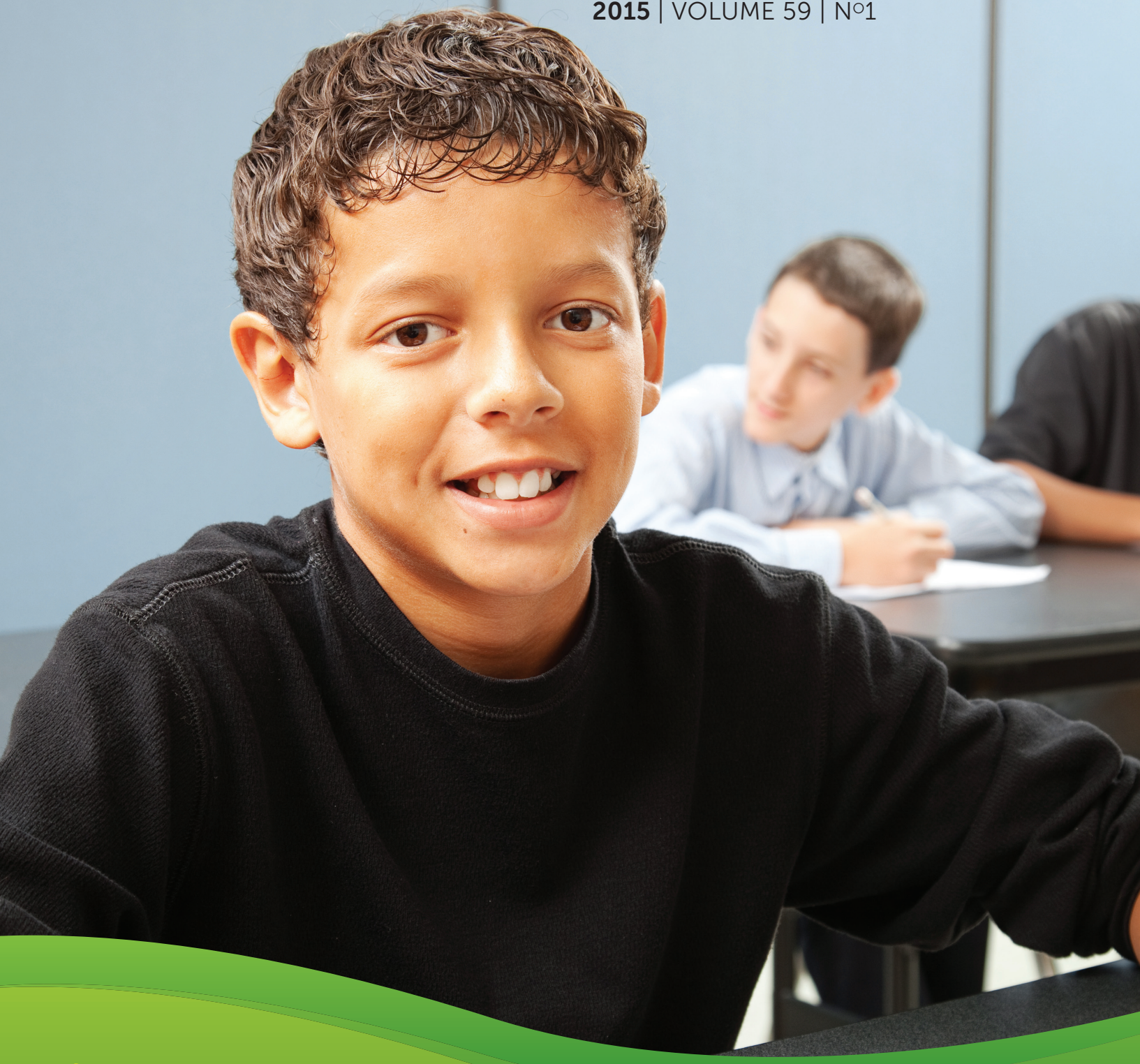
Ontario Association of Children's Aid Societies

JOURNAL

2015 | VOLUME 59 | N°1



INSIDE

Ontario Association of Children's Aid Societies
The voice of child welfare in Ontario

Ontario Association of Children's Aid Societies
JOURNAL

2015 | VOLUME 59 | NO1

OACAS JOURNAL EDITORIAL BOARD

Submissions to the OACAS Journal are reviewed anonymously by the Editorial Board and compared against a review matrix that questions the logic, research, content and discussion of the submission.

The OACAS *Journal* is a major source of information for Ontario's children's services professionals. Published twice a year, the OACAS *Journal* features articles on child welfare research and practice in Ontario, highlighting projects and initiatives to improve the well-being of children, youth and families.

The OACAS *Journal* is distributed in print and electronically to a diverse readership of over 3,000 recipients.

The OACAS *Journal* welcomes articles from researchers and professionals on programs, projects and initiatives designed to improve the lives and outcomes of children, youth and their families.

For more information on article submission visit http://www.oacas.org /pubs/oacas/journal/index.htm

Requests for subscription information, notice of change of address and undeliverable copies should be sent to:
Ontario Association of Children's Aid Societies
75 Front St East, Suite 308, Toronto, Ontario M5E 1V9
www.oacas.org
journal@oacas.org

National Library of Canada ISSN 0030-283x

TABLE OF CONTENTS

MESSAGE FROM THE EXECUTIVE DIRECTOR

Welcome to the winter issue of the Ontario Association of Children's Aid Societies (OACAS) *Journal*. This issue focuses on a wide array of topics, and highlights the range of research and innovative practices that continue to be undertaken to help support the children, youth, and families of Ontario.

Based on events from late 2013 and early 2014, the *Journal* presents a timely article from Chatham-Kent Children Services (CKCS) on the multicultural, legislative, and systems challenges that arose during their service to the Lev Tahor community, and the lessons CKCS learned throughout the process.

The health and functioning of children and youth in care continues to be a high priority in child welfare. This issue has a selection of articles that highlight challenges and strategies for improving outcomes of children in care, including programs developed to help improve outcomes. Marv Bernstein and Pat Convery's article "Ensuring Children's Well-Being" stresses the importance of having a child rights focus at all levels of child welfare and adoption work.

Building on this, and themes from the *Toronto Star*'s investigation series, "Society's Children," the article "Understanding the Symptomatology of ADHD — Part One" by Sebastiano Fazzari, Sean Robb, and Peter Bonsu sets out to help readers better understand the symptoms of ADHD in pediatric populations. This article is the first in a series, which will provide an up-to-date review of literature on the symptomatology, assessment, and treatment of ADHD from biological, psychological, and social perspectives. This first article looks at how children appear in clinical practice and how their symptoms can be characterized and explained, while the following parts will focus on assessment, diagnosis, and treatment.

I have also included in this issue an article by Patricia Howell-Blackmore that looks at the collaboration between OACAS and Lions Quest Canada to create customized training for foster parents and child protection workers.

Parental substance use and its impact on child safety and parenting capacity continues to be a priority for child welfare, and I have included in this issue an article by Deborah Goodman et al., which details some of the positive outcomes of a 2009-10 program developed for children and families where substance use is an issue and was a factor in the involvement of child welfare professionals.

Please enjoy this issue of the *Journal*, and please feel free to reach out to share any topics or issues you would like to read about in future issues. You can do so by sending us an email at journal@oacas.org.

Mary Ballantyne
Executive Director

Evidence-Informed Practice in Intervening with Children Affected by Substance Abuse (CASA)

by Deborah Goodman, Carol Baker-Lai, Carolyn Ussher, *Children's Aid Society of Toronto*
and Michelle Coutu, Diane Smylie, *Jean Tweed Centre*

This evidence-informed, multi-sector, community partnership service model called, Children Affected by Substance Abuse (CASA), was developed in 2009-10 for children and families where parental "substance use" is an issue and child welfare involvement resulted. Since terms and language can change over time as learning evolves, the preferred term now used is "substance use" instead of terms that carry stigma (e.g., "substance abuse" or "misuse"). This article details the outcomes related to one of CASA's goals, "improved service outcomes;" as well as the evaluation methodology used, the rationale for using a community partnership model, the service guidelines that were developed, coupled with a summary of the study findings and the suggested implications for practice.

KEY CHILD WELFARE SERVICE ISSUE — PARENTAL SUBSTANCE USE

Since terms and language often change over time as learning evolves, the preferred term in 2015 is "substance use;" it replaces descriptors that relay stigma, like "substance abuse" or "misuse," terms we used in 2009. What remains unchanged is that families involved with child protection where substance use has been identified and child safety issues have been noted, still constitute a significant proportion of the cases served. Fifteen years ago a landmark federal study by the US Department of Health and Human Services [DHSS] found one-third to two-thirds of all child welfare cases were impacted to some degree by substance use (DHSS, 1999). More recent studies indicate that range may be too narrow (Barth, 2009; Traube, 2012). Regarding consequences for the child, an Ontario study of over 8,400 respondents found parental substance use is twice as likely to place children at risk to both childhood physical and sexual abuse (Walsh, MacMillan & Jamieson, 2003). The longer-term risks to children whose parents have substance use issues are also well established. In comparing children whose parents have identified substance use concerns to parents who do not, the children in families where substance use is prominent are more likely to have poorer physical, social and emotional outcomes, have greater risk that they themselves will develop substance use problems, and are more likely to enter care and remain in the child welfare system longer than other children (Dubowitz et al., 2011; Institute of Medicine and National Research Council, 2013; Wulczyn et al., 2011). In sum, parental substance use is most certainly a significant issue – for the children, for the parents, for the extended family and community, and for the child welfare agencies serving the families. A key service question for child welfare is: What works in reducing risk and improving outcomes for children and their families impacted by parental substance use?

Historically, the relationship between child welfare, the substance use sectors, and culturally specific services can best be described as one with considerable tension and little trust (Baskin, Strike, McPerson, Smylie, Angeconeb, Sauve, et al., 2012; Cullen, 2006) as mandates, principles and philosophies on service differ. Yet, a review of the literature and best practices on this topic finds strong support for cross-sector collaboration in order to realize better outcomes for families impacted by substance use. For example, cross-sector services tend to be less fragmented, are more likely to offer home-based, outreach services and address treatment barriers better, and are more sensitive to the cultural context and the complex needs of women (Baskin et al., 2012; Cullen, 2006; Jansson, Svikis, Breon & Cieslak, 2003). A robust finding in the extant literature is the advantage associated with cross-sector training. In short, the benefits of providing CAS workers with education on this topic has been well established in research given child protective service (CAS) outcomes have been found to be influenced by parental substance use (Lee et al., 2009; Osterling et al., 2008;

Ryan et al., 2006). Additionally, families served by child protection agencies may have particular difficulty accessing substance use services so a partnership approach should ensure better service and timelier access. Other questions of importance are: **Can improved collaboration between the sectors occur? If yes, can this model improve service and result in better case outcomes for children and families where substance use is an issue?**

PROJECT BACKGROUND

With the aim to improve child safety and permanency outcomes, enhance family engagement and strengthen linkages between child welfare and related sectors, a partnership was created amongst the Toronto substance use treatment agencies (e.g., Centre for Addiction & Mental Health (CAMH)); the Jean Tweed Centre (JTC), a community based Toronto treatment centre for women with substance use, mental health and/or gambling problems and their families; the Ontario Association for Children's Aid Societies (OACAS); and the project lead agency, the Children's Aid Society of Toronto (CAST), which is one of four child welfare agencies serving Toronto. This multi-agency, multi-sector project was called **CASA—Children Affected by Substance Abuse (2009-2012)** and it was funded by the Ministry of Children and Youth Services (MCYS) through its Eliminating Barriers—Building on Success grant.

CASA GOALS

CASA's three overall project goals were: **Goal 1) to improve client service outcomes** by having a substance use specialist at Intake where emphasis is on child safety and permanency, intervening in a family child-centered way, and greater utilization of family and community to maintain continuity of care for children. **Goal 2) to improve worker knowledge and skills** through an evidence-informed, best practice training curriculum for staff, which included developing two different trainings on substance use: a) a provincial, online training and b) a series of agency, classroom workshops. **Goal 3) to improve service collaboration** through collaboratively developing a best practice protocol to guide the different sectors on preferred interventions with families with substance use issues. Note the focus of this article is to present the CASA model and the evaluation findings specific to Goal 1.

Goal 1—To Improve Client Service Outcomes: CASA's collaborative service intervention involved CAST partnering with the Jean Tweed Centre (JTC), who provided the CASA specialist. The home base for the CASA specialist for the duration of the project was CAST. There were two service phases. Phase 1, the CASA specialist provided training and consultation services to only CAST intake staff (2009-11); in Phase 2, CASA service included all Intake and Family Service CAST staff plus Intake staff at Catholic Children's Aid Society of Toronto (CCAST), Native Child & Family Services of Toronto (NCFST) and Jewish Family & Child Services (JF&CS) (2011-12). The CASA specialist delivered the following services:

- ✓ **Direct case consultation services** to Toronto child welfare staff to aid in building their capacity to work more effectively with families as well as accompany service staff on family visits as needed [Goals 1 & 2];
- ✓ **Delivery of standardized classroom training and workshops** in current best practices related to assessment, engagement and treatment [Goals 2 & 3];
- ✓ **General support** to child welfare staff and teams via coaching and mentoring [Goals 1, 2 & 3].

