily living are not within the scope of URIS policy and are therefore, not eligible for URIS funding. However, they are identified here to provide readers with a sense of the overall care needs that children may have while participating in community programs.

Group C procedures include:

- - passive range of motion/stretching exercises;
- exercises for strength and mobility;
- application of orthotics and prosthetics;
- oral feeding when specific skills are required;
- assistance with mobility when specific skills are required;
- chest pummelling and postural drainage;
- assistance with transfers and positioning when specific skills are required;
- assistance with:
 - oral hygiene and cleanliness of hands and face,
 - dressing,
 - toileting and/or diapering,
 - oral feeding,
 - walking;
- basic operation of a wheelchair;
- assistance with symptoms of common maladies (e.g., coughing, vomiting, diarrhea); and
- assistance with administration of pre-measured oral medication.

Group C procedures are typically accomplished by non-health-care personnel who have experience and/or training in supporting children who need assistance with activities of daily living. The URIS Committee strongly recommends that these staff persons receive a child specific orientation.

Appendix C

Disability Screens from CFSIS

The screenshot shows a software window titled "Person Disability - Any Placement Child" with a close button (X) in the top right corner. The window contains several sections:

- General:** A section with a red header. It includes a dropdown menu for "Is the person disabled?" with "Yes" selected, a date field for "Effective date:", a text field for "Well being year:", and a dropdown menu for "All ongoing health conditions and disabilities are being dealt with?".
- Navigation Tabs:** A row of tabs labeled "Type of Disability", "Medical Details", "Mental Health", "Origin", and "Adaptive Service".
- Physical Disability:** A section with a red header and a "Double click in field to open list" instruction. It features a large green text area on the left and four dropdown menus on the right: "Disability prevents self feeding:", "Requires assistance with activities of daily living:", "Requires mobility assistance:", and "Requires total physical care:".
- Sensory Perceptions:** A section with a red header and a "Double click in field to open list" instruction, containing a large green text area.
- Cognitive / Intellectual:** A section with a red header and a "Double click in field to open list" instruction, containing a large green text area.
- Developmental Delay:** A section with a red header and a "Double click in field to open list" instruction, containing a large green text area.
- Buttons:** A row of four buttons at the bottom: "Print", "Delete", "Save", and "Close".
- Page Number:** The text "Pr44" is located in the bottom right corner of the window.

Person Disability - Any Placement Child

General

Is the person disabled? **Yes** Effective date: Well being year:

All ongoing health conditions and disabilities are being dealt with?

Type of Disability | **Medical Details** | Mental Health | Origin | Adaptive Service

Chronic Health Problems — Double click in fields to open list

Medication & Physician Information

Is the person taking medications: Physician Name:

Contact Number: () -

Medications: Health Care Facility:

Medical Procedures

| Type Of Treatment | Medical Procedure |
|--------------------------------|----------------------------------|
| Complex health care procedures | Ventilator care |
| Health care routines | Tracheostomy |
| Activities of daily living | Suctioning (tracheal/pharyngeal) |

Click on a treatment type to list corresponding procedures then click on procedures to add or remove them from the list.

Print Delete Save Close

Pr44

Person Disability - Any Placement Child

General

Is the person disabled? **Yes** Effective date: Well being year:

All ongoing health conditions and disabilities are being dealt with?

Type of Disability | **Medical Details** | **Mental Health** | Origin | Adaptive Service

Diagnosed Mental Health — Double click in fields to open list

Suspected Mental Health — Double click in fields to open list

Print Delete Save Close

Pr44

Person Disability - Any Placement Child

General

Is the person disabled? **Yes** Effective date: Well being year:

All ongoing health conditions and disabilities are being dealt with?

Type of Disability | Medical Details | Mental Health | **Origin** | Adaptive Service

Origin - Cause of Disability

| Origin / Cause | Details |
|-----------------------|------------------------------------|
| Genetic or congenital | Angelman |
| Medical | Brain abnormality (Encephalopathy) |
| Family history | Cystic Fibrosis |
| Substance abuse | Down Syndrome |
| Injury | Fragile X |

Click on an Origin / Cause to list corresponding disability details then click on details to add or remove them from the list.

Print Delete Save Close

Pr44

Person Disability - Any Placement Child

General

Is the person disabled? **Yes** Effective date: Well being year:

All ongoing health conditions and disabilities are being dealt with?

