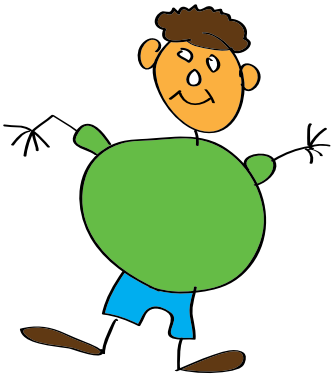
JGH Child Psychiatry

The Rose & David Bloomfield Family

Transitional Care Program



Bell Let's Talk

Hôpital général juif
Jewish General Hospital

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The program's creators are Dr. Phyllis Zelkowitz, Director of Research in the Department of Psychiatry, Jewish General Hospital; Dr. Jaswant Guzder, former Director, Child Psychiatry, Jewish General Hospital; and Rosemary Short, former Head Nurse, Child Psychiatry, Jewish General Hospital. This manual reflects the input of these program creators together with the members of the JGH Transitional Care Team: Jane Bourke, founding Coordinator; Anne Smart, Educator; and, Karen Sochaczevski, Educator. Amy Langstaff edited the manual, and Myriam Ekhauzer was the graphic designer.

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A. OVERVIEW

About the Transitional Care Program

Since 2002, the Transitional Care Program has provided support to children aged four to twelve who have graduated from the Child Psychiatry Day and Evening Hospital Programs of Montreal's Jewish General Hospital (JGH).The Transitional Care Program has been developed and refined by JGH staff from a number of professional backgrounds, including psychiatry, social work, and education. The program is rooted both in clinical knowledge and in years of experience helping children adapt to community schools following in-hospital psychiatric treatment. We believe the Transitional Care Program has supported continued progress for children after they have left the Day Hospital and reintegrated fully in their regular school settings.

In this document we have sought to capture knowledge and insights from the program in a form that is useful to professionals in fields related to pediatric mental health (teachers, social workers, educators, CLSC staff, and others). Our aim is to offer a pragmatic manual that will be helpful to those working with children and families who, after experiences at the Day Hospital or similar facilities, are re-adjusting to life at their community schools.

The Child Psychiatry Day Hospital Program

Children aged 5 to 12 are referred to the JGH Day Hospital for such problems as oppositional-defiant disorder, conduct disorder, aggressive behaviour, suicidality, attention deficit disorder, selective mutism, school refusal and post traumatic stress disorder. Referrals come from schools, social service agencies, and parents.
The Day Hospital offers a multimodal treatment program for up to one academic year for children with presenting problems so severe that they cannot attend their community schools. The program includes:

- 3 or 4 days per week of special education classes with an enrolment of 7 students per class;
- individual play therapy, social skills training, occupational therapy, and art therapy;
- weekly family therapy;
- psychological assessment of cognitive and emotional functioning; and
- consultation between hospital staff and each child's network of supports, including community school, social service agencies, and local community social services personnel.

In most cases, children who have been admitted to the day hospital are ultimately able to return to their community schools or a new school placement which meets their special needs.

How the Transitional Care Program helps children with mental health issues

Children are admitted to receive treatment at the JGH Child Psychiatry Day Hospital when their families and schools agree that they can no longer manage the child's behavior on their own. With the expert care and focused attention the Day Hospital offers, these children often make significant progress with respect to behaviour and overall wellbeing. Naturally it is in the best interests of the children, their families, and their schools that they maintain this progress after they leave the Day Hospital.

Unfortunately, the transition back to school can in itself be sufficiently stressful to cause children to regress. The Transitional Care Program was developed to provide support to familes and help children with mental health issues re-enter their community schools successfully by sustaining the patterns and skills they learned while in treatment at the Day Hospital. Specifically, the program focuses on

- **maintaining** academic behaviour and classroom performance
- **maintaining** pro-social behaviour and adaptive functioning
- **preventing** recurrence of aggressive or other problem behaviours
- **sustaining** adherence to taking medications
- **building** and consolidating appropriate community supports for these families.

The Transitional Care Program was originally designed as a six-month intervention wherein a social worker and child care worker, with support from the child psychiatry staff at JGH, would work with children, families, and schools to help Day Hospital graduates make the transition back to school and community. Over its many years of operation, the Transitional Care Program has helped numerous children and families maintain the hard-won progress they have made at the Day Hospital and settle into school life.

Today, JGH is working to make the benefits of the Transitional Care Program more widely accessible by sharing knowledge about the program with other institutions: schools, CSSSs, and social service agencies. The Transitional Care Team associated with the JGH Day Hospital does not have the capacity to support every child who might benefit from the Transitional Care Program. With this manual we aim to share insights and practices from our program for the benefit of children, families, teachers, and institutions not directly associated with the JGH who provide services to children with mental health problems.

Why people who work with children (teachers, social workers, CLSC staff, and others) can benefit from learning about the Transitional Care Program

In addition to helping children directly enrolled in the program and their families, the Transitional Care Program can deliver significant benefits to teachers, schools, and health care and social service agencies. The Transitional Care Program

- **facilitates** communication between families and institutions (especially schools)
- **promotes** early responses to signs of regression, addressing small problems at school before they grow
- **helps** various adults in a child's life to develop coordinated responses to the child's behavioural issues, making any given adult's interventions more effective.

These activities help to moderate the stress of the child's return to school, and as a result tend to reduce the time and resources teachers and schools must devote to the child. This approach helps to prevent emerging problems from reaching a crisis point, and therefore keeps families from needing to access emergency services.

Implementing a Transitional Care Program does require an investment of time and attention. In our experience, this investment results in a net benefit to teachers, schools, and service agencies. These interventions help to prevent crises that lead to much more time-consuming management problems.

THE EVIDENCE ON LONG-TERM BENEFITS

Children who access programs like the Child Psychiatry Day Hospital are not only experiencing acute difficulty at the time of their admission (difficulty that affects their families, schools, and communities), they are also at risk for developing mental disorders later in life. Effective intervention, early in development, can not only improve these children's lives over the long term, but can have potentially significant social and economic returns to society.

Tolan & Dodge, 2009

B. The Challenges The Transitional Care Program Addresses

The Transitional Care Program is designed to help maintain the gains children make at the JGH Child Psychiatry Day Hospital by supporting children, families, and schools as all three negotiate the child's return to the community school.

Gains Made At the JGH Child Psychiatry Day Hospital

Children tend to arrive at the Day Hospital Program with presenting problems so severe that they are unable to participate in a community school setting. With repeated practice and positive reinforcement at the Day Hospital, children and their families tend to gain important knowledge about how to manage the child's behaviour. In addition to receiving psychiatric treatment at the Day Hospital, children learn in a school environment characterized by small class size, individual attention, consistency, stability, and high levels of staff expertise on mental health issues. This learning environment tends to support the progress children make in their treatment at the Day Hospital.

The Challenge of Returning to School

Even for children who make great progress at the Day Hospital, the disruption of their routine and the stress of reintegrating into their community schools can cause backsliding. The transition is often stressful for families, and can place additional demands on local social service agencies and on the child's school.

Challenges for children

General change to routine

The hospital environment is highly structured and children receive extensive support both from mental health professionals and from other social services. Returning to community school means not only a change of venue and routine, but a less intensive regime of support: less individual attention, fewer people to speak to about problems, and often a return to a school environment in which the child has a history of difficulty. Home routines can also change at this time, as families have less interaction with hospital staff.

