Ontario Association of
Residences Treating Youth

Centre of Excellence for Residential Care in Ontario

Partners in Care III

Information about our children

Research Committee of OARTY

Larry Sanders, Ph.D., Research Chair, Chairman/CEO, Bayfield
Maria Gurevich, Ph.D., Assistant Professor, Ryerson University
Carol Stuart, Ph.D., Director and Associate Professor, Ryerson University
Farley Hadley, Mutual Support
Richard Solomon, Executive Director, OARTY

Consultant to the Committee and Lead Researcher
Robert Fulton, M.S.W

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Ontario Association of Residences Treating Youth
550 Alden Rd, Ste 210, Markham ON L3R 6A8
Ph: 905-475- KIDS (5437); Fax: 905-475-5430
info@oarty.net; www.oarty.net

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Executive Summary

This research provides a detailed profile of the children placed in treatment foster care and group care. A randomized sample of 618 children was selected from a total population of 2,212 children on the day of the study; 51% of member agencies responded to the questionnaires. The sample size and randomization process qualifies the findings for this study to be generalized across the population of children who are placed in the homes operated by OARTY members. Statistical analysis shows that the agency profile of respondents was no different than that of non-respondents.

There is a lack of evidence in journal and policy papers that address the differences of children living in residential care. One of the purposes of this research is to clearly describe the substantial variation in the characteristics and needs of the children placed in residential care.

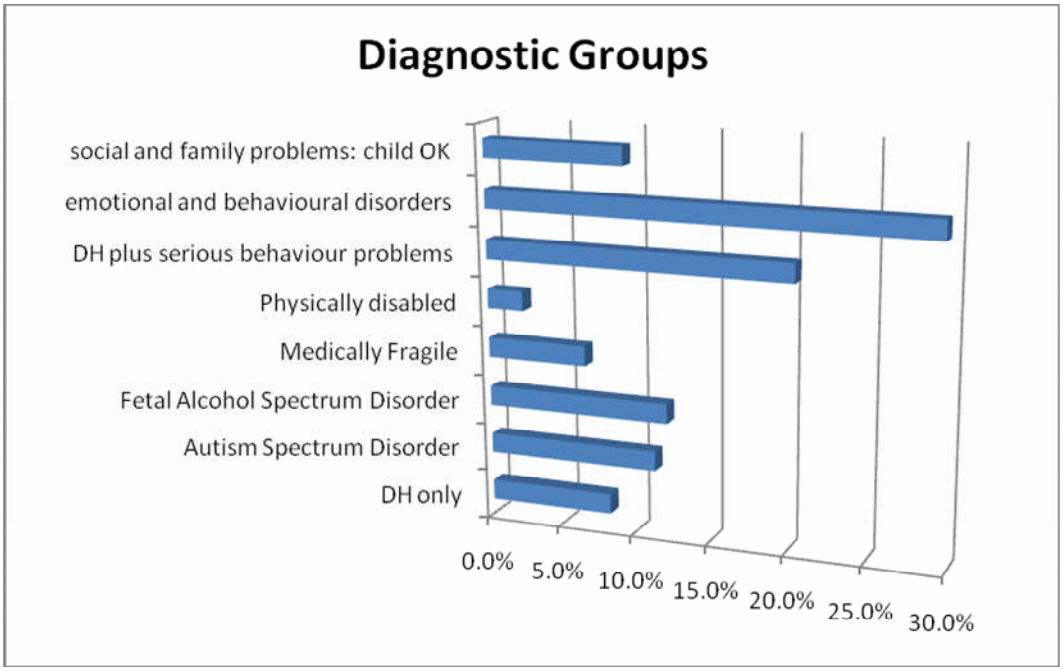
Some of the statements that we can make about the children placed in residential care may be surprising to people who do not work in this sector:

- 26% of the children are diagnosed with moderate to severe DH (intellectual disability)
- 14% have no speech
- 5% are blind
- 12% identify with the aboriginal people
- 15% have a close family member who is diagnosed DH (intellectual disability)

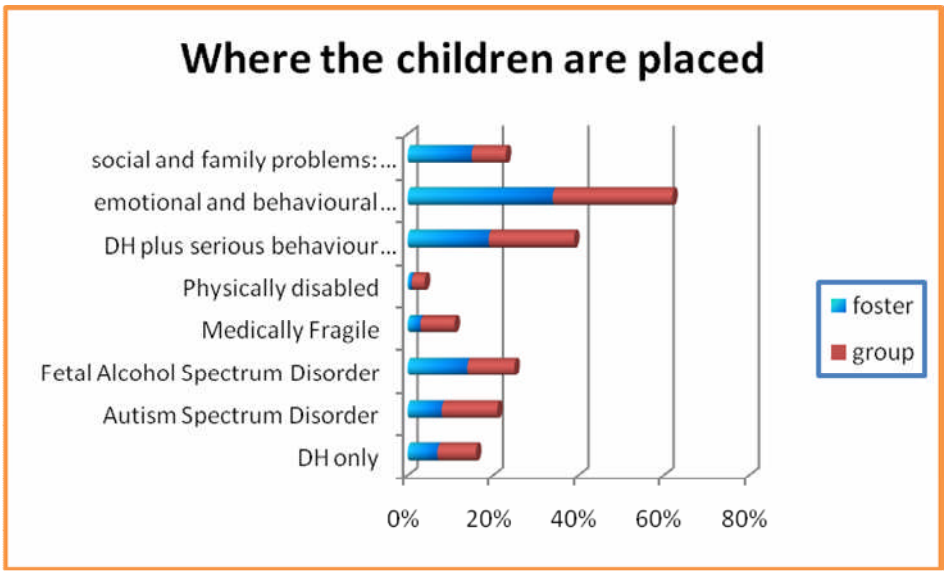
A common misperception is that the children in residential care exhibit delinquent behaviour; yet only 7% of children placed in OARTY residences have ever been sent to a custody resource under the Youth Criminal Justice Act. These children, however, present high risk behaviour. One third (34%) of these children have recently experienced injuries due to self abuse and almost one half (48%) suffer injuries due to their own aggression. One quarter (24%) of the children placed have experienced **both** physical and sexual abuse.

More than one half of the population (53%) have disabilities requiring intensive support for the rest of their lives. The average age of admission to residential care is 11.4 years. More than half of these children (51%) have lived their entire lives in poverty – not just episodic welfare or periods of hardship. These children are being cared for by front line child and youth workers whose annual income is marginally above the poverty rate for a family. The average annual base income of the staff caring for these children is $28,730 ($13.81 per hour) to an average maximum of $35,429 ($17.03 per hour). These figures are based on agency wide staffing data from 26 member agencies. The vast majority of staff has a college diploma or an undergraduate university degree. Wages are controlled by the Ministry of Children and Youth Services current rate review mechanism.

The diagnostic groups of children in the care of OARTY members are reflected below. The largest single group are emotional and behavioural disorders (ED/BD). The data indicates that the greatest increase diagnostically is children with fetal alcohol spectrum disorder (FASD).



Most of the emotionally disturbed children and the children with fetal alcohol spectrum disorder are placed in treatment foster care; most of the multiple handicapped children (i.e. medically and physically handicapped, autistic and developmentally handicapped (DH) children with serious behavioural issues) are placed in group care.



The average daily cost of care (including fees or special care agreements) in treatment foster care is $118.69. The average cost in group care is $212.82.