Type of Disability | Medical Details | Mental Health | **Origin** | Adaptive Service

Medical Double click in fields to open list

Mechanical Double click in fields to open list

Technical Double click in fields to open list

Personal Support Double click in fields to open list

Print Delete Save Close

Pr44

Appendix D

Additional Charts and Tables

Figure A 4.1
Reasons for Care by Legal Status Groups

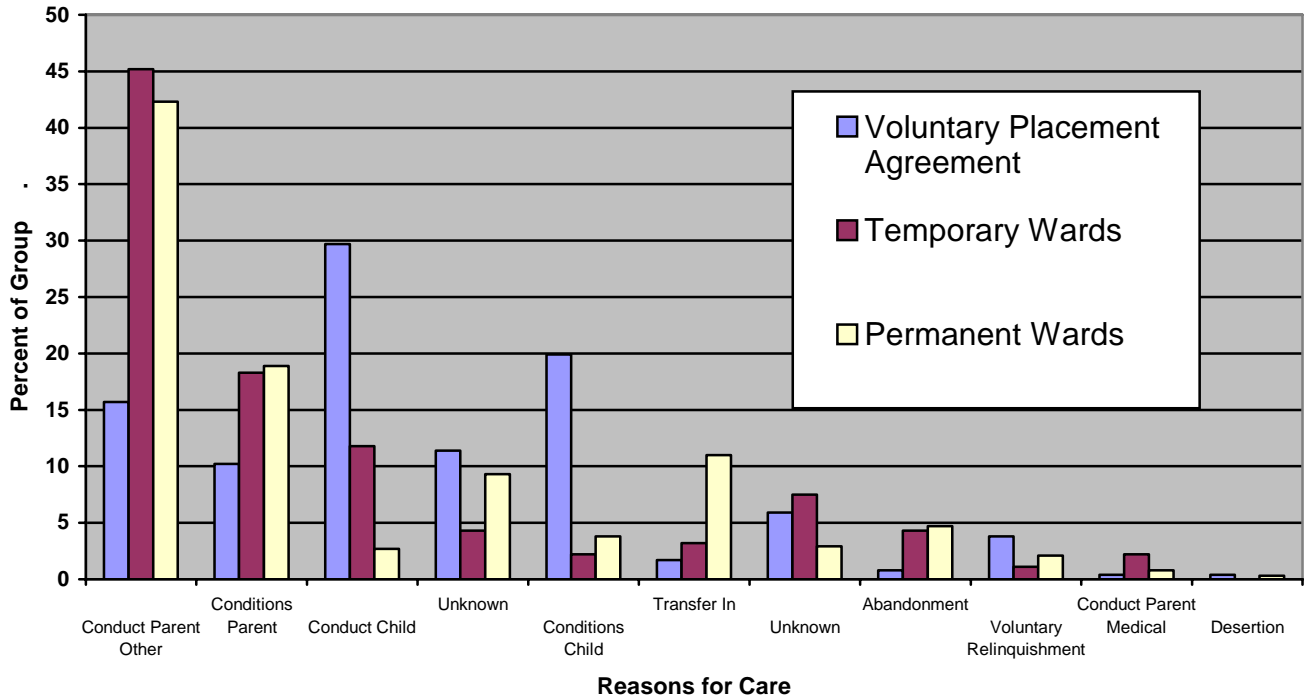


Table A 4.1
Reasons for Care by Legal Status Groups

| Reason for Coming into Care | Legal Status | | | |
|------------------------------------|-----------------------------|---------------------------|--|---------------------------------------|
| | Permanent Wards N = 1322 | Temporary Wards N = 93 | Voluntary Placement Agreement N = 236 | Total of all legal status N = 1869 |
| Conduct Parent | 559 (42.3%) | 42 (45.2%) | 37 (15.7%) | 738 (39.5%) |
| Conditions Parent | 250 (18.9%) | 17 (18.3%) | 24 (10.2%) | 323 (17.3%) |
| Conduct Child | 36 (2.7%) | 11 (11.8%) | 70 (29.7%) | 142 (7.6%) |
| Conditions Child | 50 (3.8%) | 2 (2.2%) | 47 (19.9%) | 118 (6.3%) |
| Other | 123 (9.3%) | 4 (4.3%) | 27 (11.4%) | 168 (9.0%) |
| Transfer In MB | 145 (11.0%) | 3 (3.2%) | 3 (1.3%) | 156 (8.3%) |
| Unknown | 38 (2.9%) | 7 (7.5%) | 14 (5.9%) | 63 (3.4%) |
| Abandonment | 62 (4.7%) | 4 (4.3%) | 2 (0.8%) | 77 (4.1%) |
| Transfer In Out of Province | 16 (1.2%) | 0 (0%) | 1 (0.4%) | 21 (1.1%) |
| Voluntary Relinquishment | 28 (2.1%) | 1 (1.1%) | 9 (3.8%) | 39 (2.1%) |
| Conduct Parent/Medical | 11 (0.8%) | 2 (2.2%) | 1 (0.4%) | 19 (1.0%) |
| Desertion | 4 (0.3%) | 0 (0%) | 1 (0.4%) | 5 (0.3%) |
| Total | 1322 (100%) | 93 (100%) | 226 (100%) | 1869 (100%) |