Goal 1 ~ CASA Evaluation Plan: A multi-method, multi-stakeholder approach ensured data were robust and triangulated (i.e., different methods, data from different stakeholder groups). Illustrations of the varied methods used include focus groups and surveys of CAS staff to evaluate CASA service and training impact, file reviews of CASA families (treatment group) vs. matched, non-CASA cases (comparison group), and administrative database analysis. Table 1 presents the anticipated CASA outcomes by key stakeholder groups for Goal 1.

Table 1: Anticipated CASA Outcomes for Goal 1

Stakeholders	Anticipated CASA Outcomes for GOAL 1
CAS Workers	• Workers knowledge of best practices increases in serving families with substance use; • Workers confidence improves in serving families and children impacted by substance use;
Children	• Children are less likely to be placed in care; • Children will spend less time in care;
Families	• Families receive longer CAS service; • Families complete service; • Families improve their access to community supports; • Families have improved case service plans in transfers from Intake to Family Service.

Challenges in Implementing Cross-Sector, Collaborative Models: It is an axiom to state that there is not a fast fix or quick intervention in working with families where parental substance use is an issue and child welfare services are required. The cumulative field experience of CAST and JTC identified many challenges in implementing a cross-sector model. Barriers to implementing cross-sector service partnerships noted in the literature include: (1) differing regulatory environment and administrative structures in terms of leadership, licensing, quality assurance mechanisms and management information systems; (2) varied treatment goals and philosophies (e.g., substance use systems are influenced by adult harm reduction models versus child welfare systems that prioritize child safety and permanency); (3) assessment strategies generally do not integrate co-occurring issues of child welfare and substance use; and (4) differing standards of success and failure vary across the systems (Drabble & Poole, 2011; Marsh, Smith & Bruni, 2011). To address these differences and bring a common language, definitions and practices to the CASA partnership, practice guidelines were developed.

CASA Best Practice Guidelines: *The Best Practice Guidelines for Work with Caregivers who Misuse Substances: Understanding Addiction to Better Serve Children and Youth* (2011) was created through a partnership approach that included: Toronto Substance Abuse Treatment Agencies, CAST and JTC. The development of the Guidelines was also informed by interviews and focus groups with former clients of the child welfare system, as well as youth who had been involved with child welfare due to their parents' substance use. **Ten practice principles** were identified:

1. Family-centered Approach;
2. Strengths-focused Perspective;
3. Anti-oppression Lens;
4. Harm-reduction Approach;
5. Consideration of the Social Context (Social Determinants of Health);
6. Trauma-informed Perspective;
7. Timely Service and Referrals;
8. Awareness of Concurrent Substance use and Mental Health;
9. Engagement;
10. Collaboration.

The ten practice principles are to be applied through the various stages of child welfare case service intervention, such as screening, assessment, apprehension, court, access visits, service planning, and transfer of the case. These Guidelines are meant to help the CAS workers and their supervisors apply the service principles in a way that expands the assessment process and enhances child safety and well-being. More specifically, by broadening the child welfare assessment to include issues that tend to be linked (i.e., substance use, mental health, domestic violence) the result is a more fulsome assessment compared to the more traditional approach that tends to place emphasis on one risk factor. The Guidelines also underscore that with all CAS service interventions engagement with caregivers (and the children) by the CAS worker is the best way to enhance information gathering and assessment, address caregiver and family needs, and promote the safety and well-being of children. These Guidelines can be accessed through contacting Carolyn Ussher at cussher@torontocas.ca

CASA—GOAL 1 FINDINGS

Evaluation of Goal 1 objectives was based on statistical significance set at p </= .05 and the analysis of:

A. Administrative Data Base...longitudinal analysis of 2,014 Eligibility Code 53-A and 53-B cases from 2008 to 2010 at CAST found: (1) the CASA specialist was used by the child welfare staff and use increased over time, and (2) the longer the CASA specialist was in place, the greater the percentage decline in re-opened 53A/53B Substance use cases (see Table 2).

B. Standardized File Reviews...analysis of CAST data from 26 files using a random sample selection of CASA cases (n=13) and a matched comparison group that did not receive CASA services (n=13) (see Table 3).

C. Worker CASA Training Feedback...analysis of Survey Monkey feedback on Phase 1 ~ CASA training impact from 44 CAST workers (see Table 4).

A: Administrative Data Base Analysis. Not including the baseline period, the July 2009 to September 2010 analysis examined all child welfare cases coded as 53-A or 53-B using the Eligibility Spectrum ("Caregiver with a mental health &/or substance abuse issue") as well, we tracked the use of the CASA specialist. Longitudinal analysis found that cases coded as 53A or 53B constitute 15% to 20% of all investigations. Cases where parental substance use was the primary service issue form 7% to 12% of all investigations. During the project period (2009-2012), the percentage of re-opened cases coded 53A or 53B declined from 66% to 56%, and the number of cases the CAS staff used the CASA specialist with 53A or 53B cases rose during the same period from 17.2% to 33.3% (see Table 2).

Table 2 Administrative Data Analysis: CAS Toronto							
	BASELINE/08 3 months	July-Sept/09	Oct-Dec/09	Jan-Mar/10	Apr-Jun/10	July-Sep/10	Comments
	Baseline	CASA start →				CASA end	
Total CAST Investigations	**1880**	**1621**	**2107**	**2110**	**2302**	**1741**	Quarterly fluctuations are typical re-total investigations over time
Total # 53A-53B Substance Abuse &/or Mental Health Issue	**324**	347	331	368	361	**283**	Eligibility Code at Investigation for 53A & 53B "Substance abuse and/or Mental Health Issue" =15%-20% of all investigations
% 53A-53B to All Investigations	**17.2%**	21.4%	15.7%	16.6%	15.7%	**16.2%**	
Total # 53A-53B ~ Substance use only	**162/324**	192/347	147/331	170/368	189/361	**147/283**	Substance use as a primary reason for investigation =45%-55% of all 53A-53B cases;
% Substance use only	**50%**	55.3%	44.4%	46.2%	52.3%	**51.9%**	
% Substance use to All Investigation Types	**8.6%**	11.8%	7.0%	8.0%	8.2%	**8.4%**	53A-53B~ Substance use = 7-12% of all investigations
Total # Substance use Cases	**162**	192	147	170	189	**147**	The 53A-53B cases "opened for the first time" did not appear impacted by the CASA intervention; the percentage of "re-opened" cases did show a steady reduction from 66% at start of CASA intervention to 56% at program end.
Total Opened for First Time	**127/324** **39%**	66/192 34%	53/147 36%	61/170 36%	73/189 39%	**61/147** **44%**	
Total Substance use Reopened 2x or more	**197/324** **61%**	126/192 66%	94/147 64%	109/170 64%	116/189 61%	**83/147** **56%**	

Table 2 continued...

Table 2 Administrative Data Analysis: CAS Toronto							
	BASELINE/08 3 months	**July-Sept/09**	**Oct-Dec/09**	**Jan-Mar/10**	**Apr-Jun/10**	**July-Sep/10**	**Comments**
	Baseline	**CASA start** →				**CASA end**	
CASA Specialist Service % Substance use cases	**Not Available**	**33/192** **17.2%**	49/170 28.8%	75/170 44.1%	41/189 21.7%	**49/147** **33.3%**	CASA specialist use by CAS staff rose over project period from one-in-six cases at start to one-in-three cases by project end along with a higher use by workers of CASA specialist for cases vs. consultations
Consultations		25	37	56	24	30	
Cases		8	12	19	17	19	

B. Standardized File Reviews Analysis

A total of 26 comprehensive, standardized file reviews were completed that examined and tracked key child and family outcomes over time in 13 CAST cases that received the CASA service and 13 cases that were matched on service and demographic characteristics but did not receive the CASA service. Comparing expected outcomes to actual, no difference was found between the two groups on the number of children placed in care. However, analysis did find the following positive outcomes: (1) children whose families received the CASA service were more likely to spend less time in care; (2) the CASA cases were more likely to stay open longer, which increased the likelihood the families were not only referred but received child welfare support and community services; (3) the longer CAS service opening meant the CASA families were more likely to complete these services and have access to community supports, compared to closing the case at Intake where community services may be referred but not started and not completed by the family; and (4) extending the CAS service beyond Intake for these substance use cases that are typically complex with long-standing issues resulted in more comprehensive Intake service plans prior to transfer to Family Services. See Table 3.

Table 3: Analysis of CASA Cases to Matched Non-CASA Cases

Stakeholder Group	Anticipated CASA Outcomes for GOAL 1	Actual CASA Outcomes for GOAL 1
Children	• Children are less likely to be placed in care • Children will spend less time in care	• No difference in number of children placed in care between CASA vs. non-CASA cases • CASA cases were more likely to have **children spending less time in child-welfare care** vs. non-CASA cases (r=-.70, p=.05).

Stakeholder Group	Anticipated CASA Outcomes for GOAL 1	Actual CASA Outcomes for GOAL 1
Families	• Receive longer CAS service • Complete CAS service • Improved access to community supports • Improved service plans inform Intake to Family transfer	• CASA cases experienced **less case closures** vs. non-CASA cases (X^2=4.75, *p*=.03); • CASA cases were **more likely to complete services** vs. non-CASA cases (X^2=8.03, *p*=. 01); • CASA cases had **greater access to community supports** vs. non-CASA cases; • CASA cases had **increased # of comprehensive service** plans prior to transfer to Family Service

C. Worker CASA Training Feedback Analysis

A total of 44 CAST workers completed the standardized evaluation of the six CASA classroom-based, workshop trainings delivered to service staff by the CASA specialist. In addition to high satisfaction, the preponderance of CAS trainees' (70% or greater) indicated that the CASA trainings increased their knowledge, skills and confidence on the topic, which resulted in improved service to children and families impacted by substance use. See Table 4.

Table 4: Analysis of Worker Survey on CASA Training Impact

Stakeholder Group	Anticipated CASA Outcomes for GOAL 1	Actual CASA Outcomes for GOAL 1
CAS Workers (n=44)	• Increased knowledge of best practices in serving families with substance use;	• 70% said **"knowledge of community resources in substance use"** improved due to CASA training; • 94% said **"ability to provide more effective service"** to families with substance use increased due to CASA training; • 94% said **"ability to develop more comprehnsive treatment plans"** re- families with substance use increased with CASA training;
	• Improved confidence in serving families and children impacted by substance use;	• 75% said **"CASA training helped improve skills in serving families with substance use issues";** • 70% said **"confidence in providing substance use service"** increased due to CASA training;
	• Workers satisfied with CASA training	• 80% said they were **"satisfied with CASA training"**

PRACTICE IMPLICATIONS

The CASA project provides a tangible example of how a collaborative community-based model, using a shared service model, can improve service outcomes to children and families in areas that traditionally have not taken this tactic. Also as a concept, the CASA project has the potential to be replicated in other areas of the province through a shared services model. This project also demonstrates the importance of having a strong evaluation framework to demonstrate if and where the intervention has the greatest impact.

CASA PROJECT CONCLUSIONS

The CASA results highlight the benefits that can occur for child welfare involved children and families and the staff who serve them through employing a cross-sector partnership model. The findings also underscore the importance of improving worker knowledge, skills and competencies in working with families that have substance use issues. Workers indicated that the amalgam of learning methods (i.e., evidence-informed curriculum, interactive, ongoing learning opportunities, informal and formal case discussions with the CASA specialist, and home visits with the CASA specialist) resulted in a layered learning approach (e.g., training with topic expert specialist with clinical experience) that was effective in learning and reinforcing knowledge uptake and skill acquirement over time.

The high ratings by workers who received the CASA trainings suggest that this type of training, support and consultations are needed, welcomed and utilized by child protection staff. Of great importance, the analysis of case and worker data found the CASA intervention did accrue positive outcomes for families and children. The sector collaboration model has been shown to be effective in other areas, such as in advancing evidence-informed/best practice strategies with Fetal Alcohol Spectrum Disorder (FASD) through specialist training and consultations. In summary, the shared-service, community collaboration model has considerable merit and is a needed addition to the service intervention options offered by the child welfare sector.

Despite the evidence-informed findings regarding the positive impact of this demonstration project on client outcomes, without continued and alternative funding support the CASA intervention was not able to continue. It seems the issue for child welfare may not lie in developing the cross-sector collaborations, but the challenge going forward will be in achieving sustained funding solutions for new approaches and innovative practices that are evidence-informed or have an evidence-base but are not part of core funding. It is an issue the field will need to address as we continue to shift to ensuring our interventions are evidence-informed/evidence-based.

The full CASA FINAL REPORT is available on the Child Welfare Institute portal (scroll down the right-side of the Children's Aid Society of Toronto website www.torontocas.ca; go to "Our Services", then "Research Publications").

***Deborah Goodman**, MSW, PhD., is Director of the Child Welfare Institute (CWI) at CAS Toronto and is Assistant Professor (status-only) at the Factor-Inwentash Faculty of Social Work at University of Toronto. The CWI team is involved in over 30 agency, community or academic studies aimed at advancing evidence-based practices, expanding knowledge and improving services to children, youth, families and communities served by the not-for-profit sector.*

***Carol Baker-Lai** is a graduate of the Master of Public Health program at the University of Toronto. She currently works with community agencies and social service organizations across Ontario on research, data collection, analysis and utilization. Carol has a special interest in health equity and working with organizations to address inequities.*

Carolyn Ussher, MSW, is currently the Manager, Client Services at the Children's Aid Society of Toronto where she has worked since 1994 in various roles at the front line and management levels at both Intake and Family Services. Carolyn was the co-lead on the CASA project and has a child welfare practice interest in improving service provision and coordination for children and families where substance misuse is a concern.