The findings of Partners in Care III are as follows:

- Finding #1: The sample size has sufficient power to apply to all clients
- Finding #2: Foster and Group providers are fairly represented
- Finding #3: Children with no symptoms have decreased to 9% (from 16% in 2005)
- Finding #4: Children with autism have increased to 11% (from 6% in 2005)
- Finding #5: Children with FASD have increased to 12% (from 4% in 2005)
- Finding #6: Some populations have not changed, specifically:
    - DH-only (8%)
    - DH with serious behavioural problems (20%)
    - medical and physical disabilities (9%)
- Finding #7: The percentage of children with emotional and behavioural problems has decreased to 29% (from 40.5% in 2005)
- Finding #8: Children with autism are more impaired socially than children who are DH with serious behaviour problems
- Finding #9: The group who are DH with serious behaviour problems has far greater social adversity than the children with autism
- Finding #10: FASD children are a new growing population
- Finding #11: FASD children are more needy compared to disturbed children
- Finding #12: Both FASD and ED/BD are a very high risk population
- Finding #13: FASD children have the highest level of adversity within the OARTY population
- Finding #14: Sexual and physical abuse is highest among the ED/BD population
    - 77% of the ED/BD population have been *either* physically or sexually abused
    - 32% have been *both* sexually and physically abused
- Finding #15: Medically and physically disabled children require a lifetime of care
- Finding #16: OARTY agencies are the primary service stream for the medically fragile
- Finding #17: CAS foster care is the first placement for the three largest groups of children. The first placement on admission to CAS care was a CAS foster home for:
    - 70% of FASD
    - 50% of ED/BD
    - 60% of children with DH with serious behavioural problems.
- Finding #18: 20% of disturbed children were placed in a Children's Mental Health facility

- Finding #19: Disturbed children are at risk of placement breakdown
    - 57% of disturbed children are placed in regular foster care at some point in their placement history
    - These children experienced on average 2.3 CAS foster homes up to a maximum of 8 before being placed in an OARTY agency (which may be treatment foster care or group care)
- Finding #20: Children experience on average 1 placement per year before admission to OARTY
- Finding #21: OARTY agencies provide placement stability to children
- Finding #22: OARTY children are at great risk of school drop-out
    - 73% have experienced failure in school from primary grades onward
- Finding #23: 51% of OARTY children lived for years in poverty before admission
- Finding #24: On admission, OARTY clients were at high risk of being unable to function as young adults

Table of Contents

Ontario Association of Residences Treating Youth

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Partners in Care III

Information about our children

1.0 Background and History of Surveys

OARTY (Ontario Association of Residences Treating Youth) is a provincial network of children's residential services. In 2007, the association represented 80 agencies that offer residential and non-residential treatment. There is an average of 2,212 clients in care on any given day during the year[1]. We are licensed and regulated under the Child and Family Services Act and funded on a per diem basis. OARTY provides residential care and treatment for children and youth who are physically and sexually abused, emotionally disturbed, developmentally handicapped, autistic, medically fragile, young offenders, dual diagnosed, conduct disordered, psychiatric and psychological disordered, and other hard to serve children and youth. Our services include residential care, specialized foster care, treatment facilities, education and day treatment.

The series of surveys, under the title of *Partners in Care*, contains data on:

(1) Salaries, wages, board rates and benefits for front line child and youth workers, foster parents, part time and relief staff, supervisors, managers and social workers

(2) Client flow through statistics (days of care provided, individuals in care on January 1, of the year, the number admitted and the number discharged)

(3) Total expenditures (at the agency level), expenditures by the Ministry's standard reporting format (for administration, salaries, shelter or board rate, personal needs) and total per diem revenue, including special care rates.

(4) Comprehensive clinical profile of the clients

In addition to the Partners in Care series, OARTY collects data from annual surveys to its members on a variety of administrative areas, including number of front line staff, foster parents, children and adults served, days care provided and total per diem income. In addition, OARTY recently surveyed its members on the social problems and economic background of the families of children placed and the children's' history of trauma. In total, OARTY has accumulated a research database of 1,841 clients selected at random from its member agencies.

[1] The average number of clients in care in 2007 (2,212) is based on the total number of days of care provided during the year divided by 365. Also, 79 member agencies provide residential care and one agency provides non-residential only.

1.1 Current Sample and Power Statistics

The sample size required to have statistical power to generalize the findings across the full OARTY population of clients served was computed using the following formula:

$$Ns = \frac{(Np)\,(p)\,(1-p)}{(Np-1)\,(B/C)^2 + (p)\,(1-p)}.$$

The letters in the formula refer to the following:

Ns =		completed sample size needed for desired level of precision
Np =	**2,212**	size of reference population (clients in care on day of survey)
p =	**0.52**	proportion of population expected to display measured characteristic
B =	**0.04**	acceptable amount of sampling error (4% sampling error)
C =	**1.96**	Z score of the desired confidence interval (1.96 for 95% confidence interval)

This formula allows one to answer the question: *what is the size of the random sample required in order to have a 4% margin of error (95% of the time).*

The requirement to generalize the sample statistic to the total population is 472 clients drawn at random. The requirement was exceeded with a total of 618 randomly selected clients . By over-sampling the required number of clients, we can be assured that our findings apply to the total population. The margin of error drops to 3% when examining smaller groups of clients such as medically fragile children.

Finding #1: The sample size has sufficient power to apply to all clients

The sample of clients selected for Partners in Care III exceeds the minimum number of client profiles required to generalize the findings across all of the clients of member agencies by 146 cases.

1.2-A SAMPLE CHARACTERISTICS

The Partners in Care survey was sent to 78 agencies that have separate licenses for 292 children's residences and foster care programs. These agencies were instructed to obtain a random sample of their clients from each group home and foster care program on the day of the survey and to complete the client profile.

Data was received from 40 (51%) member agencies producing a sample of 618 clients from 152 (52%) licensed programs.

An independent samples t-test was administered comparing the profiles of programs that responded to the survey to those that did not. *There was no difference between respondents and non-respondents* in terms of:

- True average per diem (including special care rates)
- Average number of clients in residence on the day of the survey
- Total days of care in the previous fiscal period
- Occupancy levels in the previous fiscal period
- Number of licensed beds
- Number of CYW staff per home
- Number of foster parents per foster care program

The Partners in Care survey over-sampled the clients in group homes. In fact 59% of group homes participated in the survey. In contrast 38% of foster care programs participated. In order to determine if the sampling difference between foster and group programs had an impact, the t-tests were separately applied to the variables above for foster care and group care. No differences emerged in the sub groups.

Finding 2: Foster and Group providers are fairly represented

There are no differences in fundamental program characteristics between participants and non participants of the Partners in Care survey. Therefore, the findings can be generalized to both group care and foster care programs.

2.0 OARTY in Context

The facts listed below are based on data published on the OACAS website and 100% of the OARTY member agencies based on the core "membership" data.

(1) In the year 2007, there were 80 member agencies of OARTY.
(2) These agencies offered a variety of residential programs, including two custom programs and two crisis programs. The two dominant programs offered are treatment foster care and group care.
    a. 16 agencies provide both treatment foster care and group care
    b. 11 agencies offered treatment foster care exclusively
    c. 52 agencies offered group care exclusively
    d. 1 agency provided non-residential care exclusively
(3) The 27 agencies providing treatment foster care (either exclusively or in combination with group care) have the following key statistics:
    a. There are 82 treatment foster care programs
    b. The average per diem is $118.69
    c. The median[2] occupancy for treatment foster care is 66%
    d. There are 1,065 beds provided in treatment foster care
    e. There were 1,302 individuals served in treatment foster care during the year
    f. There are 511 treatment home parents

[2] Median refers to the mid-point in the list of programs where 50% have lower occupancy and 50% have higher occupancy

g. There are an additional 234.85 support staff (including Child and Youth Workers and social workers) working with the treatment home parents. This means that OARTY treatment foster care programs have one support staff for every two foster homes
h. The total cost for the 1,302 individuals served was $32.9 million.
i. The total number of days of care provided was 274,606.

(4) The agencies providing group care (either exclusively or in combination with a foster care service) have the following key statistics:
   a. There are 218 group care programs
   b. The average per diem is $212.82
   c. The median occupancy for group care is 92%
   d. There are 1,521 beds provided in group care. Across both foster and group care, OARTY members provide 2,586 beds
   e. There were 1,883 individuals served in group care during the year
   f. There are 1,726.57 full time equivalent child and youth workers in group care programs
   g. There are 33 foster families in "parent-operated with staff support on shift group homes"
   h. The total cost for the 1,883 individuals served was $102.7 million
   i. The total number of days of care provided was 474,429.