Table A 4.2
Comparison of Legal Status of All CIC and CWD

| Legal Status | Total Population | | Disability Population | |
|---|------------------|-------|-----------------------|-------|
| | N | % | N | % |
| Permanent Ward * | 2909 | 51.4 | 1322 | 70.7 |
| Apprehension | 741 | 13.1 | 130 | 7.0 |
| Voluntary Placement Agreement | 694 | 12.3 | 236 | 12.6 |
| Unknown | 626 | 11.1 | --- | |
| Temporary Ward | 411 | 7.3 | 93 | 5.0 |
| Petition Filed for Further Order | 265 | 4.7 | 49 | 2.6 |
| Transitional Planning | 18 | 0.3 | 2 | 0.1 |
| Order of Supervision | --- | | 37 | 2.0 |
| Total | 5664 | 100.0 | 1869 | 100.0 |

* Total population Permanent Wards consists of Permanent Ward n = 2645 and Voluntary Surrender of Guardianship n = 264 for total N = 2909

Table A 4.3

Comparison of the Frequency and Proportion of Culture of Origin and Gender Proportion within the Cultures of Origin of All Children in Care and Children with Disabilities

| Culture of Origin | Gender | All Children in Care N = 5664 | | Children with Disabilities N = 1869 | |
|------------------------------------|--------|----------------------------------|---------|---|---------|
| | | Total | Percent | Total | Percent |
| Status (Treaty) | Male | 1935 | 52.5 | 705 | 58.1 |
| | Female | 1752 | 47.5 | 508 | 41.9 |
| Proportion of Total | | 3687 | 65.1 | 1213 | 64.9 |
| Not Aboriginal | Male | 557 | 56.1 | 245 | 66.7 |
| | Female | 436 | 43.9 | 123 | 33.4 |
| Proportion of Total | Total | 993 | 17.5 | 368 | 19.7 |
| Métis | Male | 265 | 52.1 | 119 | 63.3 |
| | Female | 244 | 47.9 | 69 | 36.7 |
| Proportion of Total | Total | 509 | 9.0 | 188 | 10.1 |
| Non-Status | Male | 137 | 51.5 | 41 | 59.4 |
| | Female | 129 | 48.5 | 28 | 40.6 |
| Proportion of Total | Total | 266 | 4.7 | 69 | 3.7 |
| Not Determined | Male | 106 | 53.3 | 16 | 55.2 |
| | Female | 93 | 46.7 | 13 | 44.8 |
| Proportion of Total | Total | 199 | 3.5 | 29 | 1.6 |
| Inuit | Male | 4 | 40.0 | 0 | 0 |
| | Female | 6 | 60.0 | 2 | 100 |
| Proportion of Total | Total | 10 | 0.2 | 2 | 0.1 |
| Total | Male | 3004 | 53.0 | 1126 | 60.2 |
| | Female | 2660 | 47.0 | 743 | 39.8 |
| Proportion of Total | Total | 5664 | 100 | 1869 | 100 |
| | | | | | |
| First Nations (grouped) | Male | 2076 | 52.4 | 746 | 58.1 |
| | Female | 1887 | 47.6 | 538 | 41.9 |
| Proportion of Total | Total | 3963 | 70.1 | 1284 | 68.7 |

Table A 4.4
Legal Status of Culturally Appropriate Authorities

| Legal Status | Culturally Appropriate Authority | | | | | | | | | | | |
|------------------------|----------------------------------|------|---------------------|------|---------|------|-------|------|--------------|------|-------|------|
| | First Nations South | | First Nations North | | General | | Métis | | Undetermined | | Total | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Permanent Ward | 668 | 77.9 | 289 | 69.6 | 182 | 49.7 | 133 | 66.5 | 12 | 52.2 | 1284 | 68.7 |
| VPA | 54 | 6.3 | 43 | 10.4 | 114 | 30.5 | 20 | 10.0 | 5 | 21.7 | 236 | 12.6 |
| Apprehension | 44 | 5.1 | 28 | 6.7 | 35 | 9.4 | 20 | 10.0 | 3 | 13.0 | 130 | 7.0 |
| Temporary Ward | 29 | 3.4 | 24 | 5.8 | 25 | 6.7 | 14 | 7.0 | 1 | 4.3 | 93 | 5.0 |
| Petition order | 18 | 2.1 | 12 | 2.9 | 10 | 2.7 | 8 | 4.0 | 1 | 4.3 | 49 | 2.6 |
| VSG | 20 | 2.3 | 11 | 2.7 | 4 | 1.1 | 2 | 1.0 | 1 | 4.3 | 38 | 2.0 |
| Order of Sup | 23 | 2.7 | 8 | 1.9 | 3 | 0.8 | 3 | 1.5 | 0 | 0.0 | 37 | 2.0 |
| Trans. Planning | 1 | 0.1 | 0 | 0.0 | 1 | 0.3 | 0 | 0.0 | 0 | 0.0 | 2 | 0.1 |
| Total | 857 | | 415 | | 374 | | 200 | | 23 | | 1869 | |