Michelle Coutu has an extensive community development and case management background working with low income families, under-housed and homeless population groups. She has facilitated the development and coordination of several successful community initiatives. For CASA, in 2010-11, she was the Jean Tweed Centre, Substance Use Consultant based out of CAST Toronto's Intake and Family Services Departments. She was also the primary counsellor for the Jean Tweed Centre's "Mom and Kids Too", an alternative treatment program for parenting women who are struggling with substance misuse, have child welfare involvement and have children 6 years and younger. Currently she is an Adult Education Instructor at George Brown College and provides training and clinical consultations on the interconnectedness of substance misuse, mental health and relationship violence against women.

Diane Smylie works with the Provincial Health Services Authority in British Columbia as a member of a provincial team of substance knowledge exchange leaders. She has worked in substance use services for over 20 years as a clinician, manager, evaluator and project manager to support new programs and system change initiatives. Recently much of her work has focused on strengthening trauma-informed practice in programs and services for people with mental health and substance use concerns.

REFERENCES

Barth, R. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. *Future of Children*, *19*(2), 95-118.

Baskin, C., (Mi'kmaq), Strike, C., McPherson, B., (Mohawk), Smylie, D., (Métis), Angeconeb, T., (Anishnawbe), Sauve, A., (Tuhltan and Cree), McKay, D., (Mi'kmaq), Archer, L., Kimewon, W., (Anishnawbe), Ross, L., & Kakekayash, JA. (Anishnawbe) (2012). Developing collaboration between pregnant/parenting Aboriginal women with substance misuse problems, substance misuse treatment counsellors, and child welfare workers. Project Final Report. Retrieved from http://www.ryerson.ca/content/dam/aec/pdfs/Women%20of%20the%20Shining%20Light%20Report.pdf

Berger, L., Slack, K., Waldfogel, J. et al. (2010). Caseworker-perceived caregiver substance abuse and child protective services outcomes. *Child Maltreatment, 15*(3), 199-210.

Brook, J., & McDonald, T. P. (2007). Evaluating the effects of comprehensive substance abuse intervention on successful reunification. *Research on Social Work Practice, 17*, 664–673.

Brook, J., McDonald, T., Yan, Y. (2012). An analysis of the impact of the Strengthening Families Program on family reunification in child welfare. *Children and Youth Services Review, 34*(4), 691-695.

Chuang, E., Wells, R., Bellettiere, J. et al. (2013). Identifying the substance abuse treatment needs of caregivers involved with child welfare. *Journal of Substance Abuse Treatment, 45*(1), 118-125.

Cullen, J. (2006), Addictions and Child Welfare Transformation. Unpublished MCYS research paper.

Dauber, S., Neighbors, C., Dosaro, C. (2012). Impact of Intensive Case Management on Child Welfare System Involvement for Substance-Dependent Parenting Women on Public Assistance. *Child Youth Service Review, 34*(7), 1359-1366.

Drabble, L. & Poole, N. (2011). Collaboration Between Addiction Treatment and Child Welfare Fields: Opportunities in a Canadian Context. *Journal of Social Work Practice in the Addictions, 11*(2), 124-149.

Grella, CE., Needell, B., Shi, Y., & Hser, Y. (2009). Do drug treatment services predict reunification outcomes for mothers and their children in child welfare? *Journal of Substance Abuse Treatment, 36*, 278–293.

Institute of Medicine and National Research Council (2013). *New Directions in Child Abuse and Neglect Research.* Washington, DC: The National Academies Press.

Jansson, L., Svikis, D, Breon, D., & Cieslak, R. (2005) Intensity of case management services: does more equal better for drug-dependent women and their children? *Social Work in Mental Health, 3(*4), 63-78.

Lee, E., Esaki, N., & Green, R. (2009). Collocation: Integrating child welfare and substance abuse services. *Journal of Social Work Practice in the Addictions, 9*, 55–70.

Marsh, JC., Cao, D., Guerrero, E., & Shin, H. C. (2009). Need-service matching in substance abuse treatment: Racial/ethnic differences. *Evaluation and Program Planning, 32*(1), 43–51.

Marsh, J., Smith, B., & Bruni, M.(2011). Integrated substance abuse and child welfare services for women: A progress review. *Child and Youth Services Review, 33*(3), 466-472.

National Center on Child Abuse Prevention Research. (2001). *Current trends in child abuse prevention, reporting, and fatalities: The 1999 fifty state survey.* Chicago: Prevent Child Abuse America.

Osterling, KL., & Austin, MJ. (2008). Substance abuse interventions for parents involved in the child welfare system: Evidence and implications. *Journal of Evidence- Based Social Work, 5*, 157–189.

Ryan, J., Marsh, J., & Testa, M. (2006). Integrating Substance Abuse Treatment and Child Welfare Services: Findings from the Illinois Alcohol and Other Drug Abuse Waiver Demonstration. *Social Work Research, 30*(2), 95-107.

Schroder, J., Lemieux, C., & Pogue, R. (2008). The collision of the Adoption and Safe Families Act and substance abuse: Research-based education and training priorities for child welfare professionals. Journal of Teaching in Social Work, 28, 227–246.

Smith, D., Johnson, A., Pears, K., Fisher, P., & DeGarmo, D. (2007). Child maltreatment and foster care: Unpacking the effects of prenatal and postnatal substance use. *Child Maltreatment* 12(2), 150-160.

Testa, M., Ryan, J., Hernandez, P., & Huang, H. (2009). Illinois Alcohol and Other Drug Abuse IV-E Waiver Demonstration: Interim Evaluation Report. *Child and Family Research Center.* Retrieved from http://cfrc.illinois.edu/pubs/rp_20090901_IllinoisAlcoholAndOtherDrugAbuseIV-EWaiverDemonstrationInterimEvaluationReportSeptember2009.pdf.

Traube, D. (2102). The missing link to child safety, permanency and well-being. Addressing substance misuse in child welfare. *Social Work Research, 36*(2), 83-87.

Walsh, C., MacMillan, H., & Jamieson, E. (2003). The relationship between parental substance abuse and child maltreatment: Findings from the Ontario Health Supplement. *Child Abuse & Neglect, 27*(12), 1409-1425.

U.S. Department of Health and Human Services. (1999). *Blending perspectives and building common ground: A report to Congress on substance abuse and child protection*. Washington, DC: U.S. Government Printing Office.

Wulczyn, F., Ernst, M., & Fisher, P. (2011). *Who Are The Infants In Out-Of-Home Care? An Epidemiological and Developmental Snapshot*. Chicago: Chapin Hall at the University of Chicago.

Ensuring Children's Well-Being: Analyzing Policies and Practices through a Child Rights Lens

by Marv Bernstein, Chief Policy Advisor, *UNICEF Canada*,
and Pat Convery, Executive Director, *Adoption Council of Ontario*

Although North Americans typically greet one another with the phrases "How are you?", "Comment allez vous?", or "Como estás?", Masai warriors say "Kasserian ingera?" (meaning "Are the children well?"). This phrase—which puts children front and center—resonates nicely for our work in child welfare, permanency planning, and adoption, and can help those of us in the child welfare and adoption communities remember the importance of having a child rights focus at all levels of our work. What better way to guide our discussions, our advocacy, and our policy than to ask: "Are the children well?"

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

Almost universally, we believe children have the right to be safe from physical harm, abuse, neglect, and exploitation. We believe children have the right to education, family relationships, and access to their culture. The list goes on. These beliefs in children's rights have been translated into obligations for us to consider in our practice by the United Nations Convention on the Rights of the Child (available at www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx).

The four guiding principles of the Convention on the Rights of the Child are:

- Non-discrimination: All rights set out in the Convention apply to all children, who shall be protected from all forms of discrimination, regardless of race, colour, gender, language, opinion, origin, disability, birth, or any other characteristic.
- Best interests of the child: In all actions concerning children, the best interests of the child shall be a primary consideration.
- Life, survival, and development: Every child has the right to life, and the state has an obligation to ensure the child's survival and development. This includes the right to a standard of living, health, and education that is adequate for the child's physical, mental, spiritual, moral, and social development.
- Respect for the child's views: Children have the right to participate and express their views freely, and have those views taken into account in matters that affect them.

Since its adoption by the United Nations in 1989, this treaty has received near-universal ratification by 193 countries (Canada has ratified the Convention; the U.S. has signed but not ratified it, although it has ratified two Optional Protocols). The treaty has inspired changes in policies to better protect children, altered the way organizations see their work for children, led to a better understanding of children as having their own rights, and served as a catalyst for children's rights advocacy and collaboration.

CHILDREN NEED SPECIAL ATTENTION DURING PROGRAM AND POLICY DESIGN

The Convention on the Rights of the Child reminds us that we must consider the potential impacts on children's rights and interests in all legislation, policies, programs, and practices. Children need this special focus for many reasons:

- Children are particularly vulnerable by virtue of their developmental stage and dependence on adults.
- Children can be disproportionately affected by adverse conditions. For example, the adverse impacts of poverty in a child's early years can be much greater than the effects of poverty in adulthood.

- As non-voting citizens, children do not have the same opportunities as adults to influence or complain about public policy; instead, they must rely on adults to advocate for them.
- Children are a significant segment of the population and are more affected by the action—or inaction—of government than any other group.
- There is no such thing as a child-neutral policy. Almost every area of government policy affects children to some degree.
- Children are also among the heaviest users of public services, such as education, health, child care, and youth services. As a result, children can suffer the most from the fragmentation of public policy and services, or from policies or services that have unintended consequences.

USING A CHILD RIGHTS IMPACT ASSESSMENT TO ENSURE THE BEST OUTCOMES FOR CHILDREN

So how do we bring the "Are the children well?" philosophy to bear on our policy and practice development? The Convention on the Rights of the Child helps us do just that.

To make sure children's best interests are given priority consideration and all the Convention's provisions are respected in policy, the monitoring United Nations Committee on the Rights of the Child has stated that Child Rights Impact Assessments (CRIA) are required of all ratifying nations, and that "this process needs to be built into government at all levels and as early as possible in the development of policy."

But a CRIA is not just something that governments should use. It can be used to good advantage by parliamentarians and legislators, child and youth advocates, schools, universities, hospitals, child welfare organizations, professionals advocating for child-centred policy and legislative change, and the private sector.

In Canada, the U.S., and internationally, the CRIA framework has already found some support. In New Brunswick, for example, a proposed law or policy going to Executive Council must have a completed CRIA. Edmonton, Alberta, and Saskatchewan have also been using aspects of CRIAs. In Tennessee, the Shelby County and Memphis governments use a web-based application to develop, modify, and assess proposals concerning safety, health, education, and land use for their potential impacts on children. England, Scotland, Wales, Western Australia, New Zealand, Belgium (Flanders), and Sweden also regularly use these assessments.

A CRIA involves a structured examination of a proposed law or policy, administrative decision, or action to determine its potential impact on all children or a specific group of children, and a determination of whether it will effectively protect and implement the rights set out for children in the Convention. Potential impacts may be positive or negative, intended or not, direct or indirect, short- or long-term. A CRIA should be undertaken whenever children might be affected by new policies, proposed legislation, regulations, or budgets being adopted, or other administrative decisions at any level of government.

There are three key steps to a CRIA:

- Selection, screening, and scoping—a CRIA should be used on those decisions most likely to have a significant impact on children, including those that directly concern children—such as child welfare or child health policy—and those that may have a more indirect impact, such as immigration or economic policies.
- Assessment—Advocates, policymakers, and administrators can use a variety of tools to assess potential impacts, including administrative data, research, checklists, and detailed modeling. The assessment should explicitly address the Convention's four core principles and the other relevant articles. The analysis can also help identify needed changes to the policy or practice.

- Communication—Publicizing the CRIA's results and recommendations is essential to informing the decision-making process. Communication may be within government agencies or to the broader community depending on where advocacy is most needed.

From time to time, legislation and policy have unintended negative consequences for the children they are meant to benefit. Sometimes ideas that work well for one group may have unintended negative consequences for another group of children. A Child Rights Impact Assessment can help avoid or mitigate such adverse impacts and balance competing rights of different groups of children.

HOW AN ASSESSMENT CAN MAKE A DIFFERENCE

Ensuring that all policies, practices, and actions have been thoroughly examined through a lens of how they affect children can help in a number of ways. Such assessments:

- Balance the interests and rights of various groups of children by analyzing the different and potentially inequitable impacts, particularly for children who are often marginalized and most vulnerable, rather than treating children as one homogenous group.
- Improve coordination across government by examining potential impacts on the whole child across the full scope of their rights, which can lead to departments jointly engaging in a stronger integrated policy development model.
- Provide an opportunity for the child's best interests to be explicitly considered in the decision-making process, improving the likelihood of positive outcomes.
- Improve the quality and quantity of information available to decision-makers.
- Recognize the need to consult with children as legitimate stakeholders in relevant policymaking areas, giving their views due consideration in the process.
- Consider second and third order effects on children—not just the immediate effects, but also those that can affect them in the long term, including future generations.
- Avoid or mitigate costly errors by addressing potential negative impacts at an early stage of the policymaking process.
- Improve public support for policy decisions by creating more transparent, collaborative, and defensible policy processes, and by bringing together external stakeholders, including children and those involved in policy development for focused discussion concerning potential impacts on children.