(5) Looking at the OARTY statistics in context:
   a. In all residential programs, OARTY members served 3,189 individuals during the year
      i. These individuals are part of the 29,385 individuals registered in CAS care during the year. This represents 11% of all CAS children in care.
      ii. The CAS agencies registered 18,497 children in care on March 31, 2006. On any given day, during 2006, OARTY agencies were caring for 2,212 individuals, representing 12% of the CAS total on one day.
   b. The total cost of serving the 3,189 individuals during the year was $135.7 million.
      i. The Child Welfare expenditure for all "outside purchased care" is $295.3 million. Payments to OARTY members represent 46% of the total payments by the CAS to all of its external suppliers of residential care.
      ii. The average per diem paid by the CAS to all of its external suppliers is $233.10 for group care compared to $212.82 for OARTY members
      iii. The average per diem paid by the CAS to all of its external suppliers of treatment foster care is $115.02 (compared to $118.69 for OARTY members)

3.0 Basic Demographics

The individuals in care on the day of the study are described as follows. The sample did not include individuals that were in care earlier in the year but were discharged before the survey.

- 66% are male and 33% are female (unchanged over a decade)
- 1,289 average days of care has been provided to date for the current population
- 11.4 years = average age on admission to OARTY resource
- 14.6 years = *the age today* of the sample population (the sample have been in residence for 3.2 years)
- 11.5% of children placed in OARTY member agencies are Aboriginal
- 88% of the residents of OARTY programs are under the age 18 years
- 12% are adults: 18 years and older

3.1 Residents of Foster Care Compared to Residents of Group Care

The sample contains 186 cases of children placed in treatment foster care. The sample contains 430 children placed in group homes plus an additional 2 children placed in a custom setting fitting neither category). There are significant demographic differences between the children placed in foster care and group care.

- In treatment foster care: 58% are male and 42% are female
- In group care: 70% are male and 29% are female

This difference is significant (chi square = 10.4, sig = .006) and indicates that girls are much more likely to be placed in treatment foster care.

- In treatment foster care: the age of placement is 10.2 years
- In group care: the age of placement is 11.8 years

This difference is significant (t-score of diff = 4.508, sig = .000) and indicates that younger children are much more likely to be placed in treatment foster care.

- In treatment foster care: the accumulated days of service is 1,083 (3.0 years)
- In group care: the accumulated days of service is 1,382 (3.6 years)

This difference is significant (t-score = 3.035, sig = .003) and indicates that children placed in group care will stay for a longer period of time. The longer length of stay is an outcome of the large proportion of children with multiple handicaps who are also more likely to be placed in group care.

- 97% of the clients in treatment foster care are under the age of 18 years and
- The oldest client in treatment foster care is 19.8 years
- 85.5% of the clients in group care are under the age of 18 years and
- The oldest client in group care is 43 years old

As noted previously, the clients with lifelong disabilities (medically fragile, physically and developmentally disabled) tend to be placed in group care and remain there often for the rest of their lives. The funding for these clients changes from the CAS when they are children to CCAC when they become adults.

There are no differences in the percentage of Aboriginal children placed in foster or group care.

4.0 Diagnostics Groups

The major diagnostic groups served by OARTY are described in the table below. The questionnaire was designed to capture a mutually exclusive set of diagnostic categories as well as the secondary diagnostic groups.

codes	diagnostic groups (best fit)	Freq	Percent in 2008	Percent in 2005	in foster 2008	in group 2008
1	DH only	51	8.3	5.6	7%	9%
2	Autism Spectrum Disorder	70	11.3	5.9	8%	13%
3	Fetal Alcohol Spectrum Disorder	75	12.1	3.7	14%	11%
4	Medically Fragile	41	6.6	5.5	3%	8%
5	Physically and Developmentally disabled	15	2.4	1.4	1%	3%
6	DH with serious behaviour problems	126	20.4	18.3	19%	20%
7	emotional and behavioural disorders	182	29.4	40.6	34%	28%
8	social and family problems: child OK	58	9.4	16.0	15%	8%
	missing values	0	-	3.2		
	Totals	618	100%	100%	100%	100%
	Multiply handicapped (2 to 6)	327	52.90	34.80		

Because of the small changes in wording between the current survey and the prior survey in 2005, we are cautious in interpreting the changes over time. Secondly, we had a smaller sample in 2005 and the margin of error was greater compared to 2008. A difference over the three year period of less than 5% may not be valid. The following findings are supported by the data:

Finding #3: Children with no symptoms or disability have decreased

The percentage of children with social and family problems who have no symptoms or personal dysfunction has decreased. This refers to their *current symptom status*; many of these children had emotional and behavioral problems on admission and now appear to be symptom free. This population represents 9.4% of the residents, plus or minus 3%. Specifically, 15% of the children residing in treatment foster care and 8% of the children residing in group care appear to be symptom free.

Finding #4: Children with autism have increased

The percentage of children diagnosed with autism who are placed in OARTY agencies has ***doubled.*** This category was qualified in the questionnaire as the "best fit" to describe the cluster of diagnostic issues. Some children who were best grouped under DH plus behavioral were also identified as having autistic features. Children best diagnosed under the category of autism represent 11.3% of the population (+- 3%). This diagnosis is made by psychologists and physicians and represents a true growth in the population entering residential care.

Finding #5: Children with FASD have increased

The percentage of children diagnosed with fetal alcohol spectrum disorder (FASD) has *more than doubled* over the last three years to 12.1%.

Finding #6: Some populations have not changed

Any differences in the percentage of children who have the following clinical features are within the margin of error for this study and, therefore, these populations remain stable over the three year period.

- DH only - with no additional serious behavioral, medical or physical problems
- Medically fragile children
- Physically and developmentally challenged children
- DH plus serious behavioral problems

The medically fragile population is more than twice as likely to be found in group care rather than treatment foster care. The others are equally distributed between foster and group (i.e. statistically equivalent and all differences are within the margin of error).

Finding #7: The percentage of children with emotional and behavioural problems has decreased

Over the last three years, there are at least 10% fewer children placed in OARTY agencies that exhibit serious emotional and behavioral problems. This population was identified using clinical cut-scores on two standardized child assessment instruments, the Conners' Global Index and the Children's Global Assessment Scale. Secondly, these children were not diagnosed as intellectually disabled or multiple handicapped using the diagnostic subgroups listed above.

Within OARTY, children with serious emotional and behavioral disorders are more common in treatment foster care (34%) compared to group care (28%).

5.0 Children with Social and Family Problems

Just over 9% of the children placed in OARTY have social and family problems but are themselves symptom free and relatively functional in society according to standardized test results. This population was studied more closely to understand their needs.

This population was contrasted with children who have intellectual disabilities but no co-morbid conditions (8.3%). The qualification, *intellectual disabilities*, is referred to in the paper by the abbreviation, DH.

5.1 Comparing symptom-free children with *DH-only*

A similar sized population of residents has a diagnosed intellectual disability but no other serious emotional, behavioral, functional, medical or physical issues. The following research question was tested: *are the children with DH-only similar to the symptom-free non-DH population.* The differences and similarities are as follows:

	Mean score		Tests for whether difference is due to random chance	
	DH-only	Symptom free Non-DH	t-score high scores mean a real difference	Sig (% probability that random chance explains difference)
Percent of adult support required for daily living	31%	15%	5.629	0.000
Recent history of injuries due to self abuse (% yes)	27%	9%	2.571	0.012
Recent history of injuries due to aggression (% yes)	37%	12%	3.115	0.003
CGAS: standardized measure of social functioning	54.82	73.17	- 6.889	0.000
CGI: standardized behaviour problem index	73.43	58.91	6.288	0.000
number of prior placements	2.63	2.21	no real difference; could be chance event	
% who had a prior placement	96%	84%	2.098	0.039
# of serious family problems and trauma history	3.55	4.62	no difference	
Age today	14.62	13.81	no difference	
age when placed	11.41	11.12	no difference	
days served to date	1,252	1,063	no difference	
average daily cost of care	$ 198.03	$ 165.71	2.904	0.004

The percent of adult support required for daily living is based on a scale of level of care required to assist the young person in 22 different practical aspects of daily living (e.g. coming and going into community, attending school, indicating their needs, etc.). The children who are symptom-free still require some adult assistance, at an average level of 15%, which is typical of all children at that age. This is a practical measure of how "normal" these children behave. The children who are diagnosed with intellectual disability but no other serious issues require twice the support (31%) and supervision from their care givers. The children classified by their care givers as *DH-only* are three times more likely to have a recent history of injuries due to self abuse or aggression.