Table A 4.5
Reason for Coming into Care by Culturally Appropriate Authority

| Reason for Coming into Care | Culturally Appropriate Authority | | | | | | | | | | | |
|-----------------------------|----------------------------------|------|---------------------|------|---------|------|-------|------|--------------|------|-------|------|
| | First Nations South | | First Nations North | | General | | Métis | | Undetermined | | Total | |
| | N | % | N | % | N | % | N | % | N | % | N | % |
| Abandonment | 35 | 4.1 | 22 | 5.3 | 7 | 1.9 | 13 | 6.5 | 0 | 0.0 | 77 | 4.1 |
| Desertion | 2 | 0.2 | 0 | 0.0 | 3 | 0.8 | 0 | 0.0 | 0 | 0.0 | 5 | 0.3 |
| Conditions/Child | 43 | 5.0 | 22 | 5.3 | 36 | 9.6 | 15 | 7.5 | 2 | 8.7 | 118 | 6.3 |
| Conditions/Parent | 150 | 17.5 | 71 | 17.1 | 64 | 17.1 | 37 | 18.5 | 1 | 4.3 | 323 | 17.3 |
| Conduct/Child | 20 | 2.3 | 18 | 4.3 | 87 | 23.3 | 17 | 8.5 | 0 | 0.0 | 142 | 7.6 |
| Vol. Relinquish | 15 | 1.8 | 6 | 1.4 | 13 | 3.5 | 4 | 2.0 | 1 | 4.3 | 39 | 2.1 |
| Medical refusal | 7 | 0.8 | 4 | 1.0 | 5 | 1.3 | 2 | 1.0 | 1 | 4.3 | 19 | 1.0 |
| Conduct/Parent | 323 | 37.7 | 187 | 45.1 | 125 | 33.4 | 97 | 48.5 | 6 | 26.1 | 738 | 39.5 |
| Other | 86 | 10.0 | 37 | 8.9 | 28 | 7.5 | 11 | 5.5 | 6 | 26.1 | 168 | 9.0 |
| Transfer in MB | 125 | 14.6 | 20 | 4.8 | 4 | 1.1 | 2 | 1.0 | 5 | 21.7 | 156 | 8.3 |
| Transfer in other | 16 | 1.9 | 1 | 0.2 | 2 | 0.5 | 2 | 1.0 | 0 | 0.0 | 21 | 1.1 |
| Unknown | 35 | 4.1 | 27 | 6.5 | 0 | 0.0 | 0 | 0.0 | 1 | 4.3 | 63 | 3.4 |
| Total | 857 | | 415 | | 374 | | 200 | | 23 | | 1869 | 100 |

Table A 4.6
Mental Health Disorders Diagnosed in Children in Care

| Types of Diagnosed Mental Health Disorders* | N | Percent |
|--|----------|----------------|
| ADHD | 620 | 72.4 |
| Attachment Disorder | 111 | 13.0 |
| Oppositional Defiant Disorder | 79 | 9.2 |
| Depression | 79 | 9.2 |
| Autism Spectrum Disorder | 72 | 8.4 |
| Suicidal | 66 | 7.7 |
| Conduct Disorder | 54 | 6.3 |
| Anxiety Disorder | 52 | 6.1 |
| Post-Traumatic Stress Disorder | 34 | 4.0 |
| Parent/Child Interpersonal Disorders | 28 | 3.3 |
| Adjustment Disorder | 28 | 3.3 |
| Tourette's Syndrome | 26 | 3.0 |
| Obsessive Compulsive Disorder | 19 | 2.2 |
| Mood Disorders | 14 | 1.6 |
| Psychotic Disorder | 12 | 1.4 |
| Disruptive Behaviour Disorder | 12 | 1.4 |
| Sleep Disorders | 12 | 1.4 |
| Behaviour Disorder | 10 | 1.2 |
| Abuse/Neglect Syndromes | 9 | 1.1 |
| Narcissistic Personality Disorder | 8 | 0.9 |
| Bipolar Disorder | 8 | 0.9 |
| Impulse Control Disorder | 7 | 0.8 |
| Substance Related Disorders | 6 | 0.7 |
| Sexual Deviance Disorder | 6 | 0.7 |
| Eating Disorders | 5 | 0.6 |
| Dissociative Disorder | 5 | 0.6 |
| Anti-Social Disorder | 4 | 0.5 |
| Borderline Personality Disorder | 4 | 0.5 |
| Schizoid Personality Disorder | 4 | 0.5 |
| Social Phobia | 3 | 0.4 |
| Severe Emotional Health Disorder | 3 | 0.4 |
| Intermittent Explosive Disorder | 3 | 0.4 |
| Trichotillomania | 3 | 0.4 |
| Gender Identity Disorder | 2 | 0.2 |
| Pica | 1 | 0.1 |
| Social Emotional Disorder | 1 | 0.1 |
| Emotional Behaviour Disorder | 1 | 0.1 |
| Complicated Bereavement | 1 | 0.1 |
| Amnesic Disorder | 1 | 0.1 |
| Family Sexual Dysfunction Syndrome | 1 | 0.1 |
| Pyromania | 1 | 0.1 |
| Total N = 1039 | 856 | |