Consider these examples of how a CRIA can avoid unintended consequences and achieve better outcomes for children:

- An agency makes a policy to never separate siblings in adoption. A sibling group of five waits for many years to be adopted because the oldest child is severely autistic and needs extensive support that many families cannot provide. If stakeholders had conducted a CRIA, they might have built in some limited, specific exceptions for adoption to proceed where it is in the best interests of the other siblings with provision for post-adoption sibling contact and expanded funding and counseling support services.
- A policy provides health coverage and educational support to youth who age out of care. A 17-year-old youth who has been in foster care for most of his life must now choose between being adopted by a relative or remaining in foster care to access the benefits. A CRIA would likely have uncovered this potential conflict, and perhaps led to extended benefits being made available to older adopted children.

The child rights framework can also help advocates frame their arguments. In Canada recently, adoptive parents and adoption organizations advocated for an increase in

employment insurance maternity benefits for adoptive parents (Biological mothers currently receive 15 weeks of maternity benefits plus 35 weeks of parental leave; adoptive parents receive only the 35-week parental leave).

Ultimately, the parliamentary committee refused the increased benefits, basing its decision not on adopted children's needs, but on a belief that biological mothers have rights that adoptive parents do not. It is possible this result may have been due, in part, to adult-focused, rather than child-centred advocacy. Instead of talking about the impact of the law on adopted children and discriminatory impacts upon those adopted children, many advocates talked about maternity benefits as a competition between biological and adoptive parents. A CRIA would have likely identified bonding as a critical element that must occur in the early stages of a parent-child relationship. In a birth family, bonding starts before the child is born. When an adopted child has experienced loss, neglect, abuse, or difficult transitions, the ability to form healthy relationships and feel secure is damaged. Adoptive families therefore need at least as much time to help adopted children adjust, recover, and bond—a consideration that wasn't properly raised by advocates or addressed by the committee.

CHILD RIGHTS-PROOFING LEGISLATION, POLICY, AND PRACTICE

Even when a Child Rights Impact Assessment is not required, advocates, policymakers, administrators, and others can use it as a tool to help ensure proposed changes result in the best possible outcomes for children. We have a collective responsibility to give the protection of children's rights the highest priority. Dialogues on the implementation of children's rights should not be the limited purview of elected officials, but should be taking place in our homes, schools, workplaces, and government offices.

Using Child Rights Impact Assessments with greater frequency will enable us to ensure laws, policies, and practices have been child rights-proofed—that we have considered carefully how they will affect children. This, in turn, will lead to more positive and affirmative responses when we pose the question "Are the children well?"

Learn more about Child Rights Impact Assessments at www.unicef.ca/en/policy-advocacy-for-children/what-is-a-child-rights-impact-assessment.

***Marv Bernstein**, B.A., J.D., LL.M. currently holds the position of Chief Policy Advisor at UNICEF Canada since returning to Toronto in 2010. From 2005 to 2010, he served as the Children's Advocate for Saskatchewan, an independent officer of the Saskatchewan Legislative Assembly. Prior to moving to Saskatchewan, Marv spent 20 years as Chief Counsel to the Catholic Children's Aid Society of Toronto and then five years as Director of Policy Development and Legal Support at the OACAS. He is currently a member of the Board of Directors of the Children's Aid Society of Toronto and the Children in Limbo Task Force and is Vice-Chair of the National Children's Law Committee of the Canadian Bar Association.*

***Pat Convery** is the executive director of the Adoption Council of Ontario. She has worked in child welfare since 1975 and in adoption since 1982.*

This article was originally published in the Spring 2013 issue of Adoptalk.

Lev Tahor — Multicultural, Legislative and Systems Challenges

by Stephen Doig (BA, MA), *Executive Director of Chatham-Kent Children's Services (CKCS),* and Bonnie Wightman (BSW, MSW), *Senior Director of Service at CKCS*

BACKGROUND

The religious community known as Lev Tahor (Pure Heart) was founded in the 1990s by Rabbi Shlomo Helbrans, an Israeli citizen. Although originally established in Israel, Rabbi Helbrans moved his community to the United States after ongoing conflict with the Israeli government. While in the United States, Rabbi Helbrans was convicted of kidnapping in 1994, and served a two year prison term before being deported to Israel in 2000. Shortly after his deportation, he was granted entry into Canada, and in 2003 was granted refugee status due to allegations of religious and political persecution if returned to Israel.

Lev Tahor followers are ultra-orthodox Hassidic Jews, who believe in the strict adherence to the Torah, reject "modern" lifestyles, follow a strict kosher diet, and predominantly speak Yiddish. Males are always in positions of authority, the women dress in traditional black clothing similar to the Muslim abaya and hijab, the young females are educated in household and childcare skills, and the boys are educated in the teachings of the Torah. The children do not attend mainstream school. The families tend to have multiple children. Although the family homes are undecorated, they do utilize some modern conveniences and some of the members of the sect are very computer and social media literate.

In 2003, the Lev Tahor community settled and expanded in Sainte-Agathe-des-Monts, Quebec, until their relocation to Chatham-Kent in late 2013.

In the period 2007 to 2013, the Director of Youth Protection (DYP) agency in Quebec became increasingly concerned about the safety and well-being of many of the Lev Tahor children. Their initial involvement began with the hospitalization of one of the women for mental health concerns, as she was allegedly being forced into marriage. This woman refused to return to the Lev Tahor group and Quebec DYP arranged for her to reside with relatives in the United States. The Quebec DYP involvement escalated briefly in 2011 when the Ministry of Education raised concerns about the apparent lack of proper education for the children. By the summer of 2013, the DYP began investigating allegations of under age marriages, child neglect, inappropriate use of non-prescribed drugs to control behaviours, social isolation, limited education for the children, and removal of children from their parental home for non-compliance with community norms. In mid-November of 2013, DYP initiated provisional court applications for three families involving 14 children—similar to a CFSA Supervision Order.

On November 18, 2013, approximately 200 adults and children left Quebec on several buses in the middle of the night and arrived in Chatham-Kent the following day. As a result of this flight, and the fact that Lev Tahor refused to produce the 14 children, on November 27, 2013 following an interim hearing, the Quebec court ordered the 14 children into foster care in order to facilitate an assessment process. In addition, the Quebec DYP obtained approximately ninety (90) "authorizations to locate and deliver" with respect to the Lev Tahor children in the community. These orders authorized any police officer to locate and deliver the children named in the orders into the care of the Director of Child Protection for the Laurentian Youth Centre.

CHATHAM-KENT MUNICIPALITY

The Municipality of Chatham-Kent is one of the larger geo-political areas in Southwestern Ontario. It is predominantly a rural community

with a total population of about 105,000 who rely on an economic base of agriculture and related automotive industries. The municipality has a small First Nation community in Moraviantown that accounts for roughly 3% of the population. The ethnic background of most of the population is Anglo-Saxon with a few small Francophone communities.

The city of Chatham, with a population of 44,000, is the largest urban centre in Chatham-Kent, and overnight its population increased by approximately 200 ultra-orthodox Hassidic Jews. The Lev Tahor community reportedly considered resettling in Peterborough and Prince Edward County, and did not reveal why they opted for Chatham-Kent.

An additional challenge for Chatham Kent Children's Services (CKCS) was that they were in the midst of a detailed and prolonged Ministry of Children and Youth Services (MCYS) review of their services and finances; as well as having an Interim Executive Director in place while they pursued a replacement for the recently retired E.D.

In order to ensure a consistent and effective response to the possibility of multiple child protection investigations concerning this sect, CKCS dedicated a team of experienced child protection workers to all interactions with the Lev Tahor community. Our senior service staff also met with the community leaders on numerous occasions in the spirit of cooperation and open communication. Due to the large number of children involved, CKCS convened an immediate community planning and collateral partnership meeting to update those social service agencies most likely to be contacted by Lev Tahor members (Public Health, Ontario Works, Chatham Kent Women's Centre, etc.).

Although the leaders were initially receptive, it became obvious that they were not cooperative, and quickly opted to utilize social media and their dedicated website in an attempt to sway public opinion and discredit CKCS.

LESSONS LEARNED RE: INTERNAL SERVICE MODEL

- Due to the influx of a large number of families and children (approximately 47 parents and 150 children) CKCS created a dedicated, integrated service team partly to develop internal expertise as well as an effective means of identifying families and their children. The Lev Tahor group reportedly moved children to other families for extended and prolonged periods of time against the wishes of the parents or children, as a means of discipline for non-compliance with the group norms.
- Due to the sheer number of families, the ever changing circumstances with Lev Tahor leaders and community members, and reports from Quebec and Israel, the importance of daily, regular communication amongst the specialized service team was critical.
- Combined with the need for effective communication was the recognition of the stress level on all aspects of the organization and the acknowledgement of the importance of staff wellness.
- Expertise and experience with media and Public Relations became an immediate need for CKCS due to comments made by DYP to the media, Lev Tahor's astute use of social and regular media to plead their situation, and the fact that Justices Fuerth and Templeton granted media access to the Children's Law Reform Act (CLRA) and CFSA proceedings. This latter decision was beneficial in allowing CKCS to fully and openly respond to reports, inaccuracies and general inquiries from all media sources.

CHILD WELFARE LEGISLATION LEGISLATIVE CHALLENGES

On November 19, 2013, Chatham Kent Children's Services (CKCS) received a request from Quebec DYP asking to enforce the court orders relating to the children in the original three Lev Tahor families. Two of those

families had secured temporary residence in Windsor and initially presented themselves to Windsor Essex Children's Aid Society seeking an assessment of any child welfare concerns. The third family and a remaining 134 children in 27 families (54 parents) and 11 persons over the age of 16 stated an intention to settle in Chatham. Quebec DYP as well as the Sûreté du Québec provided numerous documents to support their request for CKCS assistance in returning the 14 children to Quebec for a full court hearing. Some supporting documentation arrived sporadically over the following several weeks, however it lacked sufficient details on each of the families. Lastly, although the courts ordered that the information be translated prior to being sent to Chatham-Kent, much of it was in French, needing translation locally.

On December 4, 2013, CKCS presented a request in the Ontario courts to a Justice of the Peace for warrants of apprehension of the 14 children based on the Quebec request and accompanying documents. That request was denied. Subsequently, on December 11, 2013, CKCS brought an application under the Children's Law Reform Act before Justice Stephen Feurth requesting the 14 children who were wrongly removed be returned to Quebec. The court granted this application, ordering that the children remain in Chatham-Kent, but stayed its ruling to allow Lev Tahor an opportunity to appeal.

On March 5, 2014, the day the appeal was heard, Justice Templeton noted that the families had not attended court and had removed the children from CKCS jurisdiction, and subsequently ordered the children into care the moment they arrived back in Ontario. During the appeal period, the three families with 14 children fled Canada, bound for Guatemala; however, two families with 6 of these children were detained in Trinidad and Tobago and returned to Canada whereupon CKCS apprehended those children. Two other children were located in Calgary and also returned to Ontario, and taken into care. The other family and 6 children successfully entered Guatemala, where they remain to this day. The apprehensions of these 8 children involved coordinated efforts between five Children's Aid Societies (CKCS, Jewish Family and Child, Peel, Toronto, and Calgary) as well as Peel Regional Police, Toronto Police Services, Calgary Police, Canadian Border Services, Canadian Foreign Affairs, and WestJet.

On April 14, 2014, Justice Templeton granted the appeal, noting that the jurisdiction "with respect to child protection or child welfare ends at the borders of the province of that court" and that a child protection agency could not be recognized as a "person" under the CLRA, thereby overturning Justice Feurth's order. This order effectively meant that CKCS needed to conduct an independent investigation and assessment of child safety with respect to any and all children of Lev Tahor, and respond according to the Child and Family Services Act.

LESSONS LEARNED RE: LEGISLATION

- The lack of coordinated and mutually inclusive interprovincial child welfare legislation – CKCS was unable to utilize the CFSA to enforce child protection orders from Quebec and its application under the CLRA was overturned on appeal as this legislation contemplates applications by persons, not institutions/ agencies.
- Inconsistent provincial legislative definitions of child – Quebec legislation defines a child to age 18 resulting in some older children who were in fact over 16 being ordered into care under the CFSA
- Limitations of the Ontario Education Act with respect to home schooling and curriculum content – the Ontario Education Act states that unless a child has been registered with the local School Board, there is no provision for enforcement of school attendance or curriculum. The very nature of the Lev Tahor community dictated that their children were not registered.
- A balance of the rights of children to their religious and cultural beliefs and the "need

for protection" within a closed religious community relative to child development, socialization and educational needs.

- Absence of any effective mechanism through the Hague Convention between Canada and Guatemala – Guatemala is a signatory to the 1996 Convention, however Canada is not, and there was considerable pressure from the Quebec and Israeli government agencies for CKCS to facilitate the return of the 6 children subject to the Quebec court "apprehension" order.