The symptom free group has an average score of 74 on the Children's Global Assessment Scale (CGAS), a standardized measure of social functioning. The exemplar used in the actual instrument for a score in this range is as follows:

> *No more than slight impairment in functioning* at home, at school or with peers; some disturbance of behaviour or emotional distress may be present in response to life stresses (eg. parental separations, deaths, birth of a sib), but these are brief and interference with functioning is transient; such children are only minimally disturbing to others and are not considered deviant by those who know them

The children who are diagnosed *DH only* score an average of 54 on the CGAS indicating that they are significantly more impaired socially.

Similarly, the symptom-free group had an average score in the normal range (59) on the Conners' Global Index (CGI), a standardized measure of behavior problems. The children diagnosed as DH-only scored in the clinical range on the CGI (73) indicating they are more hyperactive, inattentive and impulsive than 1 in 100 children in society.

As expected both groups of children have a very high number of serious family problems and trauma in their background (e.g.) history of physical and sexual abuse, parental substance abuse, parental criminality. The symptom –free group has on average 4.5 serious family and trauma issues in their background. On longitudinal studies[3] (Werner, 1989, 1992; Kazdin & Kagan, 1994), children who have four or more stressors of this type are at very high risk of being socially dysfunctional by young adulthood. *According to this research, these children should have a lot of symptoms; they probably did have emotional and behavioral problems when admitted three years earlier. The fact that they are now symptom-free speaks to the positive outcomes of treatment.*

5.2 Comparing Symptom-free Children with Total Population

The family background and trauma history of the children is as follows:

	total OARTY population	symptom-free group (not DH)
years of poverty	51.0%	50.0%
history of sexual abuse	31.6%	27.8%
history of physical abuse	55.1%	55.6%
close family committed suicide	3.2%	5.6%
close family incarcerated	30.4%	55.6%
close family in psychiatric hospital	19.0%	11.1%
close family is DH	15.4%	11.1%
close family addicted to drugs	51.0%	72.2%
close family member raped	19.8%	33.3%
child abused drugs/alcohol	13.0%	16.7%
current domestic violence in family	17.8%	11.1%
sexually assaultive person in fam	2.4%	0.0%
child brain damaged	19.0%	0.0%
child is a long term school failure	72.9%	55.6%
child's mother started as teen Mom	21.9%	44.4%
average # checked yes	4.23	4.50

[3] Werner, E. (1989), "High Risk Children in Young Adulthood: A longitudinal study from birth to 32 years", *American Journal of Orthopsychiatry*, 59(1), 72-81

Werner, Emmy, E & Smith, Ruth, S. (1992), *Overcoming the Odds: high risk children from birth to adulthood*, Ithica, N.Y., Cornell University Press, 280 pages

Kazdin, Alan E and Jerome Kagan (1994), "Models of Dysfunction in Developmental Psychology", *Clinical Psychology: Science and Practice*, 1(1), 35-52

The group of children in treatment who were symptom free on the day of the survey have a distinctive social profile compared to the total OARTY population. The children who were symptom free (after 1,000 days of treatment) were less likely to have experienced long term school failure. Moreover, the parents of these children were more likely to exhibit risk taking behaviour (criminal misconduct, substance abuse, teenage pregnancy) and less likely to have psychiatric disorders or intellectual disability.

6.0 Autism and DH with Serious Behaviour Problems

We compared the children diagnosed as a best-fit for autism (11.3%) to children diagnosed as best fit for DH with serious behaviour problems (20.4%). The two populations were not different on three case management variables: current age, age when placed and days served. Children with autism cost more per day to care for ($209.18) than children with DH with behaviour problems ($189.65: t-score of difference in means = 2.670, sig = .008). In contrast, children with DH with behaviour problems had more placements before admission to OARTY agencies (2.44) compared to children with autism (1.48: t-score = 1.978, sig= .049).

On a standardized measure of hyperactivity, impulsiveness and emotional lability, the two populations are not different; both groups are more hyperactive than one in 1,000 children in society. On a standardized measure of social functioning, children with autism are significantly more impaired (30.96) compared to children with DH with serious behaviour problems (39.63). Children who score in these ranges are described below using the language from the test:

Children with autism measured on social functioning as:

> *Unable to function in almost all areas*, eg. stays at home, in ward or in bed all day without taking part in social activities or severe impairment in reality testing or serious impairment in communication (eg. sometimes incoherent or inappropriate)

Children with DH plus serious behavior measured on social functioning as:

> *Major impairment in functioning in several areas or unable to function in one of these areas*, ie, disturbed at home, at school, with peers, or in society at large, (eg. persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or thought disturbance, suicidal attempts with clear lethal intent; such children are likely to require special schooling and/or hospitalization or withdrawal from school (but this is not a sufficient criterion for inclusion in this category)

The level of care required across 22 different aspects of daily living was measured on a scale from 0 to 4. A score of 0 means that the child can carry out this aspect of daily living without any involvement from an adult caregiver; 1 means that the child requires daily supervision; 2 means that the child requires verbal prompting; 3 means that the child requires hand-over-hand guidance and 4 means that the staff must do everything on behalf of the child.

The two groups of children required a similar level of care in the following domains of daily living ranging from daily verbal prompting to hand-over-hand guidance.

domain	Average level of care
Manages own behaviour without instruction from others	2.41
Follow rules	2.20
Can give positive feedback to others	2.22
Obtains and responds to relevant situational cues	2.31
Accepts assistance from other	2.09
Makes choices from available alternatives	2.08
Terminates or withdraws from an activity	2.00
eating	1.41
bathing	1.86

Children diagnosed as best-fit with autism require a significantly higher level of care compared to children with DH with serious behaviour problems on the following areas:

domain	Two groups	N (number of children)	Level of care	t-score	sig
Initiates interaction	autistic	58	2.09	2.272	0.024
	DH behaviour	115	1.65		
Handles negative feedback	autistic	57	2.39	2.194	0.030
	DH behaviour	116	1.92		
Offers assistance to others	autistic	57	2.47	2.726	0.008
	DH behaviour	116	1.89		
Cope with negatives	autistic	58	2.78	2.100	0.038
	DH behaviour	116	2.37		
grooming	autistic	58	2.05	1.994	0.048
	DH behaviour	116	1.66		
toileting	autistic	58	1.71	1.972	0.050
	DH behaviour	116	1.27		
Cleaning up	autistic	58	2.34	2.422	0.016
	DH behaviour	116	1.89		
Can Identify their needs	autistic	58	1.62	2.419	0.017
	DH behaviour	116	1.09		
Going to from places	autistic	58	2.67	3.307	0.001
	DH behaviour	116	1.93		
Crossing street	autistic	58	2.64	3.846	0.000
	DH behaviour	116	1.69		
Attending school	autistic	58	2.43	2.304	0.022
	DH behaviour	115	1.91		
Attending Community rec	autistic	58	3.02	3.147	0.002
	DH behaviour	116	1.93		

In almost every domain, the autistic children required more than *verbal prompting* for all of these functions. The children described as DH with serious behavior problems required more than *daily supervision* in each area. Both groups required a very high level of care. In total, the average percentage of care required (based on the sum of all domains) for autistic children is 56.1%. For children described as DH with serious behavior problems, the average level of care required is 46.2%. The difference is statistically significant (t-score = 2.499, sig = .013). A child who needs an adult to do everything for him in all domains of daily living would score 100%.