Larger class sizes and different expectations

Upon leaving the Day Hospital, children move from an environment offering extensive individual attention and classes no larger than seven to a standard classroom with many more students and less capacity for individualized support. A typical classroom also has characteristics—such as noise, lots of visual stimulation, and frequent change (for instance, rearranging of desks to support group projects)—that work for many children but can be very unsettling for children with mental health issues.

The stigma of having been away

Children returning from the Day Hospital program often worry about how they will be received in their old school environment, and how their absence has been explained by the school to their peers. What do other children know about the reasons for their absence from school? If they had friends before their admission to the Day Hospital, will these friendships persist? If they were isolated, will they be further ostracized?

Challenges for families

Severed relationships with trusted Day Hospital staff
Children and families attending treatment in the Child Psychiatry Day Hospital tend to feel well supported, and often develop strong feelings of trust toward hospital staff. The transfer of therapeutic alliance to community partners and schools is essential to the success of day hospital program, which maintains the child in community schools in order to promote this link throughout treatment. Although graduation from the day hospital program is a positive milestone, it can have an undercurrent of fear and anxiety because it threatens to sever these important relationships. The Transitional Care Program softens this transition by ensuring continuity of care and by providing referrals as necessary.

A return to sometimes tense relationships between family and school
It is often the case that prior to children's admission into the Day Hospital program, the relationship between the child's home and the school was difficult. Communication can become strained when a child's mental health is deteriorating, while school and other resources are struggling to manage the child's deteriorating behaviour. Families may emerge from Day Hospital treatment heartened about the child's improved functioning, but nervous about resuming relationships that left off on a difficult note months earlier.

The stress of assuming more responsibility for the child's behaviour and wellbeing
When children attend the Day Hospital, parents know that the professionals there understand their child's issues and can help to manage them. By contrast, community school staff have more students and less time to deal with one child's serious mental health challenges. Parents face the stress of wondering if they will need to leave work to pick up a child whose behaviour is unmanageable, if they will receive calls from the principal, and if their child will arrive home distraught because of difficulty with peers or school staff. Parents of children with mental health issues sometimes have their own mental health concerns, and the stress of this transition can be very taxing for them.

Challenges for teachers and schools

Community schools have finite capacity and hundreds of students to manage; one child with severe behavioural issues can be a huge challenge. Classes generally have 25 to 30 students with various special learning needs. A child emerging from the Day Hospital program may have particular requirements that are not easy to accommodate in a large classroom. Moreover, schools may not realistically have the resources to follow through on Day Hospital recommendations. As a child returns to school from the Day Hospital, his or her teacher may understandably be concerned about repetition of past disruptive or even dangerous behaviour.

Challenges for social services

If a child regresses without support, he or she may end up back in the care of mental health services. In the absence of a supportive Transitional Care Team, one of two things may happen if a child regresses after Day Hospital treatment. First, parents may attempt to return to the Day Hospital to seek support. Staff may do their best to take on this additional responsibility in addition to their existing caseload, but this is an imperfect solution. Second, parents may need to seek help urgently from a hospital emergency room or contact the CSSS network. Hospitals and social services may not be familiar with the child's case and cannot offer continuity of care. In either case, since there may be significant delays before the parent and child receive any support when they need intervention and the delay can exacerbate the mental health concerns of both parent and child, the transitional care option can reduce risk for children and families and link them with other services. It is important to recognize that, according to the Mental Health Commission of Canada, up to 70 percent of young adults report that symptoms started in childhood, and that children who have mental health problems are more likely to become adolescents and then adults with mental health problems.

IN BRIEF: how the Transitional Care Program addresses these challenges

The Transitional Care Program has been designed to address each of these challenges by

- **monitoring** the child's progress at school
- **supporting** parents and caregivers with intervention strategies
- **helping** families to be consistent in reinforcing skills acquired from the Day Hospital program
- **facilitating** communication between families and schools
- **helping** schools to understand the needs of children with mental health challenges
- **helping** schools to develop and maintain workable accommodations for children with mental health issues.

C. How the Transitional Care Program works: tools, team, and approach

Child Focus: Maintaining Treatment Gains:

The Transitional Care Program supports children during their transition back to school after their discharge from the JGH Child Psychiatry Day Hospital. The program provides continuity of care that increases the transfer of skills that children have attained at the Day Hospital to the school and home environments. By supporting the child's success, the program diminishes the burden on schools and social services; reduces family stress by promoting advocacy, knowledge transfer and problem solving and helps to prevent relapse and re-admission to specialized psychiatric services.

This section lays out the principles and mechanics by which the JGH Transitional Care Team has operated, and articulates the roles that each team member has played in supporting children's adjustment to community school. Section 1 describes some important characteristics and practices of the Transitional Care Team. Section 2 lays out the program's concrete activities and how they contribute to children's success.

In the final section of this document, we offer ideas on how the approaches described here might be adapted depending on the professional resources available.

The JGH Transitional Care Program Team and their roles

Educator:

- Observe discharged children in school during class, recess, lunch, and/or daycare. (Frequency determined in collaboration with school)
- Communicate in a consultant-liaison role with school personnel (principal, teachers, resource personnel, daycare supervisors)
- Offer emotional support to school personnel
- Update social worker on child's progress in school after observation sessions
- Schedule meetings with school personnel and parents as required
- Meet monthly with team to discuss progress of case
- Consult with JGH Day Hospital staff as needed

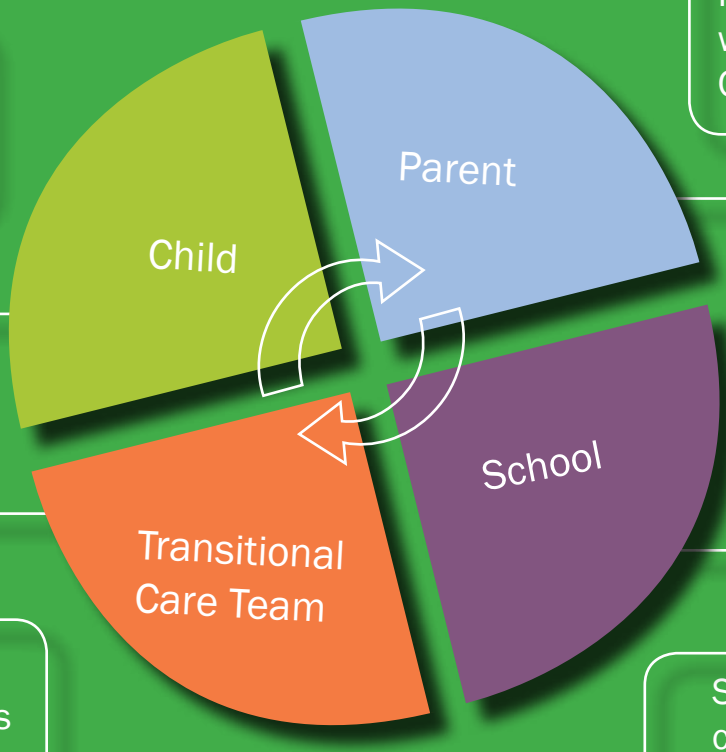
Social worker:

- Initiate at least weekly telephone contact with children's primary caregivers
- Assess child's behaviour at school, home, and in the community, looking for signs of regression
- Offer emotional support to caregivers, identify problems and possible solutions
- Help parents to become advocates for their own children on an ongoing basis
- Provide feedback to caregivers based on educators' observations in school setting
- Speak with educators weekly for updates on child's behaviour
- Coordinate monthly meetings with team
- Consult with JGH Day Hospital staff as needed

