



A Word from the Executive Director

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New Facilities at Family and Children's Services

In response to the increasing frequency of family visits occurring in our Fort Frances office, we have decided to **create a Family Room** to accommodate the rising demand. This new 300 square foot area will be located on the lower level, and will provide all the amenities required for visiting families including a refrigerator, stove, microwave and washroom facilities. The staff designing the room are intent on making the room comfortable with a "home-like" feel. The room will also include a full range of toys and games to accommodate a variety of interests.

The addition of the Family Room will facilitate the **increased usage of our Play Therapy Room** by Children's Mental Health staff for its intended purpose. The Play Therapy Room includes a one way mirror to accommodate parents and clinicians and will be equipped with a range of clinically based toys and activity centres for children of all ages.

I'd like to take this opportunity to thank those staff who have participated in the planning and development of these new facilities and for spearheading initiatives that clearly address our strategic objectives of service excellence and meeting community needs.

Vik Nowak
Executive Director



This recent upgrade to our facilities falls on the heels of the **recent development of Multi-Sensory Rooms** in our Atikokan and Fort Frances offices. These rooms were funded in part by the generous donation of the Moffat Foundation and are the only ones of their kind in the Rainy River/Kenora Region. They are available at no charge for families of special needs children.

Child Protection Services

It's About Protecting Children and Strengthening Families

The new **Differential Response Model** of Child Protection Services is a model of service delivery that supports two strength based approaches to investigations. These two approaches are defined as "traditional" and "customized".

The introduction of the new Model is reflective of a shift in culture towards a strength-based collaborative service with clients which will support the autonomy of the family unit. It encourages workers to consider the least disruptive course of action in clinical practice.

A traditional approach is used in more severe cases of suspected or verified child abuse, where risk of harm is immediate. It can be defined as a more overt or explicit use of authority, examples of which would be unannounced home visits or the apprehension of a child to a place of safety.



A customized approach is utilized in situations where the concern for child safety is less immediate or severe. The child protection worker slowly builds rapport with the client

during each contact. Parents are always viewed as potential partners in building safety.

In both approaches, it is important to engage families in making appropriate safety decisions. Effective engagement not only results in the identification of specific attainable goals, but offers the family alternatives as to how to get there. It is hoped that by engaging the family they will be proactive in making safety decisions and not require Child Protection services in the future.

A worker can make the transition between the two approaches throughout the investigation, as

several principles guide the investigation and the Worker. A few examples common to both approaches are:

- Cooperate with the person, not with the abuse.
- Maintain a focus on safety.
- Learn what the service recipient wants.
- Focus on creating small change.

These approaches have been proposed by the Ministry in response to research that has been completed on similar models used in other areas. There is a significant amount of evidence that demonstrates the effectiveness of working with families in this way.

Lindsay Kavalench,
Family Service Worker



Developmental Services

Community Integration

The Community Integration Program is a free and voluntary program which assists families and their children age 6-18 who have a developmental disability.

The focus of the program is to ensure that families and children have the necessary supports to facilitate their integration into the community, so that they can live their lives to the fullest potential.

Services include:

- Home visits with flexible hours.
- Family support services that include advocacy and education.

- Linkage with health, financial, education, and social services in the community, regionally and provincially.
- Recreational and life skills programming for children and youth.
- Adaptive skills assessments.
- Advocacy in relation to other community agencies.
- Assistance for young adults and their families in making the transition to adulthood.
- Presentations within the community about the Program

To find out more information or to refer for services, contact Community Integration Workers: **Debra in Fort Frances at (807) 274-7787 or Lorraine in Atikokan at (807) 597-2700.**



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We are on the Web!
www.facsrr.ca

Children's Mental Health Services

Attention Deficit Disorders: The Myths and Facts



Controversy, misunderstanding, and pre-conceived notions continue to circulate around

Attention Deficit Disorder (A.D.D.), and Attention Deficit Hyperactivity Disorder (A.D.H.D.).

Following are some interesting viewpoints concerning these topics:

Myth: ADHD is a "phantom disorder."

FACT: The existence of a neurobiological disorder is not an issue to be decided by the media through public debate, but rather is a matter of scientific research. Scientific studies spanning 95 years summarized in the professional writings of Dr. Russell Barkley, Dr. Sam Goldstein, and others have consistently identified a group of individuals who have trouble with concentration, impulse control, and in some cases, hyperactivity. The U.S. Surgeon General, the American Medical Association, the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Psychological Association and the American Academy of Pediatrics, among others, all recognize ADHD as a valid disorder.