Table A 4.7
Mental Health Disorders Suspected in Children in Care

| Types of Suspected Mental Health Disorder * | N | Percent |
|--|----------|----------------|
| ADHD | 133 | 41.8 |
| Attachment Disorder | 47 | 14.8 |
| Autism Spectrum Disorder | 28 | 8.8 |
| Depression | 27 | 8.5 |
| Oppositional Defiant Disorder | 25 | 7.9 |
| Suicidal | 20 | 6.3 |
| Anxiety Disorder | 19 | 6.0 |
| Post-Traumatic Stress Disorder | 18 | 5.7 |
| Bipolar Disorder | 14 | 4.4 |
| Conduct Disorder | 11 | 3.5 |
| Mood Disorders | 10 | 3.1 |
| Borderline Personality Disorder | 9 | 2.8 |
| Tourette's Syndrome | 7 | 2.2 |
| Obsessive Compulsive Disorder | 6 | 1.9 |
| Schizoid Personality Disorder | 6 | 1.9 |
| Abuse/Neglect Syndromes | 5 | 1.6 |
| Disruptive Behaviour Disorder | 4 | 1.3 |
| Anti-Social Disorder | 3 | 0.9 |
| Substance Related Disorders | 3 | 0.9 |
| Narcissistic Personality Disorder | 2 | 0.6 |
| Impulse Control Disorder | 2 | 0.6 |
| Severe Emotional Health Disorder | 2 | 0.6 |
| Social Emotional Disorder | 2 | 0.6 |
| Eating Disorders | 1 | 0.3 |
| Sexual Deviance Disorder | 1 | 0.3 |
| Dissociative Disorder | 1 | 0.3 |
| Behaviour Disorder | 1 | 0.3 |
| Social Phobia | 1 | 0.3 |
| Trichotillomania | 1 | 0.3 |
| Adjustment Disorder | 1 | 0.3 |
| Total N = 1039 | 318 | |

*Children may have more than one type of diagnosed or suspected mental health disorder. They may also have both diagnosed and suspected disorders.

Table A 4.8
Medical Disabilities Diagnosed in Children in Care

| Type of Medical Disability (Chronic Illness) | N | Percent |
|---|----------|----------------|
| Asthma / Reactive Airway Disease | 149 | 35.6 |
| Seizures | 123 | 29.4 |
| Heart | 77 | 18.4 |
| Feeding Difficulties | 63 | 15.0 |
| Respiratory Problems / Oxygen | 27 | 6.4 |
| Life Threatening Allergies | 22 | 5.3 |
| Skin | 19 | 4.5 |
| Kidney / Renal | 13 | 3.1 |
| Diabetes | 13 | 3.1 |
| Digestive Disorders | 12 | 2.9 |
| Metabolic Disorders | 8 | 1.9 |
| Burns | 5 | 1.2 |
| Thyroid | 4 | 1.0 |
| STD's | 3 | 0.7 |
| Endocrine Disorders | 3 | 0.7 |
| HIV/AIDS | 3 | 0.7 |
| Liver | 3 | 0.7 |
| Hepatitis C | 2 | 0.5 |
| Urological | 2 | 0.5 |
| Genitalia | 2 | 0.5 |
| High Blood Pressure | 1 | 0.2 |
| Total | 419 | |