APPROACH

Child fully integrated in the home school

Parents communicate with the Transitional Care Team



Transitional Care Team communicates with school and parents

School communicates with the Transitional Care Team

SUPPORT TO THE SCHOOL
- School visits
- Consultation with school personnel
- Promotion of school-home communication

Transitional Care Team

SUPPORT TO PARENTS
- Regular telephone contact
- Referral to community resources
- Promotion of parent-school cooperation

LIAISON WITH CHILD PSYCHIATRY STAFF
- Continuity of care following discharge
- Consultation re medication and further treatment

The Transitional Care Program is a bridge in post-discharge progress emphasizing accessibility, responsiveness, and early intervention

For families of children transitioning back to community school, timely access to support is crucial when problems emerge. For this reason, the JGH's Transitional Care Program has made it a priority for at least one team member to be available and responsive to families and school personnel five days a week. By offering 6 months of follow-up to parents and schools, the transitional team promotes consolidation and appraisal of long term needs. Members of the JGH Transitional Care Team have carried much smaller loads by design, making them highly responsive to parents and schools, and in turn facilitating early intervention in any emerging difficulties. While community services may have long wait lists, this intervention is a bridge support in assessing community resource needs.

CASE ILLUSTRATION

The single mother of an adopted child with reactive attachment disorder called the JGH Transitional Care Team to express her fear that her child would be denied re-entry to school after a suspension. Our team convened a meeting with mother and school personnel, and learned that home and school had been working against each other, each in a reactive state, culminating with an increase in the child's negative behaviour. Our work helped the school personnel to understand the child's and mother's actions, and eased their concerns about being able to manage the child in a regular school setting. The team provided school personnel with support and strategies to contain the disruptive behaviour, and helped the mother to understand the challenges the school faced in caring for her daughter's aggressive, avoidant behaviour. With the support of the weekly follow-up calls, the mother's reactive, overly protective and dismissive behaviour began to lessen, and the relationship with the school improved.

The Transitional Care Program emphasizes communication between home and school

Schools and parents share the responsibility for children's learning. When children have serious mental health issues, not only does learning generally become more difficult, but the partnership between home and school can become strained. In our experience with the Transitional Care Program, we have found that facilitating good communication between home and school can produce huge benefits. Strengthening collaboration of schools and families

- **reinforces** the child's skills and competency
- **reduces** stress on families and teachers by facilitating problem solving
- **diminishes** the potential for conflict and misunderstanding between home and school
- **can help** to reduce stigma and negative expectations of the home-school relationship prior to the child's admission to the Day Hospital. Parents and teachers may each have had negative experiences in the past. Communication facilitated by a Transitional Care Team can help to build a more positive and trusting relationship and ensure the transfer of knowledge about the special needs of the child, such as individual education plans (IEPs)
- **enables** home and school to provide support and hold the child to account, as circumstances warrant . Parents and teachers can inform each other of difficult moments in a child's week to plan or enable appropriate care. They can advise each other if, for instance, a child is trying to avoid accountability for homework. This situation may require changes in monitoring, positive reinforcement, and adaptation of expectations
- **enables** monitoring of the child's progress and more rapid detection of signs of regression
- **creates** a positive, cooperative network that serves as a model for the child, who experiences its benefits directly.

The goal of effective communication is not only to get families involved, but rather to have the home and school join forces in strengthening children's learning and growth. (See "Communication Booklet" under Tools and Practices, **page 21**).

Helps teachers and other school personnel to understand children's mental health issues and resulting special needs

Teachers wish for children to succeed and thrive at school. When it comes to children with severe psychiatric issues, teachers may be hampered in their efforts to promote school success by

- **a lack** of specialized knowledge about mental health
- **time** and resource constraints that make it difficult to accommodate children's individual needs; and/or
- **teachers** sense that they are alone in trying to address a child's very serious problems (that either the family or the relevant consultant e.g. school administration, Day Hospital, social services are insufficiently engaged).

Moreover, the Transitional Care team reduces tensions, e.g. if a child misbehaves severely, a teacher may feel blamed or may feel that his or her competence is in question. The JGH Transitional Care Program offers teachers the support of knowledgeable social workers and educator who specialize in children with psychiatric issues, and who also have direct access to psychiatric staff at the JGH. These team members are able to

- **help** teachers understand children's conditions and the roots of their behaviour
- **help** teachers make pragmatic accommodations; and
- **promote** communication and engagement among various parties involved in the child's life.

This support and communication can improve outcomes for the children while diminishing teachers' stress.

CASE ILLUSTRATION

One Day Hospital graduate with ADHD was repeatedly leaving books at school. This was keeping him from completing his homework, and causing him to fall farther behind the grade expectations. Disorganization is a common problem for children with ADHD. In this case, after a long day of trying to remain focused at school, the final task of getting homework organized was proving difficult. The Transitional Care Team suggested to the parents and school that he have fewer binders--two instead of five--and that his deep-bottomed knapsack be replaced with a bag that had dividers for better visibility and organization. The boy was given the responsibility of looking in his agenda at day's end and collecting the necessary work. Close monitoring and parental reinforcement, combined with some practical adjustments (the binders and bag), helped the boy begin to develop effective habits regarding his homework.

"[The social worker and educator from the Transitional Care Team] were able to explain to the parents what we had set up for the students and what should be done at home in order to increase their child's chance of having a successful reintegration. This was a stressful time for both the home and the school, so the Transitional Care Team's input and support was invaluable. We all worked together: the parents, the child, the teachers and the Transitional Care Team."

–Educator

Supports children's success by promoting consistency and structure at a time of transition

The progress children make in the Day Hospital program can be attributed in part to the structure and consistency of the hospital setting, and the fact that the Day Hospital is managed by knowledgeable staff who have the time and resources to devote considerable attention to each child and family. Children practice good behaviours repeatedly and experience positive reinforcement in a safe, predictable setting.
As children leave this closed environment and reenter their community schools, the Transitional Care Team works to help parents and teachers maintain some version of the consistency the child experienced in the Day Hospital.

Supports the child's success by supporting parents and caregivers

Parenting a child with a serious psychiatric disorder is a major challenge for any parent. This challenge can be compounded by parents' own physical or mental health issues. Moreover, many parents whose children access the Day Hospital have low incomes and are therefore unable to pay for private services, and may have to wait for public services to become available. A key element of the Transitional Care Program is the provision of support to parents and caregivers. Frequent conversations with parents (whether regularly scheduled meetings, or responses to parents' phone calls) help to draw out parents' feelings and perspectives. Step-parents, divorced parents who share custody, live-in boyfriends or girlfriends, grandparents who live in the home of the child, and others, may all be involved in the Transitional Care Program if they were involved in treatment, or if they are responsible for the child's care.

Regular telephone contact and occasional home visits by someone familiar with the child's history and condition can be important sources of support and reassurance for parents, especially those who worry about being blamed or judged by school personnel or other institutional figures. This in turn can help parents manage their own stress levels and deal with their children in more measured and consistent ways.

