

CHAPTER 9

## **Children with FASD Involved with the Manitoba Child Welfare System: The Need for Passionate Action**

*Don Fuchs, Linda Burnside,  
Shelagh Marchenski, and Andria Mudry*

Meeting the needs of children with disabilities creates significant challenges for child welfare agencies in Manitoba. Because of additional risk factors associated with disability, these already vulnerable children have a greater potential than other children for requiring the support or protection of a child welfare agency. In Manitoba, one-third of children in care fall within a broad definition of disability (Fuchs, Burnside, Marchenski, & Mudry, 2005). Significantly, 17 percent of children in care were affected by a particular disability: diagnosed or suspected Fetal Alcohol Spectrum Disorder (FASD) (Fuchs, Burnside, Marchenski, & Mudry, 2007). Children with a diagnosis of FASD present agencies with an array of complex and variable needs arising from the children's compromised neurological biology, the family systems they live in, and the many

---

**SUGGESTED CITATION:** Fuchs, D., Burnside, L., Marchenski, S., & Mudry, A. (2009). Children with FASD involved with the Manitoba child welfare system: The need for passionate action. In S. McKay, D. Fuchs, & I. Brown (Eds.), *Passion for action in child and family services: Voices from the prairies* (pp. 185-206). Regina, SK: Canadian Plains Research Center.

resulting psychosocial and environmental problems that result for them and for their families. Meeting the needs of these children in an effective way begins with an understanding of the nature of their relationship with child welfare agencies. In particular, it is important to understand *when* these children come into care and to understand their experiences *while* they are in care.

To broaden the understanding of the relationship between children with FASD and child welfare agencies, this chapter reports on the results of a study that was aimed at gathering data on the placement and legal status histories of children with FASD in care and comparing those histories to the histories of children with other disabilities and children with no disabilities. The chapter includes a brief review of FASD literature to provide a contextual background for the research. In addition, to illustrate the magnitude of concern for the risk of continued growth in the numbers of children with FASD coming into care, the chapter reports the results of a study of women of child-bearing age receiving service from Addictions Foundation of Manitoba. The implications for policy, practice and research are discussed and the chapter puts forward some directions for further research.

## THE FETAL ALCOHOL SPECTRUM DISORDER CONTEXT

The term Fetal Alcohol Spectrum Disorder (FASD) encompasses a range of conditions that are caused by maternal alcohol consumption during pregnancy and that have lifelong implications for the affected person, the family, and society. Considered to be a completely preventable condition (Nulman, Ickowicz, Koren, & Knittel-Keren, 2007; Zevenbergen & Ferraro, 2001), the adverse effects of maternal consumption of alcohol have been noted throughout history but were first described as a pattern of disabling effects under the term *Fetal Alcohol Syndrome* in the early 1970s (Overhoser, 1990). Although there are no national statistics on the rates of FASD in Canada, the incidence of FASD in Manitoba has been estimated at 7.2 per 1,000 live births (Williams, Obaido, & McGee, 1999) to as high as 101 per 1,000 live births (Square, 1997). American incidence rates of 9.1 per 1,000 live births have been reported (Sampson et al., 1997), but it should be noted that diagnosis of FASD may be delayed or missed entirely, affecting the accuracy of such statistics (Chudley et al., 2005).

Because of the range of effects that result from prenatal alcohol exposure, diagnosis of FASD can be complex (Chudley et al., 2005; Hay,

1999; Wattendorf & Muenke, 2005; Zevenbergen & Ferraro, 2001). Indicators include physical characteristics such as distinct facial features and inhibited growth, neurodevelopmental problems such as impaired fine motor skills, and behavioural and cognitive difficulties that are inconsistent with developmental level, such as learning difficulties, poor impulse control, or problems in memory, attention and/or judgment. Diagnosis is somewhat facilitated if there is a confirmation of maternal alcohol use. Diagnosis is often made between the ages of 4 and 14 (Lupton, Burd, & Harwood, 2004), and early diagnosis with accompanying intervention is recommended to ameliorate the problematic effects of FASD, through the provision of cognitive stimulation, speech and language therapy, educational supports, and other interventions (Sonander, 2000).