RELIGIOUS, CULTURAL AND PLACEMENT CHALLENGES

Chatham-Kent Children's Services had no alternate placement options for the eight (8) Lev Tahor children that would effectively meet their cultural, religious and ethnic needs. Although a Jewish agency in Montreal offered readily available foster homes, there was general consensus that the children should remain in Ontario, closer to their community. Jewish Family and Child Services (JF&C) had provided some religious and cultural education and support to the CKCS staff during the investigation and assessment of the Lev Tahor families, and offered to assist with exploring placement options for these 8 children.

Due to Lev Tahor leaders breaching the CFSA by publishing the names and addresses of the placements, JF&C required extensive security measures to ensure placement stability and security. The children appeared to have been counseled on non-compliance with any non-Lev Tahor individuals. They did briefly refuse any food (hunger strikes) which created additional challenges to inexperienced alternate caregivers, however these refusals were short lived. We also enlisted assistance from the Toronto professional and religious community including the SCAN team at Sick Children's, Hatzoloh, and Children's Aid Society of Toronto in ensuring these placements were successful.

Throughout the months of May and June 2014, CKCS received numerous allegations about the health and safety of the Lev Tahor children in Guatemala, who were technically subject to Justice Templeton's order to be brought into care upon their return to Canada. Initial inquiries regarding interventions through the Child Abduction Convention of The Hague Convention revealed that this convention does not apply between Canada and Guatemala, and therefore could not be used for the return of the children. CKCS and JF&C made a joint submission to Canadian Foreign Affairs requesting their assistance, which resulted in some intervention by way of an assessment in Guatemala, but no definitive findings or concerns were forthcoming. International Social Services were also contacted, and had no additional suggestions on returning the children to Canada. By mid-June 2014, all of the Lev Tahor community, with the exception of six (6) families, all of whom are subject to a CFSA order, had left Chatham-Kent and apparently settled in Guatemala.

LESSONS LEARNED RE: CULTURAL AND RELIGIOUS AWARENESS

- The Chatham-Kent community has a very tiny Jewish community and a lack of adequate local resources in terms of understanding the religious and cultural beliefs and practices.
- Jewish Family and Child Services immediately offered to both educate our staff in Jewish religion/culture and provided "on the ground" staff to assist with our investigations.
- Lev Tahor reported that their primary language of communication was Yiddish – a language for which there are limited translation services available, partly due to varying dialects. CKCS learned through experience that English was widely understood by the leaders and most of the older children, however there were continuing attempts to hide that fact.
- The intervention and assessment with a "closed community" challenged the agency in the application of s.37 of the CFSA, with respect to honoring community mores of education, child rearing, and rights to individual and religious freedoms.

LOCAL, PROVINCIAL, NATIONAL AND INTERNATIONAL COLLABORATION

At the onset of the investigations, CKCS was liaising with the Quebec DYP, the Sûreté du Québec, Windsor Essex Children's Aid Society, the Chatham Kent Police Services, and our Ministry of Children and Youth Services (MCYS), as well as staff from JF&C to ensure what was believed to be a simple and smooth enforcement of Quebec child protection orders. We also met with all Chatham-Kent social and health service agencies to coordinate and facilitate any services that the families and children may need. When the children were brought into care, we met with JF&C, Toronto CAS, OACAS, and MCYS to develop an effective plan of care.

As the situation became more complicated, CKCS organized conference calls with Quebec DYP, Sûreté du Québec, Canadian Border Service Agency, MCYS, the Foreign Affairs of Canada, Israel, the United States, Guatemala, the OACAS, and MCYS in an attempt to determine what actions, if any, could be taken regarding the children in Guatemala.

LESSONS LEARNED RE: PROVINCIAL, NATIONAL, AND INTERNATIONAL IMPACT

- Consistent with the difference in child welfare legislation, the quality and quantity of information contained in the Quebec documents reflected significant deviations from Ontario's standards. Additionally, although CKCS is a designated French Language Services (FLS) agency, the fact that all the documents from Quebec were sent in French created translation challenges and ensuing time delays.

- The effectiveness of outreach using the Ontario child welfare system and provincial ED/DoS networks was invaluable in obtaining immediate and unrestricted assistance from colleagues – we received cooperative services from: Windsor Essex Children's Aid Society (WECAS) in some early contact by Lev Tahor members; JF&C in particular for cultural and religious knowledge, expertise, staffing assistance and placement resources; translation and legal assistance from the Children's Aid Societies in London-Middlesex and Ottawa; as well as support from staff at the Children's Aid Society of Toronto (CAST), Niagara F&CS, and Peel CAS expertise in relation to immigration and international child welfare.
- Equally valuable was the OACAS as our provincial umbrella organization who offered their staff expertise in public relations, communication, and government relations, as well as practical expertise regarding Guatemala.
- The Ministry of Children and Youth Services expressed both financial and practical support wherever possible. There was a clear recognition of the uniqueness of challenges with the Lev Tahor community as an exceptional financial circumstance for CKCS. Ministry staff from several corporate levels also provided liaison assistance with Quebec provincial authorities, as well as with Canadian Foreign Affairs.
- CKCS assigned a single media contact person to respond to the constant demands for information and details from MCYS, media, OACAS, and other social service agencies
- The fact that both Justices allowed publication of the CLRA and CFSA court proceedings and subsequent decisions facilitated CKCS in providing accurate information to the media, as well as responding and correcting inaccurate statements made by Lev Tahor's use of social and regular media.
- CKCS learned very early the need for coordination and verification of information from varying sources – Israel, Quebec, Canadian Border Services, the local community, Ontario Jewish community, former Lev Tahor members,

family members of Lev Tahor members, Lev Tahor's ongoing use of social and regular media outlets, Foreign Affairs, and U.S. Consulate and Guatemalan officials. Often competing and conflicting intentions of existing legislation/agency mandates from the CLRA, Canadian Immigration laws, CFSA and Quebec provincial legislation, and Canadian Charter of Rights and Freedoms did not always support outcomes based on the best interests of the children.

- The limitations on the extent of local CAS authority relative to interprovincial and international child protection matters was both frustrating and a relief. When the families fled to Guatemala, one group was detained in Trinidad and Tobago largely due to the fact that two of the children were not members of that family. That family, including 6 children, was returned to Canada and the children placed in the care of CKCS. The second family successfully arrived in Guatemala, and that government continues to be reluctant to intervene. Two other children (including a minor parent) were located in Calgary and returned to Ontario. Unfortunately, due to the Trinidadian experience, the general public and some members of the Jewish community, expected CKCS to have the authority to facilitate the children's return from outside of Canada.

CURRENT SITUATION IN CHATHAM-KENT

By the beginning of July, the majority of Lev Tahor members had begun to slowly leave our community in small groups. During this time, two Ontario agencies, Niagara and Ottawa, did have brief contact with some Lev Tahor members but not with sufficient reasons for intrusive intervention, and those families were only in their communities for very short time periods.

Up until the end of August, a small number of Lev Tahor families subject to CFSA orders remained in Chatham and were relatively cooperative with CKCS, and appeared to be doing well. However in late August, all of these remaining families left Chatham-Kent with no advance notice and in violation of the court orders. The circumstances of this departure were virtually identical to the Sainte Agathe situation, where they left personal belongs and furniture behind, having left sometime during the night.

As a result, CKCS issued a Canada-wide child welfare alert with respect to concerns for the well-being of the children, however Chatham-Kent has not received any notifications regarding the whereabouts of those families and children.

In mid-September 2014, the two adolescent girls who were placed in alternate caregiver homes in the Toronto area fled their placements in spite of legislated restrictions. The two are American citizens and were successful in crossing into New York State where they contacted legal counsel. The American child welfare authorities intervened and convened a court hearing. CKCS staff attended this hearing and provided the courts with relevant information. The decision of the American courts supported a plan for the girls to return to the care of a family member residing in the United States. CKCS has initiated court applications to withdraw or terminate any CFSA orders that may have been in place on the grounds that the families are no longer in our jurisdiction.

At this time there are no members of Lev Tahor residing in Chatham-Kent.

Stephen Doig *(BA, MA) is the Executive Director of Chatham-Kent Children's Services (CKCS), an integrated children's mental health and child protection agency serving the Municipality of Chatham Kent.*

Bonnie Wightman *(BSW, MSW) is the Senior Director of Service at CKCS. Bonnie had oversight in coordinating the services provided to the Lev Tahor community while they were in Chatham-Kent.*

Understanding the Symptomatology of ADHD in Pediatric Populations from a Biopsychosocial Perspective: Translating Research into Clinical Practice — Part One

by Sebastiano Fazzari, Ph.D., Sean Robb, M.A. Candidate, and Peter Bonsu, M.D.

This article is part of a three-part series that will provide an up-to-date review of literature from cognitive neuroscience, psychology, and psychiatry on the symptomatology, assessment, and treatment of Attention-Deficit Hyperactivity Disorder (ADHD) from a biopsychosocial perspective. This first article provides insight into how children appear in clinical practice with ADHD symptomatology, and how these symptoms can be characterized and explained.

In pediatric populations, ADHD is often characterized by a plethora of symptoms that gravely impact a child's educational welfare (Remschmidt, 2005), capacity to integrate socially with peers (Alessandri, 1992; Melnick & Hinshaw, 1996; Nixon, 2001), and family relations (Anderson, Hindshaw, & Simmel, 1994; Mash & Wolfe, 2010). These systems are routinely categorized into three factors, including inattention (i.e., inattention to schoolwork, impairment in tasks requiring sustained attention, organizational difficulties, etc.), hyperactivity (i.e., squirming or fidgeting, excessive talking, psychomotor agitation, etc.), and impulsivity (i.e., risk taking, interrupts others while speaking, blurts out answers to questions prior to their completion, etc.; American Psychiatric Association, 2000; 2013; Firestone & Dozois, 2007). Epidemiological research suggests that the worldwide prevalence of ADHD is approximately 5.29% (Polanczyk, de Lima, Horta, Biederman, & Rohde, 2007) and Canadian studies indicate this could be as high as 6.1% in Canadian populations aged 4 to 16 years (Charach, Lin, & To, 2010; Froehlich et al., 2007). In addition to the considerable prevalence, ADHD has a substantial economic cost of between 31.6 billion and 52.4 billion dollars annually in the United States, with adjusted costs for Canada likely exceeding 4 billion dollars annually (Pelham, Foster, & Robb, 2007).

These staggering statistics provide immense incentive for the development of a more comprehensive understanding of the symptomatology of ADHD as well as a greater appreciation for the underlying biological (i.e., neurobiological, neurophysiological, and genetic contributions, etc.), psychological (i.e., intellectual and cognitive function, temperament and personality, socio-emotional interactions, etc.), and societal factors (i.e., environments that promote immediate gratification, ever-changing expectations both academically and vocationally, etc.) that interact and feedback on one another to contribute to the behavioural indices of ADHD. This article serves as a means to translate knowledge derived from multiple research disciplines into usable clinical knowledge that can be readily applied to one's practice. Lastly, it serves to provide clinicians with the capacity to interpret and explain behaviour of children with ADHD, as well as the language that will aid in informing parents and teachers who may, understandably, be inclined to misinterpret the cause of this behaviour (i.e., characterological in nature or reflect non-compliance/being uncooperative).

THE *DSM-5* DEFINITION OF ADHD

The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; *DSM-5*; American Psychiatric Association, 2013) defines ADHD as "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development as characterized by either inattention type or hyperactivity/impulsivity symptomatology."

The first type differentiated by *DSM-5* is inattention, which is characterized by the following criteria lasting for at least six months (American Psychiatric Association, 2013):

a. Difficulty paying close attention or making careless mistakes
b. Difficulty sustaining attention in tasks
c. Difficulty listening when directly spoken to

d. Difficulty initiating or following through on instructions
e. Difficulty in organization of tasks or activities
f. Avoiding, disliking, or reluctance to participate in mentally taxing tasks
g. Losing information or items required to complete a task
h. Easily distracted by extraneous stimuli
i. Forgetful of daily tasks

The second type is termed hyperactivity and impulsivity and it is characterized by the following criteria lasting for at least six months (American Psychiatric Association, 2013):

a. Fidgets or taps hands and/or feet or squirms
b. Leaves seat in situations when remaining in seat is expected
c. Runs about or climbs in situations where it is inappropriate
d. Unable to play or engage in leisure activities quietly
e. Displays excessive psychomotor agitation
f. Often talks excessively
g. Is disinhibited; for example, blurts out answers before the question is completed or acts without thinking
h. Has difficulty waiting his/her turn
i. Often interrupts or intrudes on others

In addition to the above criteria, the inattentive or hyperactive-impulsive symptoms

(i) need to be present prior to the age of twelve,
(ii) need to be present in two or more settings,
(iii) need to have interfered with or reduced the quality of social, academic, or occupational functioning, and
(iv) must not occur during the course of schizophrenia or another psychotic disorder or
(v) cannot be better explained by another mental disorder. This last criterion is very important because the clinician has to first look for other disorders that would explain the above symptoms before the diagnosis of ADHD is given (American Psychiatric Association, 2013).

The clinician has the responsibility to differentiate between the combined presentation, predominantly inattentive presentation, or predominantly hyperactivity/impulsivity presentation. In addition, it is important for the clinician to specify whether the symptoms are mild, moderate, or severe.