> "[The Transitional Care Team social worker] navigated the school system for us, consulted with the JGH child psychiatry team for suggestions, helped us regulate appropriate disciplinary measures, listened to our angst and insecurities, offered a reassuring presence, perspective, and validation when we felt at our absolute worst. ... In the height of the crisis, when [our son] was suspended three times, I am not certain if we would have had such a successful outcome [had the Transitional Care Team not been available to us.]"
>
> –Parent of Transitional Care Program Participant

Tools and practices

The concrete activities of the Transitional Care Team include

Regular phone calls to parents, and responsiveness to parents' calls
In the JGH Transitional Care Program, a social worker maintains telephone contact with parents for a six-month period, or until contact is no longer needed. The goal of these calls is to offer regular support and guidance to parents as they work to care for their children and maintain the gains made in the Day Hospital program. Calls happen at least once a week, but the frequency of the calls varies: some parents welcome regular check-ins, while others prefer less frequent contact as a sign that their children have improved and moved beyond the care of the Day Hospital. The content of the calls may include

- **Relaying** of information from in-school observation of the child
- **Identification** of behavioural problems, triggers and possible solutions
- **Provision** of information regarding services
- **Discussion** of parenting strategies
- **Provision** of emotional support to the parent
- **Role-playing** and repetition of skills for managing the child's behaviour.

In addition to calling parents, Transitional Care Team members make themselves available to promptly return parents' calls (see first item in the "Approach" section).

In-home visits with children and their families
Members of the Transitional Care Team sometimes observe the family at home, and work with parents to promote

- **Problem-solving**
- **Clear** communication
- **A clear** intergenerational hierarchy between parents and children
- **Structure** in the home through the use of moderately flexible rules
- **Warm**, supportive relationships with reduced conflict
- **Cooperation** among adults with respect to managing the child's behaviour.

During home visits and phone calls, the social worker evaluates whether the parent has been attending to consequences, praising versus ignoring good behaviour, using an authoritative (not authoritarian) approach, and attending to the special behavioural issues for which the child was initially referred.

CASE ILLUSTRATION

A 5-year-old boy, diagnosed with ADHD and ODD, reverted to his aggressive and defiant behaviour soon after discharge. He became unmanageable at his daycare and at home due to his physical outbursts. After a home visit with parents, it became noticeable that the child's father was having difficulty assuming his authority. He would often give a double message when demanding that his son go to his room, or would not intervene at all when the child was hitting the mother. By exploring the father's history, the Transitional Care Team learned that he respected defiance, and was subtly communicating that he enjoyed his son's acting out. A very strict plan of authority, clear communication, and consequences and rewards was needed for home and school to keep the child contained.

In-school observation (anonymous where possible)

In the JGH Transitional Care Program model, the team arranges times when an educator can observe the child anonymously in school—both in the classroom and during unstructured periods such as recess and lunch. The childcare worker observes anonymously to the extent that this is possible; he or she is not introduced as having a connection to any particular child. In some cases anonymity is impossible, but even if the observer is familiar to the child, he or she observes passively; the child has the power to set the terms of any direct interaction. In-school observation enables the Transitional Care Team to

- **monitor** the child's progress
- **provide** specific advice and information to teachers, based on observed behaviour; and
- **report** to parents on the child's reaction to the school environment.

Direct observation

In addition to enabling Transitional Care Team members to observe the children, school visits let the team observe the climate of the school, and focus advocacy efforts around measures that might help to promote school success (such as shadowing or resource support). It is not always possible for schools to follow through on recommendations from the Transitional Care Team. (In one case, the treating team recommended that a returning Grade 1 student be allowed to bounce on a large exercise ball during class time to alleviate his sensory sensitivities. The school felt this would be too disruptive to the other students who might want to join in the activity. Our educator suggested the child be allowed to stand up on occasion, and if need be to walk around the classroom, or be taken out of class for a few minutes and walk off the tension. This proved to be a workable compromise).

Fostering direct communication between home and school

In cases where children have serious mental health challenges, it is common for distrust and defensiveness to accumulate in the relationship between parents and schools. Children tend to make much more progress when their families and schools are able to work together to give them structure and consistency. For this reason, a major area of emphasis for the Transitional Care Program is to improve communication and collaboration between home and school. The Transitional Care Team does this in a number of ways. It convenes meetings between parents and school personnel (see **page 19**), it intervenes to clarify each party's perspective when conflict flares up, and it promotes the use of a "communication booklet" (see **page 21**).

"We have appreciated the [Transitional Care Team's] school visits, classroom observations, and the collaboration. The continuous feedback also provides a message to parents that continuity and follow-up is integral to maintaining positive behavioural change and the best opportunity for success in school."

– School Psychologist

"We never felt alone. There was always someone we could talk with. References and referrals were unlimited, and that meant a lot to a family struggling to understand a child with a diagnosis like my son's."

–Parent of Transitional Care Program Participant

Helping families connect with local community organizations and service providers

When supporting a child's return to community school, the JGH Transitional Care Team promotes connections with local social service providers and community-based programs such as CSSS, and the Big Brother/Big Sister organizations, in addition to cultural and religious associations. The Transitional Care Team typically helps to identify whether and what type of services are needed, provides the contact information to the parents, and supports parents in their efforts to obtain services, providing interim support while they may be on wait lists.

An emphasis on rapid reinforcements and tangible consequences

As children work to maintain the gains they have made at the Day Hospital, it is vital that the adults in their lives provide consistent and structured reinforcement. The effectiveness of reinforcement depends on timing and consequences (praise, reward, or points). Responses delivered soon after the behaviour are more effective than responses that come later (Kazdin, 2005).

> "Evidence is emerging from education and psychology that helping teachers and others who are influential in children's lives to understand and recognize mental health issues and to improve their situations can benefit youth and contribute to their later success"
>
> Tolan & Dodge, 2005

D. Strategies and tips for adapting the Transitional Care Program to other settings

Introduction

The foregoing section describes how the Transitional Care Program has operated under the auspices of the Jewish General Hospital. This section (D) suggests some ways in which these practices, which have produced good outcomes for Day Hospital graduates in our care, can be replicated or adapted by other professionals in other settings. This manual is designed to be useful to people without specialized training in mental health.

Appendix C of this document offers some online resources for professionals who are working with children with mental health issues.

A Note to Teachers

Having served as the liaisons between the Jewish General Hospital's Day Hospital Program and a number of community schools, the authors of this manual have experienced first hand the tremendous amount of hard work and expertise that goes into managing a classroom of 30 or more students with varying needs and abilities.

We recognize that the expectations placed on teachers today are immense, and the resources and supports available to them are often limited. Whereas students with specific challenges were once taught in smaller, specialized classrooms, they are now typically integrated into larger classes. Not only are schools required to educate children with diverse needs during regular school hours, they increasingly care for these children in daycare and after-school programs—often without extra resources to enable this inclusion model.

Jewish General Child Psychiatry Transitional Care Program Timeline

We have developed this manual as a resource for teachers and other educators who are working to support students with serious behavioural and mental health challenges.
Based on our experiences to date, we believe strongly that the approach outlined in this document can benefit not only the children it supports, but their teachers, families, peers, and school communities. We offer it as a practical resource and hope that it proves helpful to the educators who make use of it.

Helpful Practices and General Guidelines

An initial in-person meeting to establish shared goals and approaches

Soon after the child's discharge, any adults involved in supporting the child's transition (parents, teachers, school administrators, resource personnel, child care workers, social workers) should meet to review and share as much information as they can about the problem behaviours that led to the child's admission to a treatment program, and about the gains the child made while in treatment. Often the child's discharge is at a time of transition to a new grade, a new teacher or even a new school placement, so the hospital discharge meetings with schools may include school personnel who are not familiar with the child's history or progress. It is valuable for team members to share as many insights as possible about what strategies have helped the child in the past, and therefore what interventions might be most effective should the child show signs of regression. Ideally, the team will relay to school staff information about the child's progress and what kinds of interventions have proved successful for him or her during treatment in Day Hospital.