Finding #8: Children with autism are more impaired socially than children with DH with serious behaviour problems

Children with autism are significantly impaired socially and required a significantly higher level of care than children who are diagnosed as DH with serious behavior problems. The daily cost of care for children with autism is higher. This is logical considering the higher level of care required.

6.1 Adversity of Autism and DH with serious behaviour problems

Children diagnosed with DH with serious behavior problems have much more social adversity in their background compared to children with autism. For example, 65.4% of the children with DH with serious behaviour problems come from families that have endured years of poverty compared to children with autism (37%). Although the difference between high need groups is significant, both groups have long term deep poverty in their background.

Children with DH with serious behaviour problems have parents who display anti-social and risk taking behavior to a degree that is similar to the overall population of OARTY. The parents of children best diagnosed with autism are far less likely to display these problems

- Close family in jail (21%) vs. autism group = 0%
- Close family addicted to drugs (46%) vs. autism group = 7%
- Close family raped (19%) vs. autism group = 7%
- Domestic violence (11%) vs. autism group = 4%
- Child's mother was teen Mom (19%) vs. autism group = 7%

The parents of children with DH with serious behaviour problems are much more likely to have serious personal problems:

- Once in a psychiatric hospital (19%) vs. autism group = 11%
- Parent is diagnosed as DH (29%) vs. autism group = 19%

Despite the difference, the parents of both groups have many more special needs than typical parents in society. For example, the Government of Ontario[4] estimates the prevalence of mental retardation in the adult population is less than 1%.

The children who have DH with serious behavior have greater trauma and school failures in their background:

- Sexual abuse (37%) vs. autism group = 11%
- Physical abuse (54%) vs. autism group = 19%
- Long term school failure (87%) vs. autism group = 70%

Finding #9: Children with DH with serious behaviour have far greater social adversity than the children with autism

Children with DH with serious behavior problems have on average 4.44 of the above list of serious family problems or traumatic histories compared to 2.11 for autistic children.

[4] "The Prevalence of Ontarians Labelled as having a Developmental Disability"(1999), Developmental Services Branch, Ministry of Community and Social Services, Queens Park

7.0 FASD and Emotionally Disturbed

Children with Fetal Alcohol Spectrum Disorder (FASD) now represent 12.1% (+-3%) of the all clients placed in OARTY agencies. This subgroup has increased significantly, while at the same time, children with serious emotional and behavioral problems (29.4%) has decreased over the last three years. The first question that this raises is: *are the children diagnosed with FASD similar or different to the population diagnosed with serious emotional and behavioral problems*? The two populations are not statistically different on the following variables:

- Average daily cost of care ($182)
- Age today (14 yrs)
- Age when placed in OARTY residence (11 years)
- Percent with prior placements before OARTY (88%)
- Number of prior placements (3.7)
- Admissions to a psychiatric crisis unit (19%)
- Admissions to YCJA custody (10%)
- Admissions to a mental health centre (27%)

Children with FASD and children with emotional and behavioral problems have a similar pattern in case management decision making. There is one difference in case management approaches; 76% of children with FASD are placed in Treatment Foster Care (TFC) whereas only 58% of children ED/BD are placed in TFC.

Children with FASD have a significantly higher score on a standardized measure of behaviour problems (t-score of 85) compared to children with ED/BD (t-score of 77). Both groups are well within the clinically significant range.

Children with FASD have a significantly lower score on a standardized measure of social functioning (46) compared to children with ED/BD (54).

The significant differences between children diagnosed as FASD and ED/BD are:

- 24% of FASD and 14% of ED/BD are of aboriginal identity
- 48% of FASD and 0% of ED/BD is co-morbid with DH with behaviour problems
- 83% of FASD and 64% of ED/BD received a psychological assessment
- 79% of FASD and 50% of ED/BD were prescribed psycho-tropic medication
- 44% of FASD and 32% of ED/BD were injured due to self abusive behaviour
- 65% of FASD and 40% of ED/BD were injured due to aggression
- FASD children have many more serious family problems and histories of trauma
- FASD children have diagnoses of mental retardation from borderline to moderate
- 7% of FASD children display autistic features versus 0% for ED/BD

The co-morbidity with developmental disabilities rules out the theory that the increase in FASD children was due to a change in psychological assessment practice. The FASD children are more like multiple handicapped children and the growth of placements in this population is due to a real increase. This means there is no evident reason in our data that explains the decline in the placement of children who are emotionally disturbed.

The level of care required for daily living indicates the FASD group requires more adult supervision than the ED/BD group. They require more support on all 22 domains and are significantly higher on 17 of 22 domains. The FASD group has a total level of care score of 38% compared to 28% for the ED/BD population.

There are 2,212 children who are placed with OARTY member agencies on any given day.

270 children best fit the description of fetal alcohol spectrum disorder.

24% of these children have an aboriginal identity. 19% have been admitted to a psychiatric crisis unit or hospital.

44% have been injured by self abusive behaviour; 65% have been injured by their own aggressive behaviour.

Children with FASD present with more similarities to the children with DH plus serious behaviour problems than emotionally disturbed children.

Finding #10: FASD children are a new growing population

The growth in FASD children appears to be a real growth not a change in label that was formerly diagnosed as an emotionally disturbed child.

Finding #11: FASD children are more needy compared to disturbed children

Children designated as a "best-fit" with the category of fetal alcohol spectrum disorder are clearly more needy and are higher risk as compared to children who are emotionally and behaviourally disturbed.

Finding #12: Both FASD and ED/BD are a very high risk population

Although FASD is clearly more at risk than the ED/BD population, due to their developmental and social deficits, both groups have high needs in all indicators. More than half of the children in each group are receiving psycho-tropic medication; more than a third of children from each group have suffered medically significant injuries due to self abuse or their own aggressive behaviour.

7.1 Comparing FASD with ED/BD on Adversity

The children with FASD have by far the greatest burden of serious family and personal trauma, as evident in the following table.

	total OARTY population	ED/BD	FASD
years of poverty	51.0%	48.9%	69.2%
history of sexual abuse	31.6%	37.5%	50.0%
history of physical abuse	55.1%	71.6%	61.5%
close family committed suicide	3.2%	4.5%	11.5%
close family incarcerated	30.4%	45.5%	19.2%
close family in psychiatric hospital	19.0%	22.7%	30.8%
close family is DH	15.4%	6.8%	15.4%
close family addicted to drugs	51.0%	59.1%	88.5%
close family member raped	19.8%	20.5%	30.8%
child abused drugs/alcohol	13.0%	20.5%	0.0%
current domestic violence in family	17.8%	22.7%	30.8%
sexually assaultive person in fam	2.4%	3.4%	7.7%

	total OARTY population	ED/BD	FASD
child brain damaged	19.0%	1.1%	84.6%
child is a long term school failure	72.9%	62.5%	92.3%
child's mother started as teen Mom	21.9%	26.1%	26.9%
average # checked yes	4.23	4.53	6.19

Finding #13: FASD children have the highest level of adversity within the OARTY population

The family and trauma background of the FASD children is so severe that it overshadows the significant amount of stress in the lives of the emotionally disturbed child. The reality of overwhelming social adversity defines the FASD group; this group of children suffers from the highest degree of adversity.

Finding #14: Sexual and physical abuse is highest among the ED/BD population

A high proportion of emotionally disturbed children have been physically abused (71.6%) and 77% of the ED/BD population have been *either* physically or sexually abused. 32% have been *both* sexually and physically abused.