Although Part Two of this article speaks of a more in-depth analysis of differential and comorbid diagnoses of ADHD, suffice it to say anxiety disorders tend to mimic ADHD symptoms (CADDRA, 2006). However, the duration of the symptoms is dissimilar to that of actual ADHD, with the ADHD symptoms lasting longer and being particularly prominent in early childhood. Most importantly, the ADHD symptoms must also occur in the absence of reported anxiety (American Psychiatric Association, 2013). Individuals who have suffered physical or emotional maltreatment often present with externalizing behaviours that could reflect difficulties in self-regulation/executive function (Lezak et al., 2012). However, children with ADHD tend to manifest their symptoms in a much wider context unless, of course, they are highly interested in the activity. Maltreated children, on the other hand, tend to behave appropriately in settings in which they feel safe and secure provided that they don't have other comorbid diagnoses.

In the article by Klein, Damiani-Taraba, Koster, Cambpell, and Scholz (2014), it is advocated that a multidisciplinary team ought to be involved in the diagnosis of ADHD. This is an idea whose time has arrived. However, this idea is functional in a more idealistic setting, such as The Hospital for Sick Kids in Toronto or McMaster Medical Centre in Hamilton, Ontario, as examples. Realistically though, it is almost impossible to convene a pediatric-adolescent psychiatrist, a pediatrician, a child and adolescent psychologist, a general practitioner, teachers, school administrators, parents, and a variety of other professionals (i.e., social workers, counselors, and child and youth workers), particularly in a rural primary care setting. From a realistic perspective, the multidisciplinary team most often consists of a general practitioner, pediatrician if luck does its part, teachers, parents, and children pending

on their age. It would be wise for the assessor to use assessment instruments that gather data on evidence-based manifestations of ADHD symptoms in multiple settings and then be able to compare it to age–appropriate childhood behaviour. Children who have been traumatized (i.e., physical or sexual abuse, witnessed violence, experienced major losses, etc.), can be evaluated with well-established standardized instruments. When trauma plays a significant role in the presenting symptomatology it should be diagnosed and treated prior to the ADHD. The expert ADHD diagnostician would be wise to look for other aetiologies that account for the ADHD symptoms before providing the ADHD diagnosis (American Psychiatric Association, 2013).

ESSENTIAL FEATURES

There are certain core symptoms that are noticeable in individuals with ADHD:

- Short attention span for routine tasks
- Distractibility
- Organizational problems (of both space and time)
- Difficulty with task initiation and following through
- Poor internal supervision

The persistent pattern of inattention and/or hyperactivity/impulsivity is more frequently displayed and is more severe than what is typically observed in individuals at comparable level of development. The above symptoms are present over a prolonged period of time from an early age even though they are not evident until the child is required to concentrate or to organize his/her life. It is important to note that this population is not homogeneous, and considerable individual differences do exist. No two individuals with ADHD will be exactly alike.

SUSTAINING ATTENTION

Those with ADHD have serious difficulty maintaining attention and effort over prolonged periods of time. They usually report that their minds "wander" and more frequently than not they become distracted and think about or do other tasks other than the one that they are supposed to do. Specifically, they seem to have difficulty paying attention to routine, regular, everyday tasks such as homework, schoolwork, chores, or paperwork. These tasks seem to overwhelm individuals with ADHD. What is termed "mundane" presents a serious difficulty for individuals with ADHD. Much of the literature suggests that this is because tasks that are mundane and lack innate interest require the brain, specifically the prefrontal cortex (PFC; located within the frontal lobe) to work very hard to maintain and sustain attention on the task (Lezak, Howieson, Bigler, & Tranel, 2012). This is something that is particularly difficult for those with ADHD, and when they attempt to focus on these tasks, they are draining cognitive resources at a much faster rate relative to their non-ADHD counterparts. This is one major reason that students , on average, report considerably more fatigue after school. On the other hand, individuals with ADHD do not have a short attention span for everything. Individuals with ADHD are able to pay attention during the following:

- Novel situations or situations that are new to them
- Stimulating situations
- Interesting situations
- Frightening situations

Activities that possess the aforementioned qualities tend to provide enough intrinsic stimulation to activate the brain functions that assist individuals with ADHD to focus and concentrate. Over the last thirty years of clinical practice, the undersigned found that individuals with ADHD often report that they can pay attention "if they are interested." It seems that those with ADHD are able to focus on tasks that do not require the brain to allocate, or otherwise direct, attentional resources to maintain focus. Activities such as video games and electronic devices are particularly attractive and innately interesting to most children and adolescents, and as a result, the brain does not have to "work" very hard to keep them focused on these tasks (Halperin & Schulz, 2006). Interestingly, it is often reported collaterally by parents, teachers, and friends of those with ADHD that they get overly focused, typically referred to as hyperfocusing, on a task that is interesting or innately cognitively stimulating to them (i.e., video games, TV,

movies, etc.). Understandably, this is often cited as "evidence" that these individuals can pay attention (i.e., "look he/she can spend 10 hours playing video games with no breaks—why can't he/she pay attention for 30 minutes on his/her homework?") and that perhaps they are just not motivated enough or are "lazy." This situation frequently results in many disagreements between individuals with ADHD and those living and caring for them, often undermining the self-esteem and self-worth of the individuals with ADHD (Willcutt et al., 2005). It is important to note that the same part of the brain implicated in keeping one's attention on a mundane task, is also implicated in "pulling" attention off tasks that are very interesting when required. Within the neuropsychological literature, this is typically referred to as set-shifting—the act of moving one's attention from one task to another (Lezak et al., 2012). With significant injury to the frontal lobe, this skill is routinely impaired and individuals often perseverate or "get stuck" on a task or a cognitive concept (i.e., immense interest on an animal or popular sports figure), requiring extensive cuing to change focus. Individuals with ADHD are experiencing this phenomena as well, but to a lesser degree.

In addition to tasks that are innately interesting, individuals with ADHD are more able to direct and sustain their attention when they are excited. Being excited helps by activating or stimulating the frontal part of the brain that seems to be underactive in ADHD. Frequently, individuals with ADHD will often recognize this association, and attempt to activate themselves by engaging in exciting and sometimes in risky behaviour (Willcut et al., 2005). Knowing that this is an effective strategy used by children with ADHD, it can also be easily and effectively used by parents and teachers alike. Having a child participate in physical activity or engaging in exciting tasks prior to doing an activity that is innately less interesting, can greatly aid someone with ADHD in directing and sustaining their attention for a limited time.

It is imperative that the diagnostician asks about attention span for regular routine tasks. Often the child with ADHD may not even know that he/she has difficulty paying attention because it presents no difficulty in tasks that are of interest or that are stimulating. To obtain the proper information it is better that the clinician asks the parents and the teachers. It is also crucial that parents and teachers understand why their child might be behaving in this fashion, as a means to reduce the misinterpretation or incorrect categorization of behaviour.

DISTRACTIBILITY

ADHD experts differentiate the term distractibility from the term short attention span. Distractibility does not mean an inability to sustain attention, rather, it refers to being overly sensitive to the environment and having difficulty filtering out and suppressing non-important sensory information to continue to focus on the task at hand (Amen, 2001). Individuals with ADHD are overly sensitive to stimuli coming through their senses and have difficulty ignoring the sights and sounds of the environment.
Similar to sustaining attention, distractibility has been linked to PFC underactivity (Halperin & Schulz, 2006). When this part of the brain is under active, it fails to send inhibitory signals to the parietal lobes, the part of the brain implicated in processing somatosensation or sensory information about the environment (i.e., touch, pain, temperature, etc.). These signals serve to regulate parietal processing, and modulate the degree that information from the environment breaks through into conscious awareness. (Lezak et al., 2012). In other words, when the PFC is underactive, the parietal lobes flood us with environmental stimuli. In addition, the PFC is responsible for sending inhibitory signals to the emotional centres of the brain located within the limbic system (Lezak et al., 2012). If the PFC is underactive, it fails to send inhibitory signals to the limbic system; therefore, the individual becomes distracted by his/her own internal emotional thoughts and feelings. Being flooded with environmental stimuli is difficult enough; when you also add being distracted by one's own internal thoughts and feelings it becomes nearly impossible to stay focused on the task at hand, particularly if the task is uninteresting to the individual with ADHD.

Reading a book becomes an enormous task for children with ADHD because it requires them to block out extraneous external stimuli; however, they become distracted by the movements around them. If someone is chewing gum in the room, the child with ADHD becomes excessively bothered by the sounds of the chewing around him/her or by other sounds that other individuals around them make. Providing environments

with structure and supervision that minimize, or otherwise reduce, busy environmental stimulation will greatly aid children with ADHD in reducing their distractibility (Lezak et al., 2012).

ORGANIZATIONAL PROBLEMS

Organizational difficulties are also a common occurrence among individuals with ADHD. Spatial disorganization is probably one of the traits seen early in the lives of children with ADHD (Willcutt et al., 2005). If you look in these children's rooms, closets, desks, drawers, and backpacks you will notice that they are messy. Work is half-completed; some of it is put away while some of it is dropped wherever. Some children with ADHD may appear organized on the outside by appearing well dressed and by having part of their living space neatly organized. However, when you look into their desks, drawers, and closets you will see a different picture. Individuals with ADHD also have difficulty with organization of time as well as in their thinking (Lezak et al., 2012). They tend to be late, are unable to tell you how long it will take them to complete a task, and will agree to do too many things because they do not know the time commitment required for each task. Individuals with ADHD will get fired for being late for work too often. These individuals more often than not lack long-term goals while at the same time go from one crisis to another or from one problem to another. Lastly, they struggle to organize their thoughts in a fashion that will meet the demands of their goal (Willcutt et al., 2005).

These organizational challenges that are frequently associated with ADHD occur as a function of challenges with executive function. Executive function encapsulates the capacity to plan and organize (among other neurocognitive functions) one's behaviour in an adaptive fashion that is responsive to environmental feedback. These functions are governed by the PFC, and much of the literature suggests that planning/organization is associated with the dorsolateral (top outer) portion of this brain structure (Lezak et al., 2012). It is important to note that this structure is not solely responsible for these functions, but these functions are the product of the PFC's connections with many other regions of the brain. This structure serves a supervisory role, regulating the different brain regions in a fashion to meet the demands of the environment in an organized and systematic fashion.

Functional or structural alteration to the PFC has been shown to be the biggest contributor to impairment in functioning and loss of independence, regardless of how well the rest of the brain is functioning (Lezak et al., 2012). One analogy to characterize these types of executive function challenges is to imagine a car without a driver—it does not matter how strong or fast the engine is if there is no one to regulate and control the vehicle. Accordingly, individuals with ADHD have difficulty regulating their engine and subsequently appear disorganized behaviourally, struggling with planning and organization of their internal state, their cognitive resources, and their behaviour. The PFC continues to mature well into early adulthood, and as a result it can be expected that as a child matures, their executive function will develop as well. It is important to note that children with ADHD have deficits in executive function compared to typically developing children at the same level of maturation.

Understanding why organizational problems are frequently associated with ADHD as well as minimizing the propensity for this behaviour to be misclassified (i.e., as a defiant behaviour, etc.), greatly aids in reducing both the frustration that are commonly felt by the children with ADHD as well as their parents and teachers. This is a highly proactive step in minimizing the likelihood that children will internalize (i.e., increased depressive feelings, anxiety, etc.) or, more commonly, externalize (i.e., become aggressive, reactive and explosive behaviourally, etc.) their negative emotions associated with struggling with organization. No one likes to be disorganized and unprepared, and it is important that we remember that this is also true for individuals with ADHD. Parents and teachers can aid children with ADHD with their organizational struggles by breaking down organizational tasks into simpler tasks and effectively cuing a step-by-step plan for one to follow. As the child with ADHD becomes more able to undertake each step, parents and teachers can begin gradually reducing their cuing.

DIFFICULTY INITIATING AND FOLLOWING THROUGH ON TASKS

Individuals with ADHD often struggle with the ability to initiate as well as follow through on projects or tasks. They tend to procrastinate and put things off until the very end, when the inevitability of the deadline generates enough

stress to push them to do something. While this involves many neuropsychological skill sets, initiation of a task specifically requires the capacity to plan and organize one's behaviour to align with the task, as well as requiring the internal motivational state to begin the task. Both of these skills require the PFC to be functioning at a high level. More specifically, the anterior cingulate cortex (ACC) is required to play a role in the regulation of motivational states as a means to initiate the task (Lezak et al., 2012). Consequently, individuals with ADHD struggle with the spontaneity of behaviour. In addition to this, they often lack the power to stay on a project and see it through until the end. In order to follow through on a task, one must be able to maintain attention by decreasing the salience or importance of other potential distractors in the environment, plan and organize as well as problem solve when challenges arise. However, much like their attentional capacity (e.g., individuals with ADHD only struggle with mundane tasks, not interesting ones), if they have intense interest in the task at hand, they will stay with it, because the task requires less of these cognitive resources in the form of motivational input, as this part of the brain is underactive. Many individuals with ADHD will complete about 50% of a task and then they move on to something else because they become distracted by something else. Poor follow-through affects many aspects of life such as:

- Schoolwork
- Chores
- Work
- Finances
- Relationships

This challenge is particularly distressing to those with ADHD, but even more distressing to those living with someone with ADHD. Difficulty with task initiation and follow through becomes an area of common contention between children with ADHD and their loved ones, particularly with respect to household chores, homework, and activities of daily living among many other activities. Using direct cues (i.e., reminders) and behavioural strategies (i.e., waiting just inside a child's bedroom door as an indirect reminder that they need to unload the dishwasher, etc.) will aid in reducing everyone's frustration in the household.