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

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

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

In their study of children in care with disabilities in child and family services agencies in Manitoba, Fuchs et al. (2005) concluded that 17 percent of all children in care were affected by FASD. An overwhelming majority (89 percent) of children with FASD were in permanent care of an agency and had limited contact with biological parents. Consequently, child welfare agencies in Manitoba have a significant care responsibility for these children until their age of majority, requiring agency staff and caregivers to be cognizant of the special needs of this population during childhood and adolescence and through the transition to adulthood. There is a good deal of evidence to indicate that this is similar to other jurisdictions in Canada and the United States (Brown et al., 2006).

## **RESEARCH CONTEXT AND OBJECTIVES**

This study is a second phase of the original research by Fuchs et al. (2005) identifying children in care with disabilities. It looks more closely at children with FASD and their history as they enter the child welfare system and come to rely on the parenthood of the state. It 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.

In recognition of the high care needs and the over-representation of children with disabilities in the Manitoba child welfare system, as identified in the previous research of Fuchs et al. (2005), this study was aimed at developing a fuller understanding of the pathways into care for children with disabilities. In addition, the 2005 study found First Nations and Métis children were significantly over-represented in the population of children in care with disabilities. Because of the significant proportion of Manitoba children in care identified with a diagnosis of FASD, and because of the over-representation of First Nations children, understanding the relationship between this population and child welfare agencies is particularly important. Information on the evolution of child welfare interventions—from an initial admission into care resulting in a first legal status, to subsequent legal statuses, including the possibility of a permanent order of guardianship—has implications critical to prevention, intervention, and permanency planning for children with disabilities. It is also important to understand the role of Voluntary Placement Agreements (VPAs) as a tool for intervening with children with disabilities.<sup>1</sup> Analysis of placements and a comparison of the pattern of placements of children with and without disabilities would provide valuable information that had not previously been examined in depth. Information on the placement and legal status histories of children and comparative analysis of children with and without disabilities is useful at all levels of the service delivery system, from practitioners to policy-makers, for enhancing capacity to meet the needs of children with disabilities.

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

---

1 Voluntary Placement Agreements are agreements in which children come into care and parents give up custody of their child but retain guardianship.

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

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

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

These legislative requirements can have a significant impact on the length and type of involvement children have with the child and family services system, especially when young children are in need of protective services related to parental functioning (as was found to be the case for the majority of Manitoba children with disabilities in care in the 2005

study by Fuchs et al.) or require supportive services as a result of the child's care needs. Therefore, it is important to view the findings of this study within this legislative context, as children who are admitted to care at preschool ages may be predisposed to different care trajectories than school-age children and adolescents.

## DESIGN AND METHODOLOGY

This project sought to examine the legal status and placement histories of children with disabilities and compare this to the histories of children without a recorded disability in the care of mandated child protection agencies in Manitoba as of December 1, 2005. The researchers were able to use as a study population a cohort of children in care with and without disabilities who were identified in their previous research and who were still in care (Fuchs et al., 2005). This helped ensure that there were two discrete groups for comparison purposes.

Using CFSIS, two groups of children in the care of mandated child protection agencies in Manitoba were created: 1) children with a disability, and 2) children without a disability as recorded on their CFSIS file. To create comparable groups for further examination, the children were further divided into subgroups based on legal status and disability. Children were sorted by disability into three exclusive categories: children with either diagnosed or suspected FASD (FASD); children with a disability other than diagnosed or suspected FASD (CWD No FASD); and children without a disability (No disability).

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

This method created 6 study groups:

1. FASD PW (permanent wards with FASD)
2. FASD VPA (voluntarily placed children with FASD)
3. CWD PW no FASD (permanent wards with a disability that was not FASD)

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

From the six mutually exclusive comparison groups that were created, six random samples were drawn. To make the amount of data manageable within the resources available for this project, 25 percent of those in each group were chosen randomly from lists generated by the CFSIS system to create the sample. The sample groups are shown in Table 1.

Disability status	Random Sample (25% of Total)	
	PW n	VPA n
<b>FASD</b>	122	18 or 20*
<b>CWD No FASD</b>	94	38
<b>No Disability</b>	329	165
*Due to the small size of the FASD VPA group, all children who had adequate information on their CFSIS files were included. Sample size differs for analysis of legal status (20) and placement (18) due to the availability of file information.		