7.2 The Profile of Children with Emotional and Behavioural Problems

Children with emotional and behavioural problems have an extremely high degree of physical and sexual abuse in their background. This means that the treatment needs of these children must emphasize dealing with the trauma in their lives. The treatment includes teaching these children that they can trust adults and be secure and nurtured in their relationships. OARTY has a partner with Children's Mental Health and psychiatric hospitals in treating these children.

- 19% have been placed in a psychiatric crisis unit
- 27% have been placed in a Children's Mental Health facility

A disproportionate number of the disturbed children have an aboriginal identity (14%). The emotionally disturbed child displays high risk behavior. In particular, one third of the ED/BD population has suffered medical injuries due to self abuse; 40% have injured themselves due to their own aggression; and 50% of the ED/BD population has been prescribed psycho-tropic medication.

There are 2,212 children who are placed with OARTY member agencies on any given day.

650 children best fit the description of emotional and behavioural disorders.

14% of these children have an aboriginal identity. 19% have been admitted to a psychiatric crisis unit or hospital. 50% of these children are prescribed psycho-tropic medication.

The disturbed child displays high risk behaviour: 32% have been injured by self abusive behaviour and 40% have injured themselves by their own aggressive behaviour.

8.0 Medically Fragile and the Physically Disabled

Children described as either medically fragile or physically disabled represent 9% of the children placed in OARTY agencies. This population has remained consistent over many years.

The medically fragile are statistically different from the physically disabled on specific medical symptoms and in the percentage of children who are diagnosed as moderate or severe DH. In every other respect measured, the two clinical groups are not statistically distinct; therefore, we collapsed the two groups into one group for the data analysis purposes.

The medical symptoms that are similar or distinct are found in the table below. Children who are physically disabled suffer from injuries due to self abuse and their own aggression more frequently than the medically fragile. The physically disabled have a higher level of acquired brain injury in early childhood, which is often secondary to physical abuse or the shaken baby syndrome. 9% of children who are either medically fragile or physically disabled children are the victims of acquired brain injury.

Area of special need	Specific condition	medically fragile	physically disabled	Sig diff
Injuries due to	self abuse	19.5%	26.7%	PD more
	aggression	4.9%	13.3%	PD more
Neurological	Seizures	75.6%	53.3%	MF more
	cerebralpalsy	58.5%	60.0%	
	other_neurological	31.7%	13.3%	
	acquired brain injury	7.3%	13.3%	PD more
	microencephaly	22.0%	20.0%	
	hydroencephaly	17.1%	6.7%	MF more
Musculoskeletal	contractures	61.0%	53.3%	MF more
	scoliosis	53.7%	33.3%	MF more
	Abnormal tone	65.9%	73.3%	PD more
	Requires orthotic devices	68.3%	60.0%	MF more
Skin	skin breakdown	61.0%	46.7%	MF more
Gastrointestinal	vomiting	58.5%	33.3%	MF more
	aspiration	78.0%	46.7%	MF more
	Tubefed	68.3%	26.7%	MF more
Sensory Deficits	deaf_support	26.8%	6.7%	MF more
	blind_support	43.9%	20.0%	MF more
	inhalents	51.2%	13.3%	MF more
	lungdisease	51.2%	13.3%	MF more
	chestassess	51.2%	13.3%	MF more
	Oxygen	31.7%	0.0%	MF more
	chestphysio	46.3%	6.7%	MF more
	suctioning	39.0%	6.7%	MF more
	DH-borderline	2.4%	6.7%	PD more
	DH-mild	4.9%	6.7%	
	DH-moderate/severe	92.7%	86.7%	MF more

Finding #15: Medically and physically disabled children require a lifetime of care

The overwhelming majority of the medically and physically disabled children have a moderate to severe IQ, meaning that they will require total care for the rest of their lives. The children best diagnosed as medically fragile have significant special needs in the Musculoskeletal area, meaning that most medically fragile children are dually diagnosed with medical and physical disabilities.

8.1 Gender and Ethnicity

gender	All other children	Medically and physically dis
Missing data	0.7%	3.6%
Female	32.2%	39.3%
Male	67.1%	57.7%
Total	100.0%	100.0%

aboriginal		
no	87.7%	96.4%
yes	12.3%	3.6%
Total	100.0%	100.0%

A higher percentage of females are found among the medically fragile and physically disabled (39%) than observed all other children served by OARTY.

The prevalence of children with aboriginal identity within the medically fragile and physically disabled population is consistent with the normal population distribution. This means that the children of aboriginal identity are over-represented in the other diagnostic groups by a factor of 4-fold.

8.2 Case Management

history of prior placements	All other children	Medically and physically dis
no	16.5%	73.2%
yes	83.5%	26.8%

psychiatric crisis	All other children	Medically and physically dis
no	85.8%	100.0%
yes	14.2%	0.0%

CMHO placement	All other children	Medically and physically dis
no	78.5%	100.0%
yes	21.5%	0.0%

custody placement		
no	92.3%	100.0%
yes	7.7%	0.0%

CAS foster placements		
no	42.2%	85.7%
yes	57.8%	14.3%

This table shows that the case management decisions surrounding medically fragile children are significantly different from the other groups. Almost 75% of the medically fragile are admitted to OARTY agencies as a first placement. More than 85% of these children were not placed in CAS foster care, and none were placed in a psychiatric hospital, Children's Mental Health or custody facility.

Finding #16 OARTY agencies are the primary service stream for the medically fragile

OARTY agencies are the primary service option for the medically fragile and the physically disabled children post hospital.

8.3 Service Delivery Patterns between the Med/Physical Group and Others

		N	Mean	t	Sig. (2-tailed)
Average per diem	other children	561	$187.02	-4.998	0.000
	med-physical	56	$216.95		
age_today	other children	554	14.4	-1.597	0.116
	med-physical	55	16.3		
age placed	other children	554	11.6	2.871	0.006
	med-physical	55	9.1		
days served to date	other children	562	1,145	-4.708	0.000
	med-physical	56	2,744		
Placements	other children	544	3.35	1.834	0.067
	med-physical	56	1.67		

The table above shows that how the medical/physical group are distinct population in terms of the service stream. The average per diem including special care agreements is $218.02 compared to $187.02 for all other children. The medical/physical group is older today than the comparison group. These children were placed two years earlier (9.1 years) compared to 11.6 years for the other children. The medical/physical group have been in care for a longer period of time (7.7 years or 2,744 days to date) compared to other children (3.1 years or 1,145 days of care to date).

8.4 Clinical scores of the medical/physical group

		N	Mean	t	Sig. (2-tailed)
CGI_t_score	other children	551	78.701	5.592	0.000
	med-physical	54	62.889		
CGAS	other children	549	48.634	13.479	0.000
	med-physical	56	10.768		

On a standardized measure of behavior (CGI), the medical/physical group score in the high normal range (62.9). The other children (78.7) are significantly above the clinical range, indicative of behavioural problems. Conversely, the medical/physical group has an average score near the bottom of the CGAS, a standardized measure of social functioning. The exemplar for this score is as follows:

> *Needs constant supervision* (24 hour care) due to severely aggressive or self destructive behaviour or gross impairment in reality testing, communication, cognition, affect or personal hygiene

In a complimentary test of the level of care, the medical/physical group requires an adult to complete 90% of all basic living tasks on their behalf compared to 35% for the other children (t-score of -15.915, sig = .000).

The intense amount of care required by these children is related to the co-morbid conditions. For example,

- 86% have no speech
- 39% are blind
- 25% are deaf
- 5% have symptoms from the autism spectrum disorder (e.g. self stimulating)

The goal of treatment, while meeting their special needs, is to engage these children and empower them to affect their environment. Today, 27% of these children are able to indicate their preference when given choices and 21% are able to communicate to staff when they need or want something. Given that 86% of the population has no speech and many are deaf and blind, the percentage who is nevertheless engaged in making choices is an indicator of the quality of care in OARTY agencies.