Table A 4.9
Diagnosed Mental Health Disorders by Culture of Origin

| Diagnosed Mental Health Disorder | Culture of Origin | | | | | | | |
|----------------------------------|-------------------|------|----------------|------|-------|------|----------------|-----|
| | First Nations | | Not Aboriginal | | Métis | | Not Determined | |
| | N | % | N | % | N | % | N | % |
| ADHD | 389 | 30.3 | 165 | 44.8 | 64 | 34.0 | 2 | 6.9 |
| Attachment | 66 | 5.1 | 25 | 6.8 | 20 | 10.6 | 0 | 0.0 |
| Oppositional Defiant | 32 | 2.5 | 40 | 10.9 | 6 | 3.2 | 1 | 3.4 |
| Depression | 35 | 2.7 | 32 | 8.7 | 10 | 5.3 | 0 | 0.0 |
| Autism | 26 | 2.0 | 36 | 9.8 | 9 | 4.8 | 1 | 3.4 |
| Suicidal | 40 | 3.1 | 17 | 4.6 | 9 | 4.8 | 0 | 0.0 |
| Conduct | 29 | 2.3 | 19 | 5.2 | 6 | 3.2 | 0 | 0.0 |
| Anxiety | 24 | 1.9 | 25 | 6.8 | 3 | 1.6 | 0 | 0.0 |
| PTSD | 18 | 1.4 | 11 | 3.0 | 5 | 2.7 | 0 | 0.0 |
| Relationship Disorders | 8 | 0.6 | 15 | 4.1 | 4 | 2.1 | 1 | 3.4 |
| Adjustment | 18 | 1.4 | 8 | 2.2 | 2 | 1.1 | 0 | 0.0 |

Table A 4.10
Number of Disabilities by Culture of Origin

| Culture of Origin | Number of Disabilities | | | | | | | | | |
|-----------------------|------------------------|------|----------------|------|----------------|------|----------------|------|----------------|-----|
| | 1 Disability | | 2 Disabilities | | 3 Disabilities | | 4 Disabilities | | 5 Disabilities | |
| | N | % | N | % | N | % | N | % | N | % |
| First Nations | 531 | 41.4 | 518 | 40.3 | 190 | 14.8 | 40 | 3.1 | 5 | 0.4 |
| Non-Aboriginal | 154 | 41.8 | 126 | 34.2 | 58 | 15.8 | 28 | 7.6 | 2 | 0.5 |
| Métis | 85 | 45.2 | 77 | 41.0 | 22 | 11.7 | 4 | 2.1 | 0 | 0.0 |
| Not Determined | 14 | 48.3 | 8 | 27.6 | 4 | 13.8 | 3 | 10.3 | 0 | 0.0 |

Table A 4.11
Age and Gender in Problem Behaviours

| Problem Behaviour | Age in Years | | | Male Gender | |
|---|---------------------|--------|------|--------------------|------|
| | Mean | Median | Mode | N | % |
| Aggression N = 803 | 11.35 | 12 | 13 | 553 | 68.9 |
| Sexually Acting Out N = 294 | 12.12 | 13 | 13 | 176 | 59.9 |
| In Conflict with the Law N = 212 | 14.83 | 15 | 16 | 151 | 71.2 |
| Total Population N=1869 | 10.52 | 11 | 13 | 1126 | 60.2 |

Table A 4.12
The Occurrence of Problem Behaviours as a Percentage of the Disability Group

| Behaviour Problem | Intellectual N = 1403 | Mental Health N= 856 | FASD N = 640 | Medical N = 419 | Physical N = 334 | Learning N = 47 | Sensory N = 90 |
|--|--------------------------|-------------------------|-----------------|--------------------|---------------------|--------------------|-------------------|
| | % (N) | % (N) | % (N) | % (N) | % (N) | % (N) | % (N) |
| Aggression N = 803 | 39.7 (557) | 59.8 (512) | 41.4 (265) | 33.2 (139) | 27.5 (92) | 61.4 (35) | 26.7 (24) |
| Sexually Acting Out N = 294 | 15.1 (212) | 20.8 (178) | 15.3 (98) | 8.6 (36) | 10.8 (36) | 17.5 (10) | 6.7 (6) |
| In Conflict with the Law N = 212 | 7.8 (110) | 17.9 (153) | 8.1 (52) | 5.7 (24) | 1.8 (6) | 12.36 (7) | 2.2 (2) |
| Total Population N = 1869 | 75.1 (1403) | 45.8 (856) | 34.2 (640) | 22.4 (419) | 17.9 (334) | 3.0 (57) | 4.8 (90) |