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

## **FINDINGS**

### **Comparing In-care Trajectories of Children with Disabilities and Children with No Disabilities**

For the purposes of this phase of the research project, only children who were permanent wards or were under VPAs on December 1, 2005, were examined as part of the 6 comparison groups. Although they were all either permanent wards or under a VPA on that date, their legal status

histories could consist of a variety of legal statuses and may have included Apprehension, Temporary Ward, Permanent Ward (PW), Transition Planning, Voluntary Placement Agreement (VPA), Voluntary Surrender of Guardianship (VSG) and/or Unknown legal statuses. The legal status of children was derived from the recordings in CFSIS.

Children with permanent ward status were further examined to determine the length of time from their first legal status to the time they became permanent wards. The FASD PW population had the shortest period of time between the two legal statuses ( $M = 2.11$  years). At just over 2 years on average between their first legal status and becoming a permanent ward, this was almost a year shorter than other children who became permanent wards. The No disability PW group was just over 3 years ( $M = 3.05$  years), as was the CWD PW no FASD group ( $M = 3.29$  years). This may be partially due to the legal status legislative requirements under the *Child and Family Services Act* (1985) that apply to children who are involved with the child welfare system at different ages, as discussed earlier. Since the PW FASD group on average is first involved with the system at 2.49 years of age, the amount of time they can be in care under temporary status is less than children who are older than 5 years of age when they first come into care.

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

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

The mean length of time in placements of children in the six legal status by disability groups was determined and compared. As expected, permanent wards spent the longest time in placement. However, of the

permanent wards, those with FASD spent the most time in child welfare agency placements ( $M = 7.20$  years,  $SD = 2.97$ ), compared to permanent wards with other disabilities ( $M = 5.98$  years,  $SD = 2.98$ ), and permanent wards with no disabilities ( $M = 5.08$  years,  $SD = 3.12$ ). The VPA groups did not follow the same pattern. Children with FASD in care under a VPA were in placements much less time ( $M = 2.72$  years,  $SD = 1.70$ ) than other children with disabilities ( $M = 4.73$  years,  $SD = 4.16$ ), although their time in placement was greater than children with no disabilities ( $M = 1.69$  years,  $SD = 1.43$ ).

The total time in placement for each child was divided by their total number of placements to determine the mean length of placements for each child. A mean of those means was calculated for the established legal status disability groups and a comparison was made across groups. The children who were permanent wards tended to have longer placements than children in care under a VPA.

The total length of time each child had spent in an agency placement was calculated as a proportion of their age at December 1, 2005. A mean of the proportions was determined for each disability legal status group. The comparison of mean proportions showed that children with FASD spent on average greater than 70 percent of their lives in care ( $M = 73.14\%$ ). This was a higher proportion than permanent wards with no disabilities ( $M = 59.22\%$ ), and considerably higher than permanent wards with other disabilities ( $M = 53.08\%$ ) (See Table 2).

It is clear from these findings that permanent wards who receive a diagnosis of FASD have come into care for the first time at a younger age (2.5 years) than children with no disability (3.6 years) and at a considerably younger age than children with other disabilities (4.3 years). The

**Table 2. Mean Years in Placement as a Proportion of Age**

Group	Sample N	Mean Years in Placement as % of Age	SD	Median %
No Disability VPA	165	19.91	22.76	12.19
FASD VPA	18	21.36	13.72	15.70
CWD VPA No FASD	38	34.45	28.62	22.95
CWD PW No FASD	94	53.08	23.09	52.34
No Disability PW	329	59.22	26.68	58.35
FASD PW	122	73.14	23.57	76.52

data also demonstrated that children in the FASD group became permanent wards more quickly than children in either of the other permanent ward groups. Their time from first legal status to a permanent order was approximately 2 years, compared to 3 years for other children. This fast track, compounded by an earlier initial legal status, results in the children with FASD becoming permanent wards at a much earlier age, at approximately 4 years of age, compared to 6 years of age for children with no disabilities and over 7 years of age for children with other disabilities.