A discussion that pools all the relevant information available can help to get the team aligned about how to support the child's progress. The adults supporting the child may deploy a range of positive interventions (point programs, charts with stickers, praise, and rewards), and negative interventions (time-outs, withdrawal of privileges) as necessary. (Appendix C offers examples of these tools). As in all aspects of this transition process, consistency and communication are important.

Accessibility and responsiveness of all parties involved in the child's care

For professionals working with children with mental health challenges, accessibility and responsiveness should be important considerations. But it is important to keep in mind that consistency, cooperation and communication among adults, and early intervention in negative behaviour are critical to these children's success. The ideal is for families to feel that teachers and resource personnel are receptive to communication, and vice versa. In cases where social workers and educators are also contributing to the child's care, it is helpful for both teachers and families to be able to reach out even with relatively minor concerns and quickly get some advice or help. Many professionals in educational and social service settings have large caseloads, and may not be able to respond as quickly as they would like. Creating a general sense that contact is welcome and appropriate reduces distress of parents with special needs children post discharge.

Use of a Communication Booklet that circulates daily between home and school

A Communication Booklet is a valuable tool for fostering strong communication between parents and school personnel (especially classroom teachers). It also helps to promote consistency in all parties' approach to the child's behaviour. The booklet can be as simple as a blank notebook that circulates daily between home and school; it can also be modified to include specific fields to be filled in (on topics such as the day's behaviour, homework, and medication). Some JGH children are on a tracking or point system when they leave JGH. Some trackers are general (for instance, points for completing homework) while others are specific to the child, measuring specific behaviours or issues. Trackers can be less time-consuming than having to produce a written description each day on all necessary topics.

Daily communication through the booklet enables parents and teachers to share information about stresses on the child or notable events of the day (refusal of medication, for instance). This enables both parents and teachers to anticipate problems and prepare for them. Direct communication between home and school also prevents some children from playing parents and teachers against each other; this can help home and school to ensure that children are held accountable for their own behaviour and responsibilities.

Inclusion of parents and respect for their role

The JGH Transitional Care Program places a great deal of emphasis on supporting parents: arranging home visits to learn about the home context; helping parents manage their own stress relating to the child's situation; and helping parents develop the skills to become effective advocates for their own children. Although not every institution will have the capacity to arrange home visits and frequent telephone contact with parents or caregivers, supporting children with mental health challenges requires an understanding of parents as essential partners in the process. One-way communication from the school, for instance (whether of instructions or information about the child's behaviour), is far less desirable than regular two-way communication, including acknowledgement of the parents' stresses and challenges. A sense of common cause between child, family, school, and other professionals can be a vital asset in the effort for successful reintegration. Conversely, neglecting parents' feelings of defensiveness or of being unfairly singled out may degrade the parent-school relationship over time and ultimately undermine the child's progress. It is important to bear in mind that some parents may fear and mistrust a system they feel has let them down. Open, regular, and positive communication can make an enormous difference.

The evidence on family-school cooperation

Research indicates that family involvement in schools increases student achievement, higher grades, better attendance, greater completion of homework, with more positive attitudes and behaviour. Family-school relationships have been identified as primary domains of protective factors for children, particularly those living in high-risk circumstances.

Christenson & Sheridan, 2001

School visits by an educator, social worker, or any other professional who shares responsibility for the child's wellbeing and success

In cases where a child is being supported by a professional outside the school setting such as a social worker, educators, or counselor, it is extremely valuable for those professionals to observe the child's behaviour at school. Because negative behaviour is generally triggered by particular circumstances, gaining an understanding of those circumstances can help adults to support the child in adjusting his or her reactions. School visits can also help the non-school professional to understand the school itself—what resources and supports are available to the child, and which personnel are best positioned to offer support in the future.

Observation during class time

It is helpful to schedule observations during classroom activities where the child has had success in the past, and where the child has had difficulty. If a language class or mathematics class has been difficult for the child in the past, the observer from the Transitional Care Team should try to see how the child is now coping during these periods.

- **Is the child** focused, on task, listening to the teacher, cooperating?
- **Is the child** positioned so that distractions are at a minimum?
- **How** organized is the child? Does he or she have all the materials necessary to work? How is the child relating to the other students?
- **What** is the child's affect?

The observer will then typically communicate his or her assessments to the appropriate school personnel. This communication may be a telephone conversation, an email, or a meeting. If the child is progressing well, the team may choose to keep in close touch with a designated individual at the school to monitor progress. Should there be signs of regression, the team might continue observing directly, and would likely devise a plan to help the school to implement recommendations from the treating team in Child Psychiatry.

Observation during unstructured time

Children with mental health issues tend to have difficulty interacting successfully with peers. Also, unstructured parts of the school day such as recess and lunch often produce stress for children who have poor social skills, impulsivity, and low frustration tolerance. A shove that most children might assume to be accidental can be interpreted differently by a child with mental health issues. Depending on whether the child is able to recall and enact skills for dealing with the incident (pausing, staying calm, considering different interpretations of the event), he or she may respond unpredictably. Because these kinds of scenarios are typical during recess, observation of unstructured time can offer early warning of regression and can also give clues about possible solutions to social and behavioural challenges. (See also **page 34**, "The importance of unstructured time").

How to plan and conduct a school visit

The best time to conduct a school visit is when the visitor can observe the child's functioning in both structured (classroom) time and unstructured time such as lunch or recess. It is also important to schedule the visit at a time when you can talk to the teacher (s) and possibly other school staff either before or after your observation. For instance, meeting with the teacher before the school day begins, observing a first period and staying through recess is a good set-up.

Here is a description of the approach that the Transitional Care Team uses for school visits:

Upon arrival at the school

- **Introduce** yourself in the main office, likely to the school secretary. Leave some written information about the transitional care program for future reference
- **Ask** to be introduced to the principal if he or she is available. If possible and if this hasn't already been done, briefly outline the 6-month transition program and your role in it
- **Have** the secretary or the principal direct you to the child's classroom. Sometimes the teacher will meet you at the office if they have a spare period
- **The teacher** may or may not introduce you to the class. (On the matter of anonymous observation, see note on **page 17**).

Conversation with teacher(s)

Important topics to cover when you speak to the child's teacher(s)

- **Briefly** outline the six-month transition program
- **Check** if the child is coded (that is, identified as having special needs or a psychiatric diagnosis)
- **Ask** for the code number or the code name
- **If the child** is not coded but the teacher feels he or she should be, find out what information is required in order to establish coding needs. You will need to speak with resource or the principal to advance this process. The attending psychiatrist will carry out the necessary formal correspondence
- **Find out** if the child is taking medication, and, if so, how consistently
- **Find out** how well the medication is working
- **Find out** whether a communication book is in use and, if so, how it is set up and how effective it is
- **Ask** the teacher how you can be of service to him/her, and leave behind a business card indicating how you can be reached.

Additional areas to explore as possible

- **Learn** how the teacher sees the child's strengths and weaknesses
- **Learn** how the child relates to peers. Does he or she have any friends?
- **Learn** how the teacher sees the family, and whether he or she feels supported by the child's parents.

Remember to pay attention to the implicit parts of this conversation. Does the teacher seem to accept and support the child? Does he or she seem to understand the child's situation?