Myth: ADD is just a lack of willpower. People with ADD focus

well on things that interest them; they could focus on any other tasks if they really wanted to.

FACT: ADD/ADHD looks like a willpower problem, but it isn't. It's a chemical problem in the management system of the brain.

Myth: Medications for ADD/ADHD are likely to cause longer-term problems with substance abuse or other health concerns, especially for children taking these medications.

FACT: The risks of using appropriate medications to treat ADD are minimal, whereas the risks of not using medication to treat ADD/ADHD are significant. The medications used for treating ADD/ADHD are among the best researched for any disorder.

Myth: ADHD kids are learning to make excuses, rather than take responsibility for their actions.

FACT: Therapists, physicians, and educators routinely teach children/adolescents that ADHD is a challenge, not an excuse. Medication corrects their underlying chemical imbalance, allowing for a fair chance of facing the challenges of growing up to be productive citizens.

Myth: ADHD is basically due to bad parenting and lack of discipline, and all that ADHD children really need is old-fashioned discipline, not any of

these "phony" therapies.

FACT: A body of family interaction research conducted by Dr. Russell Barkley and others has unequivocally demonstrated that simply providing more discipline without any other interventions worsens rather than improves the behaviour of children/youth with ADHD.

Myth: Efforts by teachers and others to help children who have attentional problems can make more of a difference than medications such as Ritalin.

FACT: Recent scientific evidence from the multi-modal treatment trials sponsored by the National Institute of Mental Health suggest this is a myth. In these studies, stimulant medication alone was compared to stimulant medication plus a multi-modal psychological and educational treatment, as treatments for children with ADHD. The scientists found that the multi-modal treatment plus the medication was not much better than the medication alone. Teachers and therapists need to continue to help individuals with ADHD, however, it is vital to realize that the underlying biological factors that affect ADHD must also be addressed.

Jamie Sterling, M.A. (C.Psych. Associate, Supervised Practice)



Community Services & Quality Assurance

A Word from the Family Conferencing Coordinator...

In January of 2008, Family and Children's Services and our community partner, Integrated Services Northwest, participated in a training retreat to formally implement the revised Case Management system that links with the



Northern Framework for Ministry-Funded Children and Youth Services.

During the training, the Family Centred Conferencing program was presented and Alternative Dispute Resolution was explained. Both services which can be provided at FACS. 2008 marks two years since the changes in case management were initiated. Along the way we had many modifications.

During these two years the program has been very successful servicing 24 families, coordinating 17 Family Centred Conferences, and approximately 50 follow up conferences.

If you have any questions, please contact **Tina Arnold**, Family Conferencing Coordinator at 274-7787, ext 223.



Call your local office of Family & Children's Services 24 Hours a day, 7 Days a week Or visit us on the web www.facsrr.ca



Children's Services

Resource Families

Finding and keeping resource families (both foster and adoptive) for children in care has become a critical issue in Ontario. Family based care, rather than group home type of settings are the preferred option for our children entering care. There is much research and literature that points to the reality that children, who are living in foster or adoptive homes do considerably better in the areas of education, emotional and psychological health, physical health, attachments and socialization.

The gap between the children who need homes and the resource families available to provide that care continues to grow at an alarming rate. The need for experienced, well trained resource homes has never been higher but it is increasingly

difficult to recruit and retain new families.

The **Parent Resources for Information, Development and Education (PRIDE)** is a comprehensive model for the development and support of resource families. PRIDE was developed by the Child Welfare League of America as a tool for assisting with recruiting and keeping resource families. The PRIDE model is designed to strengthen the quality of family foster care and adoptive resources by providing a standardized, structured framework for recruiting, preparing and selecting resource families. It has been developed based on the premise that children in care have exceptional needs and our resource families require the competencies and capacities to meet those needs.

PRIDE is a competency-based training

approach that focuses on skill building in the areas of:

- Protecting and nurturing children.
- Meeting children's developmental needs.
- Supporting the relationship between children and their families of origin.
- Connecting children to safe, nurturing relationships intended to last a lifetime working as a member of a professional team.

The issues of attracting and keeping resource families has become part of our day-to-day thinking. Keeping our resource families is imperative if we are to meet the needs of our vulnerable children.

If you have any questions about the process involved in becoming a resource home for our Agency, please contact Christa Little.

"Where Families Matter"