Given the shorter time period between first legal status and the granting of permanent guardianship, one would expect that the FASD permanent ward group would have a lower mean number of legal status changes.<sup>2</sup> That is precisely what the data demonstrated. Fewer opportunities were occurring for these children to be re-united with their families of origin. Once the children were in care, they moved comparatively quickly and directly to becoming permanent wards. As previously discussed, this shortened pathway into care for children with FASD may be entirely a consequence of the conditions imposed by the *Child and Family Services Act* (1985). What this research demonstrates is that the conditions specified in the Act appear to have a greater impact on the legal status history of children with FASD, as a result of their younger age at admission to care.

The placement history of permanent wards mirrors their legal status history. PWs with FASD spent the longest time in placements, on average more than 2 years longer than children with no disability. Possibly as a consequence of being in care longer, they have a higher number of placements than other permanent wards.

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

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

---

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

used, they tended to be used for less time for children with FASD than for children with other disabilities but for longer than children with no disability.

There are some notable differences between children with FASD who become permanent wards and those whose relationship with an agency is proscribed by a Voluntary Placement Agreement. The age of first legal status is markedly different. Permanent wards with FASD had their first legal status on average at age 2.5 years and VPAs with FASD did not have a legal status until 6 years later at a mean age of 8.6 years.

The mean number of legal statuses for children under a VPA (6.6) was also greater than the mean number for children who became permanent wards (4.8). Although the VPA group had more legal statuses, the amount of time they spent with a legal status or in a placement was significantly less than children in the permanent ward group.

In summary, children with FASD who become permanent wards in Manitoba tended to become children in care of an agency at a much earlier age than other children with disabilities or children with no disabilities. Once in care, they were more likely to continue in agency placements than other children. They became permanent wards more quickly than other children. While VPAs provide a means of supporting families of children with other disabilities, they are not commonly used for children with FASD.

### **Women of Child-Bearing Age with Alcohol Problems in Manitoba and the Risk for Children with FASD Coming in Care**

Recognizing the significant number of alcohol-affected children in the child welfare system, the researchers felt it was important to learn more about the possible number of children in Manitoba who might be similarly affected, and about the women who might give birth to them. There were no reliable provincial statistics identifying the number of children with FASD in the general population, as there are in all probability many women using alcohol during pregnancy who are not known to the social services, medical, or legal professions. Still, to begin to develop an awareness of the scope of this issue, information on one particularly vulnerable group of women was obtained from the Addictions Foundation of Manitoba (AFM): women of child-bearing age (19 to 45 years) who were involved with an addictions program in 2005-2006, the year of the study. This sample is not intended to be representative of Manitoba

women who might have children affected by FASD, but rather to serve as an example of one group, among many, of women who appear to be at risk for having such children.

AFM provided summary data on women who participated in screening for addictions-related programs. Many of the women who sought treatment were compelled to seek treatment, either because of a probation order or as a requirement for the return of their children from care. The screening tool is a self-report questionnaire completed by all potential AFM clients. AFM reported that in 2005-2006 the number of women in the 19-45 age group who participated in screening was 1,212. The number of respondents varied from item to item in the screen with a range for general questions from a high of 1,212 answering the question "How many children do you have?" to a low of 584 answering "Have you ever attempted suicide?" The average number of respondents to general questions was 1,084. Although women might be involved with AFM for any addiction, over 90 percent reported feeling a need to cut down on alcohol or drug use.

Of particular interest to this study is the potential number of children in situations of maternal alcohol abuse. In this population, 65 women (6 percent of respondents) were pregnant at the time they filled out the screen. The number of women who responded to the question "How many children do you have?" was 1,239. Of those, 312 reported no children, 230 had one child, 264 had two children, 207 had three children, 104 had four children, 70 had five children, and 52 had six or more children. Based on their report and using six as the maximum number of children, we can conclude that these mothers account for at least 2,457 children. Although 312 women reported having no children, 669 women indicated that they had no children living with them.