Observation

It is important to observe the child in both structured and unstructured activities, as some children may do well in one setting but experience anxiety or act out in another. Useful information to gather

- **How many** children are in the class?
- **Where** is the child seated?
- **Who** sits with/beside the child?
- **Is the child** able to remain seated when necessary? Does the child respect the boundaries given his/her seating arrangement?
- **Look at** the child's work area. Is it clean or messy?
- **When** the teacher instructs the class, how does the child respond? Is he or she active or passive? Compare this to the other children in the class
- **Is the child** able to find the appropriate work materials in order to follow along in the class?
- **Is the child** able to focus on the task at hand? If so, for how long? What causes him/her to lose focus? Can the child get back to the task at hand on his/her own, does he/she need a cue from the teacher or a peer or other outside support?
- **How quickly** does the child regress when an incident occurs that is either funny/silly or frustrating/challenging? Compare this to the class. How long does it take the child to regain his/her composure?
- **Does the child** instigate defiance or distraction? How easily is the child influenced by the noncompliant behaviour of peers?
- **In what manner** does the child interact with peers? How do the other children in the class respond to the child? What is the child's reaction?
- **What** is the child's affect in general? Is it appropriate?
- **Does the child** seem anxious? Do particular activities or environments seem to cause him or her stress?
- **Does the child** seem isolated? Or does he or she have companions in class and at recess?
- **When** the teacher instructs the child, how quick is the child to respond?
- **Do peers** seem to have as much influence over the child as does the teacher?

Cooperation between home and school

Because integration is an imperative in most schools, children with serious behavioural issues who might have been permanently removed from their community schools in the past are often kept on in their regular classrooms. Many children, given the right support, benefit from this approach and make good progress in their community schools. Integration can nevetheless present challenges for educators, who typically have large classrooms to manage. Cultivating a strong working relationship with families can help to ensure that structures and approaches are consistent both at home and at school. This consistency can go a long way toward promoting improved behavoiur.

Building school-parent partnerships is essential to success. Ideally, all parties in the child's life should be working together actively and consciously for the benefit of the child. This process may be imperfect and school personnel may also benefit from support and encouragement when dealing with complex cases. As discussed elsewhere in this document, the challenge of managing the behaviour of a child with serious mental health issues can put serious stress on the relationships between adults at home and at school. Remaining committed to the home-school relationship, however, is critical to the child's success. Improving this relationship can also create a virtuous cycle whereby cooperation improves consistency and structure both at home and at school, the child's behaviour improves, parents and teachers become less frustrated, and further cooperation becomes easier.

Strategies for managing children's behaviour

Use rapid reinforcement

For children with mental health issues, situations and interactions that are unproblematic for others may trigger outbursts. For instance, while most students in most schools can get through the average day without any conflict, for a child in treatment it may be a challenge to simply walk from the classroom door to their desk without incident. Special vigilance is necessary in order to catch negative behaviour before it gets worse. In this case, the adult in charge would ask the student to go back to the door and to try again to enter the classroom more calmly. Any time consumed by these kinds of corrections is "paid back" during free time.

Catching noncompliance early has two benefits. First, it enables the supervising adults to prevent the snowballing of negative behaviour (a common outcome when negative behaviour is not acknowledged as a problem). Second, it enables adults to better pinpoint where exactly the child's behaviour is breaking down—and therefore to understand and address the possible triggers for the behaviour.

Evidence shows that the most effective reinforcement of behaviour happens immediately. For instance, if a child is on time in the morning for the school bus, a parent should provide praise immediately; praise that is postponed until the end of the day may have little or no effect. A goal for teachers, child care workers, and resource personnel should be to "catch" children engaged in positive behaviors and praise them.

Use reward systems, and adapt them to increase their effectiveness

Praise is not always enough to reinforce good behaviour; sometimes tangible consequences are necessary. Charts that let the child accumulate stars, points, or check marks for good behaviour—and an agreement that enables the child exchange these for special activities (extra computer time, for instance)—can be effective.

In cases where poor behaviour has become a serious problem, it is sometimes necessary to strip the child of privileges and then give him or her the opportunity to earn these privileges back. In these cases a contract can help to make explicit the behaviours expected of the child, and the terms by which privileges can be recovered.

It can be helpful to set priorities in reward systems. We suggest highlighting three or four behaviours that are most disruptive to your class and also tracking one or two positive behaviours that are relatively easy for the child to achieve.

	AM Before recess	AM After recess	PM
Had all necessary books			
Completed homework			
Followed class rules: • **Raised hand before speaking**			
• **Remained seated**			
• **Completed classwork within required time**			
Polite to peers			
Polite to staff			

Deepen your awareness of individual children's patterns to make outbursts more manageable and less stressful for everyone

Change can be very difficult for children with psychiatric issues. It is useful to pay close attention to the triggers for individual children in order to be prepared. Look for the cues before escalation. For instance, does the child's body language change before an outburst, when he or she is becoming agitated? Keep in mind that adults' reactions play a part in the resolution; staying calm, patient, and reassuring can help to moderate the situation instead of escalating it. It is important to understand

- **the factors** that precipitate the negative behaviour
- **the factors** that increase or decrease the frequency of the behaviour
- **the context** in which the behaviour tends to occur.

Watch for regression, and try to figure out why it might be happening

If a child shows signs of regression or a parent feels his or her efforts at guiding behaviour are becoming less effective, a social worker or educators may help the parent to evaluate his or her existing approaches and consider how they might be adapted for greater effectiveness. This person might also help the parent think through any changes that may be affecting the child's behaviour

- **Have** there been any changes in the home, changes to the schedule, or changes to the child or parent's stress level?
- **Is the parent** feeling overwhelmed with the challenges of their child's care?
- **Is the child** overwhelmed with the pace of change?
- **Might they** require some practice and role-playing to help them get back on track?

Discharge from the Day Hospital program is a time when the child and family celebrate the child's success—but it is also a period of apprehension, because all recognize that these hard-won skills will now be tested in a new environment, and an environment in which the child's last experience was generally negative. The first three months following discharge are critical: behavioural difficulties can quickly snowball as children fall back into their old patterns.

Keep in mind that although it is prudent to be on top of the child's negative behaviour, a few signs of regression may not signal a gathering storm. Many children, having made great progress, go through periods of testing behaviours that did not serve them well in the past. They may in part be testing the school environment for reassurance that it is able to provide the necessary limits. Provided the child moves on from these experiments relatively quickly and without much intervention, they can be viewed as positive—confirmations of the child's new skills. We typically see this testing period in the third month after the child's return to school, when the child has become more comfortable in the new environment. As children become more confident in their own skills and in the school's ability to manage their behaviour, they will generally grow more compliant.

CASE ILLUSTRATION

Michael*, 6 years old, was referred to the Early Childhood Disorders Clinic due to his verbally and physically aggressive behavior at home and school, as well as non-compliance, anxiety, and perfectionist tendencies.

Michael was a bright boy who needed constant attention from authority figures; this mode of relating to adults negatively affected his relationship with his peers. When Michael did not get his way or became overwhelmed, he would become verbally or physically aggressive.

Michael had supportive, involved parents, but his mother was dealing with her own anxiety. She struggled to contain her concerns over Michael's lack of control when anxious, and she projected her fears of his regressing. The mother needed support to separate her own anxieties from her son's.

With support from the Transitional Care Team, Michael was able to maintain the gains he and his parents had made in treatment. Nevertheless, he continued to display an anxious, perfectionist style that might require further treatment in the future. In view of these ongoing challenges, one important role of the Transitional Care Team was to support the mother in encouraging him to separate and develop prosocial skills rather than regressing into a very dependent position.