Table A 4.13
The Proportion of Disability Groups within Problem Behaviour Categories

| Behaviour Problem | Intellectual N = 1403 | Mental Health N= 856 | FASD N = 640 | Medical N = 419 | Physical N = 334 | Learning N = 47 | Sensory N = 90 |
|--|--------------------------|-------------------------|-----------------|--------------------|---------------------|--------------------|-------------------|
| | % (N) | % (N) | % (N) | % (N) | % (N) | % (N) | % (N) |
| Aggression N = 803 | 69.4 (557) | 63.8 (512) | 33.0 (265) | 17.3 (139) | 11.5 (92) | 4.4 (35) | 3.0 (24) |
| Sexually Acting Out N = 294 | 72.1 (212) | 60.5 (178) | 33.3 (98) | 12.2 (36) | 12.2 (36) | 3.4 (10) | 2.0 (6) |
| In Conflict with the Law N = 212 | 51.9 (110) | 72.2 (153) | 24.5 (52) | 11.3 (24) | 2.8 (6) | 3.3 (7) | 0.9 (2) |
| Total Population N = 1869 | 75.1 (1403) | 45.8 (856) | 34.2 (640) | 22.4 (419) | 17.9 (334) | 3.0 (57) | 4.8 (90) |

Table A 4.14
Proportion of Disability Group Receiving Services Provided to Children in Care

| Disability | Care | | | | | | | | | | | | |
|------------------------|----------|------------------|------|--------------------|------|---------|------|-------------------|------|----------------|------|---------------------|-----|
| | N = 1869 | Daily Activities | | Behaviour Guidance | | Respite | | 24-HR Supervision | | In-Home Worker | | Family Preservation | |
| | | N | % | N | % | N | % | N | % | N | % | N | % |
| Sensory | 90 | 61 | 67.8 | 25 | 27.8 | 57 | 63.3 | 12 | 2.2 | 16 | 6.7 | 1 | 1.1 |
| Physical | 334 | 180 | 53.9 | 107 | 32.0 | 167 | 50.0 | 37 | 11.1 | 55 | 16.5 | 2 | 0.6 |
| Medical | 419 | 203 | 48.4 | 129 | 30.8 | 224 | 53.5 | 43 | 10.3 | 72 | 17.2 | 7 | 1.6 |
| Intellectual | 1403 | 413 | 29.4 | 556 | 39.6 | 646 | 46.0 | 82 | 5.8 | 232 | 16.5 | 15 | 1.1 |
| Mental Health | 856 | 169 | 19.7 | 481 | 56.2 | 364 | 42.5 | 48 | 5.6 | 153 | 17.9 | 16 | 1.9 |
| Learning | 57 | 7 | 12.3 | 24 | 42.1 | 26 | 45.6 | 8 | 14.0 | 14 | 24.6 | 2 | 3.5 |
| Actual Services | 2528 | 469 | 25.1 | 810 | 43.3 | 805 | 43.1 | 100 | 5.4 | 313 | 16.7 | 31 | 1.7 |

Table A 4.15
Proportion of Services Provided to Disability Groups of Children in Care

| Disability | Care | | | | | | | | | | | | |
|------------------------------|--------|------------------|--------------|--------------------|--------------|---------|--------------|-------------------|--------------|----------------|--------------|---------------------|--------------|
| | N 1869 | Daily Activities | | Behaviour Guidance | | Respite | | 24-HR Supervision | | In-Home Worker | | Family Preservation | |
| | | N | % of service | N | % of service | N | % of service | N | % of service | N | % of service | N | % of service |
| Intellectual | 1403 | 413 | 88.1 | 556 | 68.7 | 646 | 80.3 | 82 | 82 | 232 | 74.1 | 15 | 48.4 |
| Mental Health | 856 | 169 | 36.0 | 481 | 59.4 | 364 | 45.2 | 48 | 48 | 153 | 48.9 | 16 | 51.6 |
| Medical | 419 | 203 | 48.4 | 129 | 15.9 | 224 | 27.9 | 43 | 43 | 72 | 23.0 | 7 | 22.5 |
| Physical | 334 | 180 | 38.4 | 107 | 13.3 | 167 | 20.8 | 37 | 37 | 55 | 17.6 | 2 | 6.5 |
| Sensory | 90 | 61 | 13.0 | 25 | 3.1 | 57 | 7.1 | 12 | 12 | 16 | 5.1 | 1 | 3.2 |
| Learning | 57 | 7 | 1.5 | 24 | 3.0 | 26 | 3.2 | 8 | 8 | 14 | 4.5 | 2 | 6.5 |
| Actual Total Services | 2528 | 469 | 18.6 | 810 | 32.0 | 805 | 31.8 | 100 | 4.0 | 313 | 12.4 | 31 | 1.2 |

Table A 4.16
Services Provided by Education to Children with Disabilities in Care

| CFS Funded Services Total 346 or 18.5% of children | Number | Percent |
|---|---------------|----------------|
| Counselling | 267 | 14.3 |
| Therapy (Play, Music, Art) | 44 | 2.4 |
| Tutor | 20 | 1.1 |
| Occupational Therapy | 10 | 0.5 |
| Speech and Language | 8 | 0.4 |
| Behaviour Modification | 4 | 0.2 |
| Massage Therapy | 4 | 0.2 |
| Physiotherapy | 3 | 0.2 |
| Mentor | 1 | 0.1 |