POOR PROBLEM SOLVING AND INTERNAL SUPERVISION

A common complaint frequently reported by the parents and teachers of individuals with ADHD is that they appear to struggle with problem-solving. They also appear not to "think" before they act (impulsivity), they do not anticipate consequences of their decisions or actions, and they frequently are unaware that they are making these errors (error monitoring). As discussed before, the PFC is implicated in the executive functioning of the brain, underlying its involvement with forethought, planning, impulse control, and decision-making. The individual who has difficulty in this area of the brain, such as an individual with ADHD, will struggle with forethought, and thus illustrate difficulties in being able to anticipate and predict consequences of behaviour, based on previous experience, as well as adjust both thinking and behaviour to meet the environmental demands. In addition to this, the ACC (located in the PFC), which plays a role in error monitoring and detecting when an error or mistake has taken place (Lezak et al., 2012) is also underactivated in individuals with ADHD. Consequently, those with ADHD may be less inclined to notice their errors or self-correct based on environmental feedback.

Individuals with ADHD also struggle to inhibit their internal desires and often have challenges with delaying gratification. The frontal part of the brain helps one think about what to say or do before one says or does it. It is supposed to assist an individual based on his/her personal experience in selecting the best option for the individual from a number of alternatives. When the prefrontal cortex functions well, one is able to focus, control one's impulses, get organized, set goals and plan for them, make good judgments, show empathy, regulate one's emotions, have insights, and learn from one's mistakes (Lezak et al., 2012). For individuals with ADHD, the moment is what matters the most. They struggle at school and on the job because deadlines come and go and their tasks go uncompleted. They tend to need constant stress in order to get anything done. The stress, however, tends to destroy all the other individuals involved in the life of the individual with ADHD. They tend to move from one crisis to the next.

There seems to be significant difficulties with individuals with ADHD, but also tend to have

left temporal lobe abnormalities (diagnosed typically with electroencephalograph [EEG] and/or behavioural indices). For these individuals, aggression and dark or violent thoughts are very prominent problems because they are very sensitive to slights. In addition, these individuals have difficulty finding the right word; have auditory processing problems, reading difficulties, and emotional instability. When the aggression is externally expressed, these individuals can be quite violent. When the aggression is internally expressed, suicidal thoughts or behaviour may be quite prominent. For individuals with left temporal lobe alteration, medications that regulate temporal lobe activity (i.e., anticonvulsant medication, etc.) can be quite helpful in their treatment (Amen, 2001).

Individuals with left temporal lobe abnormalities usually do not become paranoid like individuals with schizophrenia, but they do have bouts of mild paranoia. They often think that others are talking about them or that others are laughing at them when there is no evidence for it. This mild paranoia or sensitivity can cause serious relational as well as work difficulties. If the back half of the left temporal lobe is underactive, the likelihood is that the individual will have difficulties reading.

Right temporal lobe abnormalities more often than not involve social skills problems, particularly in being able to read and recognize facial expressions and voice intonations. Abnormal activity in either or both temporal lobes can cause a large number of symptoms, including sensory illusions, memory problems, feelings of déjà vu, jamais vu (not recognizing familiar places), periods of panic or fear for no apparent reason, periods of confusion, and preoccupations with moral issues. It is important to discriminate these behaviours from those experienced in mood and thought disorders, as the aetiology of these behaviours differs in ADHD relative to those disorders and can be a point of diagnostic confusion. It appears that stimulants like Ritalin and Adderall make ADHD symptoms worse for those with right temporal lobe abnormalities, particularly if these stimulants are prescribed without anticonvulsant medication to stabilize temporal lobe functions. The stimulants will cause the individual to become more irritable and at times even more aggressive. Anticonvulsant medications such as Depakote, Neurontin, Tegretol, or Trileptal can be very beneficial and prevent individuals from feeling despair, hatred, and self-loathing. Only after the temporal lobes have been stabilized may stimulant medication be helpful to assist the individual with concentration (Amen, 2001).

Part Two will address the assessment of ADHD.

***Sebastiano Fazzari**, Ph.D., (C)O.A.C.C.P.P., R.S.W., is the recipient of Niagara University's Counselor of the Year Award (1999) and Supervisor of the Year Award (2011). He has served as an Adjunct Professor in the Graduate Counseling Program at Niagara University where he currently serves as a Field Instructor for the Social Work Department. He is the Supervisor of School Counseling Services for the Niagara Catholic District School Board, and has thirty-five years of experience as an assessor/counselor. He has published in the area of Parenting Capacity Assessment in the Journal, and on assessment methodologies in Psychologica (2013).*

***Sean Robb** is a graduate student in clinical neuropsychology at Brock University. He works predominantly with individuals who are experiencing neural compromise and who are subsequently experiencing psychiatric symptoms. In his research, Sean investigates the relationship between acquired brain injury and comorbid mood disorders, as well as arousal-based neurohabilitative techniques to aid these individuals. He has published in the fields of brain injury and psychiatry and he presented his research at both national and international conferences.*

***Peter Bonsu**, M.D., F.R.C.P. (C), F.A.A.P. (C) has served as Chief of Pediatrics at the Welland General Hospital. He is an Assistant Clinical Professor at McMaster University, Department of Pediatrics, and has extensive experience working with children and families. He has published in the Journal in the area of Parenting Capacity Assessment. Dr. Bonsu has a pediatric practice in the City of Welland.*

REFERENCES

Alessandri, S. (1992). Attention, play and social behaviour in ADHD preschoolers. *Journal of Abnormal Child Psychology, 20*(3), 289-302.

Amen, D. (2001). *Healing ADD—The breakthrough program that allows you to see and heal the 6 types of ADD.* New York, NY: The Berkley Publishing Company

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders.* (4th ed.) Washington, DC: American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders.* (5th ed.) Washington, DC: American Psychiatric Association

Anderson, C., Hinshaw, S., & Simmel, C. (1994). Mother-child interactions in ADHD and comparison boys: Relationships with overt and covert externalizing behaviour. *Journal of Abnormal Child Psychology, 22*(2), 247-265.

Charach, A., Lin, E., & To, T. (2010). Evaluating the hyperactivity/inattention subscale of the national longitudinal survey of children and youth. *Statistics Canada, 21*(2), 45-54.

Firestone, P., & Dozois, D. J. (2007). *Abnormal psychology perspectives*. (3rd Ed). Toronto, ON: Pearson Education.

Froehlich, T., Lanphear, B., Epstein, J., Barbaresi, W., Katuisc, S., & Kahn, R. (2007). Prevalence, recognition and treatment of attention-deficit/hyperactivity disorder in a national sample of US children. *Archived Pediatric and Adolescent Medicine, 161*(9), 857-864.

Halperin, J., & Schulz, K. (2006). Revisiting the role of the prefrontal cortex in the pathophysiology of attention-deficit/hyperactivity disorder. *Psychological Bulletin,132*(4), 560-581.

Jain, U., Hechtman, L., Quinn, D., Turgay, A., Yaremoko., & Mutch, C. (2006). Canadian attention deficit hyperactivity disorder resource alliance (CADDRA): Canadian ADHD Practice Guidelines.

Klein, B., Damiani-Taraba, G., Koster, A., Cambpell, J., & Scholz, C. (2014). Diagnosing attention-deficit hyperactivity disorder (ADHD) in children involved with child protection services: are current diagnostic guidelines acceptable for vulnerable populations? *Child: Care, Health and Development,* doi: 10.1111/cch.12168

Lezak, M., Howieson, D., Bigler, E., & Tranel, D. (2012). Neuropsychological Assessment (5th Ed). New York, NY: Oxford University Press.

Mash, E., & Wolfe, D. (2010). *Abnormal child psychology.* (4th Ed.) Belmont, CA: Wadsworth.

Melnick, S., & Hinshaw, S. (1996). What they want and what they get: The social goals of boys with ADHD and comparison boys. *Journal of Abnormal Psychology, 24*(2), 169-185. doi: 0091-0627/96/0400-0169

Nixon, E. (2001). The social competence of child with attention deficit hyperactivity disorder: A review of the literature. *Child Psychology & Psychiatry Review, 6*(4), 172-179

Pelham, W., Foster, M., & Robb, J. (2007). The economic impact of attention-deficit/hyperactivity disorder in children and adolescents. *Ambulatory Pediatrics, 7*(1S), 121-131.

Polanczyk, G., Silva de Lima, M., Horta, B., Biederman, J., Rohde, L. (2007). The worldwide prevalence of ADHD: A systematic review and metaregression analysis. *American Journal of Psychiatry, 164*, 942-948.

Remschmidt, H. (2005). Global consensus on ADHD/HKD. *European Child and Adolescent Psychiatry, 14*, 127-137.

Willcutt, E., Doyle, A., Nigg, J., Faraone, S., & Pennington, B. (2005). Validity of the executive function theory of attention deficit/hyperactivity disorder: A meta-analytic review. *Biological Psychology, 57*, 1336-1346.

Lions Quest Canada Collaborates with the Ontario Association of Children's Aid Societies

Patricia Howell-Blackmore, *Lions Quest Canada – The Centre for Positive Youth Development*

All kids are our kids. This simple idea is at the centre of everything Lions Club members do—from sponsoring sports teams, building recreation facilities, organizing family-oriented events, encouraging young people to be proud Canadians, teaching young people the message of peace, providing devices, support, and training for children with special needs, organizing youth exchange opportunities, hosting camps for children and youth of all abilities, and working to make sure that Canadian communities are the best place in the world for children and youth to live.

The understanding that all kids are our kids is also central to the work of Lions Quest Canada—The Centre for Positive Youth Development. Historically the work of the Centre has been focused on the school setting with the internationally recognized Lions Quest Skills for Growing, Skills for Adolescence, and Skills for Action programs. The research base that forms the Conceptual Model for the Lions Quest Skills Programs draws from the work of Dr. Peter Benson of the Search Institute and can be used in any setting where children and youth live, learn, grow and play.

In 2012, Lions Quest Canada was contacted to provide consulting services to the Ontario Association of Children's Aid Societies (OACAS) as part of their Ontario Looking After Children program (OnLAC). The program has had an important impact on promoting and monitoring outcomes for children and youth in the care of a child welfare agency. Within the Assessment and Action Record (AAR) tool that foster parents, youth, and professionals complete, there is a Developmental Assets Profile that is based on the same research as the Lions Quest Skills Programs.

In an effort to build understanding and strategies regarding Developmental Assets the OACAS and Lions Quest Canada have worked together to create a customized training for foster parents and child protection social workers. Over 30 OACAS professionals have been trained to deliver the training and to date they have reached more than 300 agency staff members and foster family members with a number of training opportunities scheduled for the coming months. The training equips the trainers with a working knowledge of the research and tools to work with foster families, agency staff, and caring community members. The OACAS views Lions Quest Canada as a valuable resource equipped with research, tools, videos, Canadian content, wisdom, knowledge, and the ability to bring a perspective from the general population to this unique group.

Morag Demers and Marlyn Wall, Ontario Practice Model Development Professionals for OACAS, shared that child welfare professionals and caregivers see asset building as a way to make positive changes to the way they work with children, communicate as a team, and to their outlook on working with children in their care. Agencies value this research-based approach that provides a natural way to connect with schools, families, mental health services, public health, recreation services, and community groups.

Trainers encourage foster parents to be intentional and deliberate in their everyday interactions to contribute to better outcomes for the children. It is important to remember that the community is impacted by the child in foster care, and the child is impacted by the way the community interacts with them. It is normal for all children and youth to struggle with challenges along the way and if we create communities that surround all young people with messages of support as well as caring adults their chances improve.

Debbie Michaud, Supervisor of Resources and Child Care at Kenora-Rainy River Child and Family Services, has begun the process of training all child care workers and foster families. Debbie shares, "We are currently documenting missing Development Assets that are identified from the AAR and pulling these forward with concrete tasks to address them in the Plan of Care. Child care workers and foster families are getting quite good at ensuring that all assets are being addressed. Our agencies believe that tapping into Developmental Assets has promising implications for our work with families as well. We intend to move forward with an approach in which Developmental Assets are assessed in at-risk families and brought forward in service plans."

Lions Club Member Tim Cronin has been a foster parent since 1992 and it was during a training facilitated by Lions Quest Canada for Family and Children Services of Waterloo Region that he realized the connection. Tim is also a trainer for the local service and he was certified at a session facilitated by Lions Quest Canada in 2012. Tim feels the trainers and foster parents intuitively know what they are supposed to do, but that Lions Quest Canada training brought the practical tools, coaching and message to effectively go out and present it to others.

Tim shares, "As a foster parent it is a positive model that I can really work with. Most of our kids come to us with such low self-esteem so to be able to put a positive spin on it by using the asset building approach makes a huge difference. Kids learn 'no' very easily, but to be able to redirect them with a positive action or to build on their strengths instead is such a strong opportunity for foster parents. Moving things in a positive direction can change the course of these children's lives forever. The more I can teach people about how to do things in a positive way the bigger difference I can make."

For more information about how Lions Quest Canada is working in communities and with agencies across Canada visit our website at www.lionsquest.ca or contact Patricia Howell-Blackmore, Director of Communications and Program, at pat@lionsquest.ca. For more information about Lions Clubs International, the largest service organization in the world visit www.lionsclubs.org.