Although there may be other explanations for children not living with their mothers, many of these mothers have, at least temporarily, lost custody of their child/ren to an agency. Child and Family Services (CFS) was noted as the referral source for 234 women. When asked about specific events that occurred in the past year, 370 women reported the loss or apprehension of a child to a CFS agency. It is not possible from the information provided to determine how many children were involved or whether there were previous apprehensions. However, the screening tool does gather information on current involvement with the legal system. Of 479 women who indicated being involved with the legal

system, 156 reported a child & family services order as the nature of that involvement. When asked if alcohol was related to their involvement in the court system, 291 women indicated that it was. In summary, there is evidence that approximately one-third of women screened for acceptance into an AFM program have been involved with a child and family service agency.

It is possible from the data collected to describe the main socio-demographic characteristics of the group of women 19-45 years completing the AFM screening in 2005/06. The majority, approximately 70 percent, were from the Winnipeg region, which includes the city of Winnipeg and extends as far west as Portage la Prairie and includes all of southeast Manitoba. Approximately half of the women (615 or 51%) had not completed high school: 181 (15%) had less than grade 9 education, and 434 (36%) had incomplete high school. Of the remaining half, 244 (20%) had completed high school, 203 (17%) had some college or university, and 99 (8%) had a college or university degree.

Only 309 (26%) of these women were employed: 202 (17%) were employed full-time and 107 (9%) part-time. Women most commonly described themselves as unemployed (578 or 49%). Another 119 (10%) described themselves as homemakers. For those completing this item, household incomes were generally low, with 365 (31.7%) reporting an income of less than \$10,000 and 175 (15%) citing the \$10,000 to \$19,000 category. Only 244 women (21%) reported household incomes above \$20,000, with 88 of those in the \$20,000 to \$29,000 range. This item was poorly completed: 287 (25%) responded "don't know" and another 80 (7%) declined to answer.

Present marital status was single for 661 (57%), married/common law for 283 (25%), divorced/separated for 164 (14%), and widowed for 10 (1%). Half of the women (541) described themselves as having been seen at some time for emotional or mental health issues, and 594 (53%) have at some time been prescribed antidepressant medications. Emotional or mental health issues were serious enough to have resulted in hospitalization for 231 (22%). Violent behaviour when either sober or straight was reported by 329 women (29%) and self-reports of violent behaviour increased to 620 (55%) when using alcohol or other drugs. An overdose of drugs or alcohol was reported by 339 (31%) women in the group; this had occurred within the past 12 months to 157 women.

In summary, in Manitoba in 2005-06, more than 1,200 adult women of child-bearing age were screened for services related to addictions at the Addictions Foundation of Manitoba, which is only one of the service providers for women of child-bearing age in Manitoba. These women tended to be single, unemployed, and of low economic status. Many have less than a high school education and half of them have had a history of emotional or mental health issues. They were mothers to 2,500 children but were not currently custodial parents to all of their children. In addition it is important to note that there were 312 women who reported having no children.

### **IMPLICATIONS FOR CHILD AND FAMILY SERVICE POLICY AND SERVICE PROVISION**

The data reported in these two studies suggests that FASD presents a significant issue for child welfare agencies in Manitoba. Large numbers of children with FASD find themselves in the care of a child welfare agency. They spend a greater proportion of their lives in agency care than other children. Of the groups of children examined in this study, this group (children with FASD) are the most reliant on the state to serve as their parents. Therefore, their needs must be anticipated and strategically addressed by child and family service agencies. This creates a range of implications for service delivery, policy, and prevention.

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

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

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

In summary, workers, foster parents and other service providers must be prepared to provide the kind of care that best supports children presenting with this configuration of needs. Connections to FASD expertise must be made to adequately provide for the needs of alcohol-affected children. Whether this means increasing the expertise within CFS or integrating FASD services with other service providers, it is essential to have knowledge and skills related to FASD available to every affected child in care.

The review of the number of women of child-bearing age who are involved with AFM gives a cursory indication of the scope of addiction issues among women in the province of Manitoba. The potential for children to be affected by alcohol both biologically as a result of prenatal exposure, and environmentally as a result of postnatal exposure, is significant. The child welfare system appears to be a primary intervener

with this high-risk population. CFS policy direction and resource allocation must recognize the prevalence and complex needs of this group.