Table A 4.17
External Services Funded by CFS

| Education Service Total 948 or 50.7% of children | Number | Percent of Services |
|---|---------------|----------------------------|
| Teacher Assistant | 488 | 26.1 |
| Modified/Adapted Program | 265 | 14.2 |
| Level 2 Funding | 202 | 10.8 |
| Speech and Language | 198 | 10.6 |
| Individualized Education Plan (IEP) | 173 | 9.3 |
| Special Needs Program | 135 | 7.2 |
| Level 3 Funding | 125 | 6.7 |
| Resource Assistance | 103 | 5.5 |
| Occupational Therapy | 89 | 4.8 |
| Guidance/Counselling | 78 | 4.2 |
| Physiotherapy | 52 | 2.8 |
| Behaviour Modification Program | 49 | 2.6 |
| Life Skills | 33 | 1.8 |
| Reading Program | 30 | 1.6 |
| Tutor | 7 | 0.4 |

Table A 4.18
Percent of Service Provided to Age Groups by Particular Service Providers

| AGE GROUP | CFS | | RHA | | POTC | | CSS | | FASD | |
|------------------------|-----|------|-----|------|------|------|-----|------|------|------|
| | N | % | N | % | N | % | N | % | N | % |
| 0-5 (N = 300) | 12 | 3.5 | 61 | 34.5 | 70 | 49.0 | 31 | 56.4 | 19 | 28.4 |
| 6-12 (N = 820) | 172 | 49.9 | 46 | 26.0 | 54 | 37.8 | 13 | 23.6 | 43 | 64.2 |
| 13-20 (N = 749) | 161 | 46.7 | 70 | 39.5 | 19 | 13.3 | 11 | 20.0 | 5 | 7.5 |
| ALL (N = 1869) | 345 | 100 | 177 | 100 | 143 | 100 | 55 | 100 | 67 | 100 |

Note: FASD Outreach Services are provided to 59 children with diagnosed FASD and 8 children without a diagnosis on file.

Table A 4.19
Percent of Age Group Receiving Services

| AGE GROUP | CFS | | RHA | | POTC | | CSS | | FASD | |
|------------------------|-----|------|-----|------|------|------|-----|------|------|-----|
| | N | % | N | % | N | % | N | % | N | % |
| 0-5 (N = 300) | 12 | 4.0 | 61 | 20.3 | 70 | 23.3 | 31 | 10.3 | 19 | 6.3 |
| 6-12 (N = 820) | 172 | 21.0 | 46 | 5.6 | 54 | 6.6 | 13 | 1.6 | 43 | 5.2 |
| 13-20 (N = 749) | 161 | 21.5 | 70 | 9.3 | 19 | 2.5 | 11 | 1.5 | 5 | 0.7 |
| ALL (N = 1869) | 345 | 18.5 | 177 | 9.5 | 143 | 7.7 | 55 | 2.9 | 67 | 3.6 |

Table A 4.20
Services Provided per Type of Disability for Children Not in Care

| Disability | Non-Care | | | | | | | | | | | | |
|------------------------|----------|------------------|------|--------------------|------|---------|------|-----------------|------|----------------|------|---------------------|-----|
| | N = 226 | Daily Activities | | Behaviour Guidance | | Respite | | 24-HR Supervise | | In-Home Worker | | Family Preservation | |
| | | N | % | N | % | N | % | N | % | N | % | N | % |
| Intellect. | 115 | 25 | 21.7 | 27 | 23.5 | 24 | 20.9 | 4 | 3.5 | 52 | 45.2 | 2 | 1.7 |
| Mental Health | 113 | 9 | 8.0 | 25 | 22.1 | 33 | 29.2 | 4 | 3.5 | 58 | 51.3 | 4 | 3.5 |
| Physical | 45 | 21 | 46.7 | 7 | 15.6 | 15 | 31.9 | 3 | 6.7 | 21 | 46.7 | 1 | 2.2 |
| Medical | 40 | 14 | 35.0 | 6 | 15.0 | 15 | 37.5 | 4 | 10.0 | 14 | 35.0 | 0 | 0 |
| Sensory | 17 | 7 | 41.2 | 1 | 5.9 | 5 | 29.4 | 2 | 11.8 | 4 | 23.5 | 0 | 0 |
| Learning | 7 | 2 | 28.6 | 0 | 0 | 2 | 28.6 | 2 | 28.6 | 5 | 71.4 | 0 | 0 |
| Actual Services | 253 | 34 | 15.0 | 44 | 19.5 | 56 | 24.8 | 8 | 3.5 | 105 | 46.5 | 6 | 2.7 |

Note: Because children have multiple disabilities, totals are more than 100%.