*The name of the child in the case illustration has been changed.

Boundaries are critical

Although it is stressful teaching and supporting a child with mental health challenges, it is safe to assume that the child's stress is equal to or greater than that of the adults charged with his or her schooling. Children with mental health challenges typically require a very structured environment. With firm boundaries, these children are generally able to feel more in control. Children with behavioural issues typically push the adults in their environment to provide the necessary limits in an effort to feel safe. This awareness can be useful in responding to a child's negative behaviour.

Some general information on negative behaviour

A. Rudolf Dreikurs, who applied Alfred Adler's psychological model to managing behavioural issues in children, argued in his influential work "The Four Goals of the Maladjusted Child" (Dreikurs, 1947) that the child's main desire is to belong: every action children undertake in a school setting is an attempt to gain social status. Nelson, Lott and Glenn (2000) contend that children make assumptions about their importance based on the perception of their experiences. Children who are able to contribute to the group in a harmonious fashion experience acceptance from others. Unfortunately, not all children understand which actions will help to bring about the acceptance they desire. In an effort to belong, Dreikurs postulated that some children move through four goals of misbehaviour

- **Attention:** The child attempts to be noticed however they can. Unable to gain positive attention, the child will settle for negative attention, often at their own expense, which they view as being better than none.

What to do

- **Ignore** attention-seeking behaviour by drawing the child's attention elsewhere
- **Praise** on-task behaviour
- **Catch** the child being good.

- **Power:** When misbehaviour through attention-seeking does not bring about the desired response, the child moves to power-seeking in an effort to gain control.

What to do

- **Don't stoop** to the child's level. You won't model good solutions or win
- **Appear** calm in spite of the battle at hand while conveying your disapproval of the child's inappropriate behaviour.

- **Revenge:** Not able to gain control through power, the child moves on to hurt others in order to feel significant.

What to do

- **In an effort** to feel love the child may feel so rejected that he/she resorts to punishing others. Acknowledge the child's hurt/sadness
- **Remove** the audience. Don't allow the child to further shame himself/herself
- **Tell/show** the child you care.

- **Inadequacy:** At this point attention, power and revenge have not afforded the child the acceptance he/she desires. The child now feels inadequate. Learned helplessness now becomes a part of the child's role.

What to do

- **The misbehaviour** is now focused on not doing rather than doing. The child is now very discouraged. These children are typically more difficult to reach. Be cognizant of your feelings toward the child. You need to feel and convey interest in the child, accompanying but not over-reacting in your presentation
- **Look for** small successes and build on them to reinforce maturation and provide hope for positive growth.

It goes without saying, it is much easier to work with a child who is acting out than it is to effect change in a child who has given up hope.

Additional classroom management tips

- **A child** with a mental health issue should be seated near the teacher

- **If possible**, assign the newly integrated child classroom chores that will make him or her feel privileged (if deserved, of course)

- **Children** with attention deficit disorder (with or without hyperactivity) may require extra passes to leave their seats. Individual cueing can be helpful for inattentive children

- **Encourage** self-reflective behaviour to promote self-management. Try providing a sheet of "faces" for the child to fill in to depict his or her mood at different times. Ask the child to comment on his or her own behaviour at different times of day. Do not insist on total honesty; the real goal is consideration and reflection

- **Be very clear** about your expectations. Although we can all empathize with a child who might have a difficult home life or other struggles, it is important to present expectations clearly, and to ensure that rewards and punishments follow behaviour clearly and reliably

- **Some children** who are unsure of themselves act dependent, asking for help more often than necessary. Reassure the child that you will help when it's possible for you and necessary for them—but that help must not be constant. E.g. Try providing something like popsicle sticks that represent the number of times the child can ask questions; encourage him or her to consider whether it's really necessary to "spend" a question on some matters. Support self reflection and self regulation

- **A timer** can be helpful for these children to stay on track when doing homework. Breaking tasks down into smaller components can also be useful.

Strategies for supporting parents

Parents are critical to promoting the success of children with mental health issues. They also have a strong influence on their children's perception of school as fair or unfair, worth working at or not. This section outlines some strategies that social workers, teachers, and others can use both to improve their own relationships with parents, and to help parents care for their children effectively and consistently.

The value of support systems: Building a social network for parental support

Parents of children with psychiatric issues often experience considerable stress about being called away from work by their child's school because of a behavioural crisis. It can be effective for social workers or other professionals to encourage parents to think through contingency plans for these circumstances: how can the parent prepare for the call they dread from the principal? Does their employer offer any flexibility? Can someone in the family make themselves available for the child? Are there any neighbours or friends who might help out in an emergency?

Advice on homework, a common power-struggle in households of children with mental health issues

Although spending a short time on homework might seem like a straightforward task to an adult, for an elementary child who has spent all day in school, returning to a desk to work can be very difficult. They may be tired and frustrated from their day, and may need a break, which should be part of the afterschool routine. Have they had the necessary time to decompress from school? Have they had a snack, and possibly some physical activity? If yes, then parents can let them talk about their day for a short period (only a few minutes) and listen attentively. Next, parents should calmly but firmly say, "Let's get this done, and then you can go and play." They may test the parents' authority, but after a while children generally relax and do the work. Should the work be too hard, the parent should help the child complete whatever they can and write to the teacher (in the communication book) about the work that presented problems.

CASE ILLUSTRATION

One of the Transitional Care Program families was a single, self-employed mother and her son. Her son's previous suspensions from school had left her scrambling to cancel appointments with clients in order to care for her son at home. Leaving work to pick up her son at a moment's notice was very difficult for her. She was understandably worried about the effect this pattern would have on her livelihood. There was no family in the city she could turn to for help. A member of the Transitional Care Team suggested she find someone in the neighborhood who could babysit. As it turned out, she did have a neighbour who looked after her son during some afternoons. This mother worked out an agreement with this woman for emergency situations should her son receive a suspension. This diminished her stress about the possibility of being called away from work at the last minute.

Acknowledgment and management of parents' stress

Most parents worry at times about doing the right things. For parents of children with ADHD, Oppositional Defiant Disorder, or other mental health challenges, this worry is compounded. It is important that teachers, social workers, educators, and parents themselves recognize the scale of these demands.

Parents must take active steps to keep themselves healthy and fit to keep going. Breaks are important, especially for single parents. If family members or reliable neighbors are available, they might be of help. It is also important to schedule fun with the child so that the parent-child relationship is not one of relentless discipline.

It can be helpful for parents and children to take time to reflect together on the accomplishments they have made over time. It is easy to focus on the remaining problems, but marking progress can support everyone through less successful periods.

CASE ILLUSTRATION

A single parent we worked with was often exhausted by the attention and demands her daughter placed on her time and energy. Having few supports outside the family did not allow for many breaks. This dedicated parent often spoke of being exhausted and out of patience, and she worried for her child's future needs. Both mother and daughter needed other outlets separate from one another. Placing her child in a swimming program gave them some time apart, but what was most helpful was a support group the mother joined for parents who also had challenging children. This gave the mother a chance to both voice some of her needs and receive support to reduce her social isolation in solving parenting issues.

Discussing medication

Many parents do not like the idea of their children being medicated. There are various reasons for this, including concerns about long-term side-effects. There is a need for more psychoeducation on medication issues. It is a good idea to direct parents to speak to their child's pediatrician about their concerns.