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

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

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

## **CONCLUSIONS AND DIRECTIONS IN FUTURE RESEARCH**

A number of important questions arise from this research. They are related to preferred practices in service provision, policy and prevention. Although children in care with FASD have now been identified and their legal and placement histories described, they are still largely unknown. What are the reasons they come into care, what is the nature of their relationship with their family of origin, their siblings, and their extended family? What are the social problems experienced by the biological mother / father that contribute to the need for care? Are there opportunities for maintaining family relationships? What are needs of sibling groupings of children with FASD? What are the factors that make it possible for some placements to be sustained over long periods of time? What is their success in achieving independence? A longitudinal study of a cohort of

children from families dealing with addictions would offer an opportunity to obtain information of immeasurable value.

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

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

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

The findings show that children with FASD come into care in Manitoba earlier and become permanent wards more quickly than other children. This raises the question of the efficacy of the permanency planning provision of the Act in relation to children with FASD. It appears that the Act's intention to meet the needs of children for a stable permanent home have a particular impact on children with FASD because they enter the child welfare system in Manitoba at an earlier mean age than other children. If there was more time to support families struggling with addictions, would it be possible for more children with FASD to return to their families of origin? This issue may not be adequately addressed without a concurrent increase in community addiction services to better and more quickly support these families when children first come into care. In a related question, can voluntary placement agreements be used more effectively to maintain parental involvement in the care of children with FASD?

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

FASD is a disability that has significant impacts on the legal status and placement histories of children in care in Manitoba. Because children with FASD enter the child welfare system at a younger age and spend a greater proportion of their lives in care than other children, their needs present an additional challenge to the child welfare system. The data on the increasing number of children coming into care and the prevalence data from the Addictions Foundation of Manitoba indicate that there is a growing degree of urgency for health, education and child welfare systems to develop effective integrated health and service policy and programs to respond to the increasing numbers of children and families with FASD and to develop a broad cross-sectoral preventive strategy. Truly, there is great need for much more passion for action to address this complex and compelling social issue.

## REFERENCES

- Barth, R. P. (2001). Research outcomes of prenatal substance exposure and the need to review policies and procedures regarding child abuse reporting. *Child Welfare, 80*(2), 275-296.
- Bartholet, E. (1999). *Nobody's children: Abuse and neglect, foster drift, and the adoption alternative*. Boston: Beacon Press.
- Brown, J., Bednar, L., & Wiebe, B. (2004). Motives of currently licensed Manitoba foster parents. *Envision: The Manitoba Journal of Child Welfare, 3*(2), 1-13.
- Brown, J. D., Sigvaldason, N., & Bednar, L. M. (2006). Motives for fostering children with alcohol-related disabilities. *Journal of Child and Family Studies*. Retrieved January 20, 2007, from <http://www.springerlink.com.proxy2.lib.umanitoba.ca/content/p30ll1662x70m271/fulltext.pdf>
- Child and Youth Officer for British Columbia. (2006). A bridge to adulthood: Maximizing the independence of youth in care with fetal alcohol spectrum disorder. Retrieved November 29, 2006, from [http://www.gov.bc.ca/cyo/download/cyo\\_fasd\\_sept28.pdf](http://www.gov.bc.ca/cyo/download/cyo_fasd_sept28.pdf)