8.5 Comparing the medical/physical group with all others on adversity

	comparison group	medically physically disabled
years of poverty	53.2%	7.9%
history of sexual abuse	33.2%	9.5%
history of physical abuse	57.4%	14.3%
close family committed suicide	3.4%	1.6%
close family incarcerated	31.5%	10.3%
close family in psychiatric hospital	19.1%	3.2%
close family is DH	16.2%	16.7%
close family addicted to drugs	53.2%	9.5%
close family member raped	20.9%	2.4%
child abused drugs/alcohol	13.6%	2.4%
current domestic violence in family	17.9%	6.3%
sexually assaultive person in fam	2.6%	0.8%
child brain damaged	15.7%	62.7%
child is a long term school failure	71.5%	90.5%
child's mother started as teen Mom	22.6%	9.5%
average # checked yes	4.32	2.48

The most revealing difference between the medically and physically disabled children and other children served by OARTY is years of poverty. The question on the survey was:

> *years of hardship and deprivation including poverty (e.g. family dependent on welfare or FBA all their childhood ... do not check off if family's dependence on welfare is episodic or recent)*

Before being placed at 9 years of age, 7.9% of the medical/physical group had lived in circumstances of hardship and deprivation compared to 53.2% for all others. The medical/physical group reflects the general population in social and economic background to a closer degree than any other group. Most children in this group acquired their special needs from prenatal and neonatal conditions, including genetic disorders.

The medical/physical group is equal to the others on only one indicator of adversity, *close family member with intellectually disability* (16.7%). The medical/physical group exceeds the other group in brain damage (63%) and long term school failure (91%). Only 14% of the medical/physical group had been physically abused; and 9% have acquired brain injury secondary to the abuse (usually from shaken baby syndrome).

In comparison, 57% of the rest of the client group have a history of physical abuse and only 1% has acquired brain injury.

8.6 Profile of the medical-physical group

The children that best fit the description of medically fragile or physically disabled represent 9% of the children placed in OARTY agencies. These children have a social and economic background that is typical of the general population, except for a *history of long term school failure*, which is a consequence of their condition, and a *close family member is DH*, which may reflect genetic risk in the family. A minority sub group within the medical fragile (18%) have a history of abuse (either physical or sexual) and half of these children have acquired brain injury from the abuse.

These children cannot live without constant care from adults. Specifically, 90% of the functions of daily living, (e.g.) getting dressed, eating, are dependent on adult support. For example, 70% of the medically fragile group are tube fed. Most of these children (60%) have a diagnosis of cerebral palsy followed by microencephaly (20%). Many of these children also have behavior problems and 20% injure themselves through self abuse that is often serving a self stimulating function.

The medical-physical group of children has a unique profile in the service delivery system with distinctive case management approaches:

- 75% of these children are placed directly into the OARTY resource from hospital or their family of origin and have no other placements.
- 14% were in CAS foster care before coming to OARTY
- Children from this group have never been placed in a children's mental health facility.
- Care is $20.00 per day more costly than the rest of the OARTY population
- Average length of service to date for children currently placed is 7.7 years compared to 3.1 years for the other children

9.0 Placement History

More than three quarters (78.3%) of the children in OARTY programs had at least one placement before the current one. The children with a history of prior placements had an average of 3.27 placements. Children were admitted to care at 7.7 years of age and spend four years in care before being placed in an OARTY resource. This table shows the age when the first placement happened by type of child for two groups: children with a prior history of placements and children placed directly into OARTY.

	Children with a history of placements before admitted to OARTY resource				Children admitted to OARTY direct from home	
type of child	# of placements	age when first admitted	age when admitted to OARTY	years before OARTY	% with no prior admissions	age when the *no prior* group admitted
DH-only	2.7	7.6	10.8	3.3	3.9%	10.8
autism	2.3	9.3	13.2	3.9	35.7%	11.2
FASD	4.5	5.4	10.9	5.5	8.0%	8.4
medical-physical	1.7	5.1	11.1	6.1	73.2%	8.4
DH-behaviour	3.0	7.4	11.3	3.9	21.4%	11.3
ED/BD	3.8	8.5	12.2	3.6	13.2%	10.5
symptom free	2.6	8.2	11.4	3.2	15.5%	11.2
Total	3.3	7.7	11.7	4.0	21.7%	10.1

This table shows that:

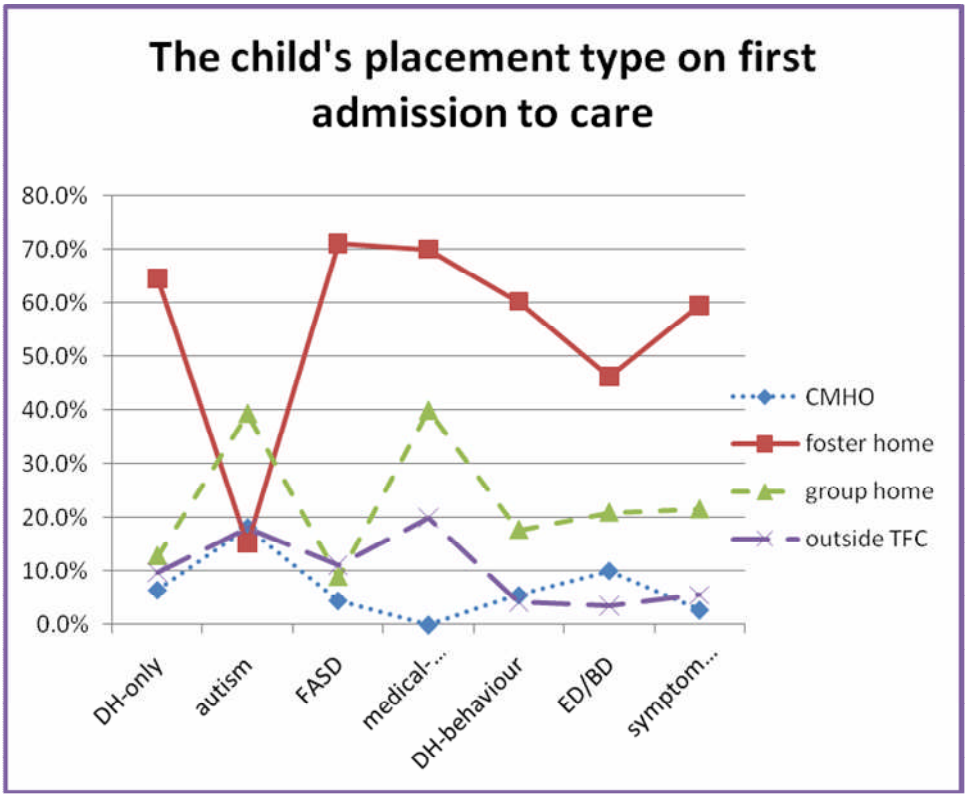
- the children described as DH-only had the lowest percentage of direct placements into an OARTY resource (3.9%)

- the medical-physical group had the highest percentage (73.2%) of direct placements

- the vast majority of children with FASD (92%) are placed in internal CAS resources before being placed in OARTY
    - the FASD group has the highest number of placements (4.5) prior to admission to an OARTY agency

- a large majority of children with emotional and behavioural problems (87%) have a history of placements before OARTY.
    - The children with prior placements who have ED/BD were first admitted to CAS care at 8.5 years
    - They spent 3.6 years in care and experienced 3.8 placements before being placed in an OARTY agency at 12.2 years of age
    - Conversely, 13% of the children with ED/BD were admitted to an OARTY agency directly at 10.5 years of age

The chart below examines where the children that had prior placements were first placed:



This graph shows that:

- 70% of the children with FASD were first placed in CAS foster care
- 50% of the children with ED/BD were first placed in CAS foster care
- 60% of the children with DH with serious behaviour problems were first placed in CAS foster care
- Up to 40% of children with autism were first placed in an OARTY residence before the current one
- 10% of children with EB/BD were first placed in Children's Mental Health and 10% were placed in another OARTY resource

Finding #17 CAS foster care is the first placement for the three largest groups of children

The first placement on admission to CAS care was a CAS foster home for 70% of FASD, 50% of ED/BD and 60% of children with DH with serious behavioural problems.