Patricia Howell-Blackmore *is the Director of Communications and Programs for Lions Quest Canada — The Centre for Positive Youth Development.*

She has presented workshops and keynote addresses on topics including Positive Youth Development, Asset Building, Character Education, Social Skill Development, Community Development, Capacity Building, Bullying Prevention and other youth development related topics to national and international audiences for over 20 years.

Pat acts as a liaison with community groups, educators, Lions Club members, and School Board personnel. She provides consulting services to organizations that wish to invigorate their programs and training with a Positive Youth Development approach. Pat also coordinates the print and promotional material, website, manuscript development and publications, program development and marketing efforts for Lions Quest Canada — The Canadian Centre for Positive Youth Development.

Ontario Association of Children's Aid Societies

The voice of child welfare in Ontario

Practice Notes

Practice Note
Educating Parents on Safer Sleeping Environments for Infants

This practice note is to assist practitioners in providing information to the families with whom they work, to share with colleagues and other community professionals, and to support the work they do to keep children safe. Sudden Infant Death Syndrome (SIDS) and other infant deaths that occur during sleep are recognized as major public health concerns by the Public Health Agency of Canada. Researchers have identified risk factors in the infant sleeping environment that may contribute not only to SIDS, but to deaths from suffocation due to overlaying or entrapment. Factors associated with unsafe sleeping environments include infants sharing a sleeping surface with an adult or another child, and the presence of soft bedding (www.publichealth.gc.ca/safesleep).

Room-sharing vs. Bed-sharing

Bed-sharing refers to a sleeping arrangement in which the baby shares the same sleeping surface with another person. Room-sharing refers to a sleeping arrangement in which an infant is within arm's reach of his or her caregiver, but not on the same sleeping surface.

No sleep environment is completely risk-free, but much can be done to educate parents on the provision of safer sleeping environments for their infants. The advice we give must be guided by available evidence-based data, which indicate that when infants sleep in their own crib, they are significantly safer than when they bed-share (Canadian Pediatric Society).

Safe Sleeping Practice Tips [1]:

- Advise parents that all infant sleep needs to be in a safe sleep environment at all times including night-sleeping and naps.
- Advise parents/caregivers to place infants alone, on their back, lightly clothed, on a firm mattress with a tight-fitting sheet, and in an age-appropriate crib/bassinet/cradle that meets current Health Canada safety regulations.
- Encourage parents/caregivers to practice room-sharing (sleeping in the same room, but on a separate sleep surface) with their infants for at least the first six months of life.
- Advise parents/caregivers that bed-sharing (sharing a sleep surface - including bed, mattress, sofa, arm chair, couch or futon) at any time with an infant can be hazardous because of the associated risks of accidental injury or death. Furthermore, the risk of SIDS and other deaths that occur during sleep increases when an infant shares a sleeping surface with a parent or caregiver who smokes, is impaired by alcohol or drugs including prescribed medication, is overly tired or obese[2].
- Educate parents/caregivers about the significant risk of sudden infant deaths that occurs within unsafe sleep environments, with potential risks due to overlay, suffocation, entrapment, wedging, decreased air flow, and over-heating (such environments include circumstances of bed-sharing).
- Remind parents/caregivers not to place any extra padding, bedding, pillows, toys or other objects under, on top of, or around the infant while sleeping.
- Advise parents/caregivers that car seats, strollers, swings, bouncy chairs etc are not designed, tested, or approved for safe infant sleep; the position of the infant's head while seated for extended periods may cause constriction of the airway.

[1] These tips are consistent with the Canadian Paediatric Societ
[2] Obesity as a risk factor for unsafe sleep is consistent with the
Deaths under Five Committee report.

Education Services
Transforming Knowledge into Skills

Avis de pratique
Éducation des parents relativement aux environnements de sommeil plus sécuritaires pour les nourrissons

Le présent avis de pratique vise à aider les praticiens à offrir de l'information aux familles avec lesquelles ils travaillent, à partager l'information avec les collègues et d'autres professionnels de la communauté, ainsi qu'à appuyer le travail que toutes ces personnes accomplissent pour assurer la sécurité des enfants. Le syndrome de mort subite du nourrisson (SMSN) et d'autres formes de décès de nourrissons survenant durant le sommeil sont reconnus comme étant d'importantes préoccupations de santé publique de la part de l'Agence de la santé publique du Canada. Les chercheurs ont déterminé des facteurs de risque dans l'environnement de sommeil des nourrissons qui peuvent contribuer non seulement au SMSN, mais aussi aux décès par suffocation parce que l'enfant est recouvert ou coincé. Les facteurs associés aux environnements de sommeil non sécuritaires incluent le partage d'une surface de sommeil avec un adulte ou un autre enfant et la présence d'accessoires de literie moelleux. (http://www.phac-aspc.gc.ca/hp-ps/dca-dea/stages-etapes/childhood-enfance_0-2/sids/index-fra.php)

Partage de la chambre ou partage du lit

Le partage du lit est une pratique de sommeil où un bébé partage une surface de sommeil avec une autre personne. Le partage de la chambre est une pratique de sommeil où un nourrisson se trouve à proximité de sa personne responsable, mais sans partager une surface de sommeil.

Aucun environnement de sommeil ne comporte absolument aucun risque, mais on peut prendre de nombreuses dispositions pour éduquer les parents sur les façons de procurer un environnement de sommeil plus sécuritaire à leurs nourrissons. Les conseils que nous donnons sont guidés par les données fondées sur les faits disponibles, qui indiquent que les nourrissons dormant dans leur propre couchette sont beaucoup plus en sécurité que les nourrissons partageant un lit (Société canadienne de pédiatrie).

Conseils de pratiques de sommeil sécuritaires [1]:

- Informer les parents ou personnes responsables que toute forme de sommeil d'un nourrisson doit avoir lieu dans un environnement de sommeil sécuritaire en tout temps, qu'il s'agisse du sommeil nocturne ou de siestes.
- Conseiller aux parents ou personnes responsables de placer le nourrisson seul, sur le dos, légèrement vêtu, sur un matelas ferme en l'abritant d'un drap bien ajusté, dans une couchette, un lit de bébé ou un berceau appropriés à son âge qui respectent les normes de sécurité de Santé Canada.
- Encourager les parents ou personnes responsables à pratiquer le partage de la chambre (coucher dans la même chambre, mais sur une surface de sommeil distincte) avec leur nourrisson durant au moins les six premiers mois de sa vie.
- Informer les parents ou personnes responsables que le partage du lit (partage d'une surface de sommeil – incluant un lit, un matelas, un canapé, un fauteuil ou un futon) en tout temps avec un nourrisson peut être dangereux à cause des risques de lésions ou de mort accidentels qui y sont associés. De plus, le risque de SMSN et d'autres formes de décès survenant durant le sommeil s'accroît lorsqu'un nourrisson partage une surface de sommeil avec un parent ou une personne responsable si ces derniers fument ou sont intoxiqués par l'alcool ou des drogues, y compris des médicaments prescrits, extrêmement fatigués ou obèses[2].
- Renseigner les parents ou personnes responsables relativement au fort risque de mort subite du nourrisson qui survient dans des environnements de sommeil non sécuritaires, notamment les risques possibles découlant du fait que le nourrisson soit recouvert ou coincé, suffoque ou ait un débit d'air réduit ou qu'il ait trop chaud (de tels environnements incluent les situations où on partage le lit).
- Rappeler aux parents ou personnes responsables de ne pas placer de bordures de protection, d'oreillers, de jouets ou autres objets en dessous, au-dessus ou autour du nourrisson lorsqu'il dort.
- Informer les parents ou personnes responsables qu'entre autres, les sièges d'auto, les poussettes, les balançoires d'enfant et les sièges sauteurs ne sont pas conçus, testés ni approuvés en tant que matériel de sommeil sécuritaire pour les nourrissons; la position de la tête du nourrisson lorsqu'il est assis durant de longues périodes peut causer l'obstruction des voies respiratoires.

[1] Ces conseils sont conformes aux recommandations de la Société canadienne de pédiatrie, qui sont fondées sur un examen des preuves scientifiques disponibles.
[2] L'obésité en tant que facteur de risque lié au sommeil non sécuritaire cadre avec la recommandation du rapport annuel du Comité d'examen des décès d'enfants et du Comité d'examen des décès d'enfants de moins de cinq ans (juin 2007).

Service de formation

All Practice Notes are available in English and French.

OACAS publishes Practice Notes on a variety of topics for child welfare professionals, caregivers, and resource families.

The Practice Notes are designed to be quick reference tools for child welfare professionals, and contain links to other resources for further information.

Topics covered in the Practice Notes include:

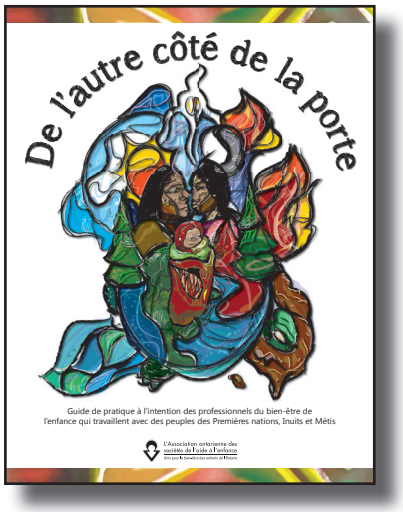
- Obtaining Consent for the Release of Information
- Safer Sleeping Environments
- Bathtub Safety
- Fire Safety
- Pool Safety
- Farm Safety
- Infant Mental Health
- Youth Suicide
- Woman Abuse Resources in Ontario
- OACAS Learning Resources on the Topic of Woman Abuse
- Adoption Openness Provisions in the Child and Family Services Act
- Best Practice Guidelines: Case Closure and Maternal Pregnancy

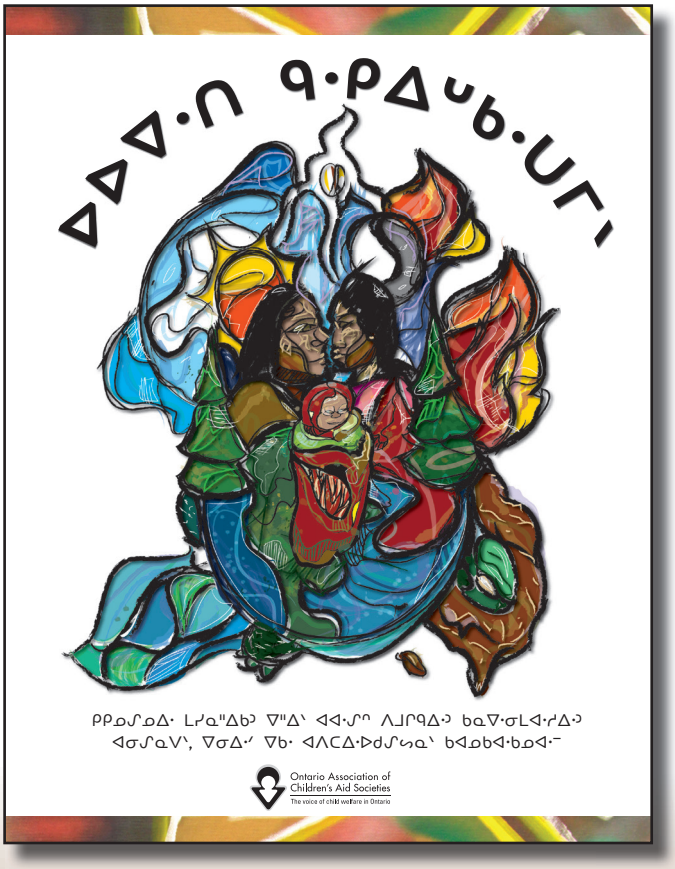
Practice Notes can be accessed on the OACAS public site, www.oacas.org, under Publications > Practice Notes

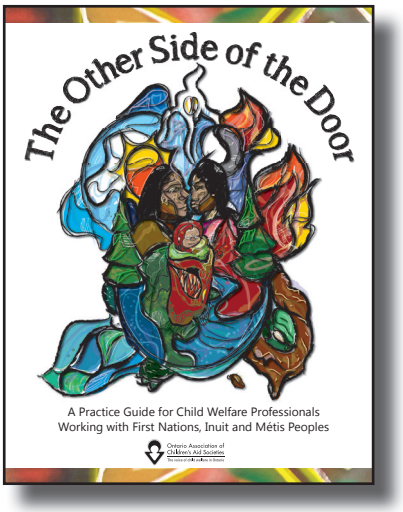
OACAS Members can also view these resources on the members website, www2.oacas.org

The Other Side of the Door

A Practice Guide for Child Welfare Professionals Working with First Nations, Inuit and Métis Peoples







The Other Side of the Door was written by Kenn Richard, Executive Director of Native Child and Family Services of Toronto, and edited by OACAS, with selected illustrations and cover art provided by Isaac Weber (7th Generation Image Makers). The practice guide is designed to develop and strengthen understanding of the culture and history of First Nations, Inuit and Métis (FNIM) families and communities. It is hoped that the practice guide will help to create a lasting change in practice by supporting the entire child welfare field to learn about their obligations to FNIM children and families.

English edition now available on Shopify for $7
Oji-Cree and French editions available Spring 2015 on Shopify for $7

Ontario Association of Children's Aid Societies
The voice of child welfare in Ontario