- Chudley, A. E., Conry, J., Cook, J. L., Loock, C., Rosales, T., & LeBlanc, N. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal*, *172*, 1-21.
- Fuchs, D., Burnside, L., Marchenski, S., & Mudry, A. (2005). Children with disabilities receiving services from child welfare agencies in Manitoba. Retrieved December 1, 2006, from <http://www.cecw-cepb.ca/DocsEng/DisabilitiesManitobaFinal.pdf>
- Fuchs, D., Burnside, L., Marchenski, S., & Mudry, A. (2007). Children with FASD: Involved with the Manitoba Child Welfare System. Retrieved January 11, 2007, from <http://cecw-cepb.ca/files/file/en/FASD%20Final%20Report.pdf>
- Gammon, H. (2002). Fetal alcohol disorders, stress, and the female caregiver. *Envision: The Manitoba Journal of Child Welfare*, *1*(2), 43-53.
- Hay, M. (1999). A practical roadmap for the imperfect but practical-minded clinician. In J. Turpin & G. Schmidt (Eds.), *Fetal alcohol syndrome/effect: Developing a community response* (pp. 26-43). Halifax, NS: Fernwood.
- Jones, K. (1999). The ecology of FAS/E: Developing an interdisciplinary approach to intervention with alcohol-affected children and their families. In J. Turpin & G. Schmidt (Eds.), *Fetal alcohol syndrome/effect: Developing a community response* (pp. 80-87). Halifax, NS: Fernwood.
- Jones, K. (2004). Successfully raising resilient foster children who have fetal alcohol syndrome: What works? *Envision: The Manitoba Journal of Child Welfare*, *3*(1), 1-18.
- Lupton, C., Burd, L., & Harwood, R. (2004). Cost of fetal alcohol spectrum disorders. *American Journal of Medical Genetics Part C*, *127C*, 42-50.
- McCarty, C., Waterman, J., Burge, D., & Edelstein, S. B. (1999). Experiences, concerns and service needs of families adopting children with prenatal substance exposure: Summary and recommendations. *Child Welfare*, *78*(5), 561-577.
- Nulman, I., Ickowicz, A., Koren, G., & Knittle-Keren, D. (2007). Fetal alcohol spectrum disorder. In I. Brown, & M. Percy (Eds.), *A comprehensive guide to intellectual and developmental disabilities* (pp. 213-227). Baltimore: Paul H. Brookes Publishing.
- Overhoser, J. C. (1990). Fetal alcohol syndrome: A review of the disorder. *Journal of Contemporary Psychotherapy*, *20*(3), 163-176.
- Reid, C., & Dudding, P. (2006). *Building a future together: Issues and outcomes for transition-aged youth*. Ottawa, ON: Child Welfare League of Canada.
- Sampson, P. D., Streissguth, A. P., Bookstein, F. L., Little, R. E., Clarren, S. K., Dehaene, P., Hanson, J. W., & Graham, J. M. (1997). Incidence of fetal alcohol syndrome and prevalence of alcohol-related neurodevelopmental disorder. *Teratology*, *56*(5), 317-326.

- Schubler, B., & McEwan-Morris, A. (2006). Strengthening our youth: Their journey to competence and independence. Retrieved December 1, 2006, from <http://www.childrensadvocate.mb.ca/English/Assets/Strengthening%20Our%20Youth%20-%20Final%202006.pdf>
- Sonnander, K. (2000). Early identification of children with developmental disabilities. *Acta Paediatrica*, 434, 17-23.
- Square, D. (1997). Fetal alcohol syndrome epidemic on Manitoba reserve. *Canadian Medical Association Journal*, 157(1), 59-60.
- Streissguth, A. P., Barr, H. M., Bookstein, F. L., Sampson, P. D., & Olson, H. C. (1999). The long-term neurocognitive consequences of prenatal alcohol exposure: A 14-year study. *Psychological Science*, 10(3), 186-190.
- Streissguth, A. P., Barr, H. M., Koga, J., & Bookstein, F. L. (1996). *Understanding the occurrence of secondary disabilities in clients with FAS and FAE*. Seattle, WA: University of Washington Fetal Alcohol and Drug Unit.
- The Child and Family Services Act. (1985). Government of Manitoba. Retrieved July 14, 2008, from <http://web2.gov.mb.ca/laws/statutes/ccsm/co8oe.php>
- Warner, K. (1999). Parenting children with fetal alcohol syndrome. In J. Turpin & G. Schmidt (Eds.) *Fetal alcohol syndrome/effect: Developing a community response* (pp. 14-25). Halifax, NS: Fernwood.
- Wattendorf, D. J., & Muenke, M. (2005). Fetal alcohol spectrum disorders. *American Family Physician*, 72(2), 279-285.
- Williams, R. J., Obaido, F. S., & McGee, J. M. (1999). Incidence of fetal alcohol syndrome in northeastern Manitoba. *Canadian Journal of Public Health*, 90(3), 192-194.
- Wilton, G., & Plane, M. B. (2006). The family empowerment network: A service model to address the needs of children and families affected by fetal alcohol spectrum disorders. *Pediatric Nursing*, 32(4), 299-306.
- Zevenbergen, A. A., & Ferraro, F. R. (2001). Assessment and treatment of fetal alcohol syndrome in children and adolescents. *Journal of Developmental and Physical Disabilities*, 13(2), 123-136.