The second most frequent choice for placement on first admission was a group home – operated by another OARTY agency or a Children Mental Health Centre.

The large majority of children who have FASD (90%), DH with serious behaviour problems (78%) and children with emotional and behavioural problems (87%) were placed in other resources before being admitted to OARTY.

Finding #18 20% of disturbed children were placed in a Children's Mental Health facility

10% of the children with ED/BD were *first placed* in a Children's Mental Health facility (CMHO). An additional 10% (for a total of 20%) were placed in a CMHO after first being placed in foster care.

Finding #19 Disturbed children are at risk of placement breakdown

57% of disturbed children are placed in foster care at some point in their placement history. These children experienced on average 2.3 CAS foster homes up to a maximum of 8 foster homes before being placed in an OARTY agency.

Finding #20 Children experience 1 placement per year before admission to OARTY

Over the four year period before the children were placed in an OARTY agency, they have been in 3.3 placements; some groups such as FASD have 4.5 prior placements and ED/BD have 3.8 prior placements. This is close to a rate of 1 placement per year.

Finding #21 OARTY agencies provide placement stability to these children

Once placed in the OARTY agency, the children have remained in the same placement for 3.5 years to date.

10.0 Summary of Adversity

The most common types of adversity experienced by the children placed in OARTY resources are as follows:

child is a long term school failure	72.9%
history of physical abuse	55.1%
years of poverty	51.0%
close family addicted to drugs	51.0%
history of sexual abuse	31.6%
close family incarcerated	30.4%
child's mother started as teen Mom	21.9%
close family member raped	19.8%
close family in psychiatric hospital	19.0%
child brain damaged	19.0%
current domestic violence in family	17.8%
close family is DH	15.4%
child abused drugs/alcohol	13.0%
close family committed suicide	3.2%
sexually assaultive person in fam	2.4%

Finding #22 OARTY children are at great risk of school drop-out

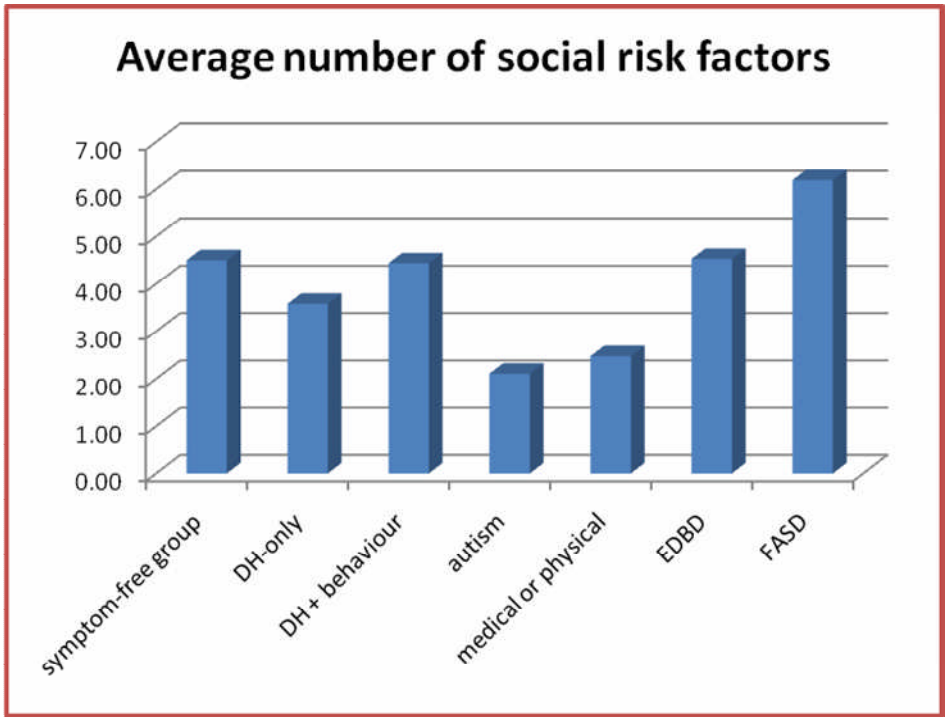
Almost three quarters of children placed in OARTY resources (73%) have experienced failure in school from primary grades onward. Transforming these children from school failures into graduates is the most common need of all OARTY residents.

Finding #23 51% of OARTY children lived for years in poverty before admission

The children placed have experienced significant adversity including physical and sexual abuse in addition to the special needs behind their diagnosis. Adding to this suffering, 51% of the children lived for years in poverty (not just episodes of welfare or periods of hardship).

Finding #24 On admission, OARTY clients are at high risk of being unable to function as young adults

Most groups of children placed in OARTY resources carry on average 4 or more social risk factors from the list above; this amount of adversity has been found in longitudinal studies (Werner, 1992, ibid) to predict an inability to function as an independent, competent young adult for 70% of individuals. The groups of clients with less social adversity include autism, medically fragile/physically disabled children and the DH-only group, who have fewer social risk factors, but their special needs have an impact across the lifespan.



11.0 Salary and Wages

The base annual income of full time child and youth workers is $28,730 or $13.81 per hour based on a 40 hour work week. This goes to a high of $35,429 or $17.03. Part time staff are paid significantly less than this. Part time staff earn $12.87 at the base wage rate up to a high of $14.27. These figures are based on agency-wide staffing data and represent the true base and highest current rate of pay for the 26 agencies who responded.

12.0 Findings

The findings of Partners in Care III are as follows:

- Finding #1: The sample size has sufficient power to apply to all clients
- Finding #2: Foster and Group providers are fairly represented
- Finding #3: Children with no symptoms have decreased to 9% (from 16% in 2005)
- Finding #4: Children with autism have increased to 11% (from 6% in 2005)
- Finding #5: Children with FASD have increased to 12% (from 4% in 2005)
- Finding #6: Some populations have not changed, specifically:
    - DH-only (8%)
    - DH with serious behavioural problems (20%)
    - medical and physical disabilities (9%)
- Finding #7: The percentage of children with emotional and behavioural problems has decreased to 29% (from 40.6% in 2005)
- Finding #8: Children with autism are more impaired socially than children who are DH with serious behaviour problems
- Finding #9: The group who are DH with serious behaviour problems has far greater social adversity than the children with autism
- Finding #10: FASD children are a new growing population
- Finding #11: FASD children are more needy compared to disturbed children
- Finding #12: Both FASD and ED/BD are a very high risk population
- Finding #13: FASD children have the highest level of adversity within the OARTY population
- Finding #14: Sexual and physical abuse is highest among the ED/BD population
    - 77% of the ED/BD population have been *either* physically or sexually abused
    - 32% have been *both* sexually and physically abused
- Finding #15: Medically and physically disabled children require a lifetime of care
- Finding #16: OARTY agencies are the primary service stream for the medically fragile
- Finding #17:CAS foster care is the first placement for the three largest groups of children. The first placement on admission to CAS care was a CAS foster home for:
    - 70% of FASD
    - 50% of ED/BD
    - 60% of children with DH with serious behavioural problems.
- Finding #18: 20% of disturbed children were placed in a Children's Mental Health facility

- Finding #19: Disturbed children are at risk of placement breakdown
    - 57% of disturbed children are placed in regular foster care at some point in their placement history
    - These children experienced on average 2.3 CAS foster homes up to a maximum of 8 before being placed in an OARTY agency (which may be treatment foster care or group care)
- Finding #20: Children experience on average 1 placement per year before admission to OARTY
- Finding #21: OARTY agencies provide placement stability to children
- Finding #22: OARTY children are at great risk of school drop-out
    - 73% have experienced failure in school from primary grades onward
- Finding #23: 51% of OARTY children lived for years in poverty before admission
- Finding #24: On admission, OARTY clients were at high risk of being unable to function as young adults

Robert Fulton, Lead Researcher

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