Teachers or social workers may wish to remind parents that appropriate medication can help some children to be less impulsive and more focused, which can lead to success at school, which can lead to self-esteem—creating a positive cycle. It is also true that using medication now does not necessarily mean using it forever. Medications have to be reassessed yearly or more often in some cases (eg. new side effects, the child matures with puberty, gains weight) so school observations of changes should be conveyed to parents to discuss with the prescribing physician. But ultimately medication is a matter best discussed between parents and their pediatrician. Switching from short acting to long acting forms of ADHD medication can lead to less mood dsyregulation and more consistent dosing. Sometimes various medications have to be tried to find the one that is most efficacious and tolerated with the least side effects.

CASE ILLUSTRATION

Many parents worry about the consequences of long-term use of medication on their child's growing body and mind. In one case, the treating team at the Jewish General Hospital suggested to a family that their child be placed on Ritalin to see if his impulsive behaviour could be reduced. The parents preferred to try another approach, and turned to Omega 3 supplements. Over a period of several months this seemed to have little effect on their son's impulsive, disruptive behaviour. Though bright, the child was not able to keep up with the class work; this affected his self-esteem. The school was also reluctant to have the child join his class on school outings because of his behaviour. In our work together we continued to look at options for their child, and to discuss the parents' views and reasoning. After much careful thought and research the parents agreed to try Ritalin. Their son's focus did improve, and with time he was able to attend class outings.

Getting Individualized Educational Plans (IEPs) implemented

If a child has an Individualized Educational Plan (IEP) that is not being implemented, the social worker should encourage the parent to meet with the child's school principal and/or other personnel. It can be frustrating for all involved when the child's needs are documented, but the funding for the school to address them is not there. The first step is to learn whether the school has the resources to do what is necessary. If so, parents (perhaps with support from social workers) should ask for a timeline for implementing the IEP. If not, it will be necessary to look at resources outside the school. There are agencies, associations, and volunteer groups that may be able to help. Sometimes additional resources including computer aides or headphones have been requested on the basis of coding and can be reviewed during such school case conferences. But the first step is to get to the bottom of what's happening at the school and why.

CASE EXAMPLE

One of our children had an extensive IEP written by the school's teachers and school psychologist who had worked with him. Recommendations for a speech therapist and one-on-one teaching assistance were implemented where possible. The parents however, were very frustrated by their child's lack of progress. They convened a meeting with the school principal, teachers and psychologist to explain in detail the IEP, and to determine what was feasible in terms of the requested services. In their son's case, he needed more services than the school was able to provide. Understanding this helped the parents to initiate private services to shore up the gaps in the system's recommendations.

Starting the day on the right foot

Mornings are difficult in any household, let alone one where there is a child who has difficulty focusing and getting organized. The first step is communicating expectations clearly. Parents should inform their child of the morning schedule and include them in decisions where reasonably possible. Everything possible should be done the night before: clothes set out, bag packed, and so on. It helps to minimize distraction by putting toys away. Allow a certain amount of time for waking (this depends on the child's biological clock; some take longer than others). After the allowed time, the parent should inform the child that it is time to dress and come to the kitchen for breakfast. Should they not be ready, the parent should say calmly but firmly that it is time to eat and that in X minutes the school bus will be waiting for them.

If these steps are not enough, look to what is getting in the way. Others in the household? Are there distractions in the room? Tiredness? Lack of focus? Oppositional behaviour? Pinpointing the snag is the first step to addressing it.

School outings: to go or not to go?

Parents are often nervous about sending their child on school outings, which represent a change of routine and sometimes minor safety risks (such as navigating public transit or a short walk). It may be a good idea for parents to check in with school personnel to compare notes about the child's recent behaviour, and decide together whether he or she is ready. One solution for concerned parents is to volunteer to accompany the trip and oversee their own child. Prior to the outing, parents should talk to their child about their expectations for the trip, and try to anticipate any experiences on this particular trip that might cause trouble for the child.

Communication to keep family and school working together

A common complaint we hear from parents is that their child is being singled out. Once a child has been identified with behavioural issues, some parents say they feel their child is under a microscope. Teachers face the challenge of managing the child's behaviour while being sensitive to the child's sense of being treated differently.

It is worth communicating to the parent that even though the child may not be returning to the same teacher or class, he or she may have developed a reputation at the school for being volatile or disruptive. The child and family must acknowledge that past behaviour has taken a toll, and they must be sensitized to the fact that the school may have some apprehension about the child's return. On the other side of the relationship, teachers must be made aware of the parents'/child's concerns. They must also appreciate that helping the child adjust to the classroom again will involve some ups and downs. A general atmosphere of cooperation and goodwill between family and school is very beneficial to the child as he or she reintegrates.

Another major source of stress for parents is a sense of always wondering whether the child is misbehaving. (Some parents say they are never at ease unless their child is home with them, since this is the only time they can be sure the child is not causing trouble at school). One way to address this sense of always wondering is for the teacher or child care worker to fill in a daily checklist that tracks the child's behaviour and keeps the parent from having to worry whether no news is good news.

CASE ILLUSTRATION

The principal from M.'s school contacted the Transitional Care Team and explained that the previous day M had been playing outside with peers, began to lose a game and started to become aggressive.

Peers went to the teacher on duty and explained the situation. The teacher told the children, "If M. is aggressive, don't play with him." The same teacher wrote a note home to the parents to let them know of the incident as they had asked to be kept informed. Mom called the school back, angry, saying, "How dare you tell the children not to play with my son." She went on to tell the principal she intended to remove M. from the school.

In response to this incident, the Transitional Care Team coordinator made a call to the family that day and the Transitional Care educator visited the school the next morning. In conversation with the teacher, the educator raised the fact that M.'s mother had been upset by the sentence, 'Please talk to your son.' The teacher had not intended the sentence to be especially pointed (she said she often included it in correspondence with parents) but the educator suggested M's mother may have interpreted it to mean she wasn't doing her job as a parent.

The teacher then went over what had occurred the day of the incident. She explained, "When I asked the group what happened they all said 'M. did this, M did that.' When I asked M. for his side, he just walked away." The educator explained that M.'s disability makes it difficult for him to put his thoughts into words and that he needs support in this area. Indeed, walking away was likely the most positive way M. could find to deal with the situation at the time.

Prior to treatment, given the same scenario, the outcome would have had been different. M. would not have been able to contain his frustration about being unable to express himself and would have lashed out at the other children. The fact he was able to remove himself without aggression, although it seemed standoffish to the teacher, in fact represented great progress.

The educator gave concrete examples of how to help M. articulate his thoughts. In this scenario, a few approaches that may have worked include

- **Talking with the child individually**. Help him find the words he needs to articulate his thoughts.
- **Role-play**.
- **Helping the child to see** the incident from the other children's perspective.
- **Have the group come together** to discuss the incident, allowing each to hear the other's side.
- **Help the group to work out** how they would handle the same situation differently the next time.

In the end, it was decided communication between home and school be conducted over the phone with the parent, to avoid confusion.

Strategies for managing academic performance

Incomplete homework

The first steps are quite standard, and likely familiar to most teachers and school staff: contacting parent(s) by phone or in writing, and (if that proves ineffective) convening a meeting with them to discuss options for improving the situation. This meeting might address questions such as, What is the homework routine? How can the routine be changed so it works better? Is private tutoring an option?

If after these initial steps homework is still frequently incomplete, some additional measures may include

- **Recording expectations** and performance. Have the parent initial the agenda each day. This serves two purposes. First, it requires the parent assume a more active role in their child's education. Second, it gives the child the message that home and school are working together and that the parent supports classroom expectations. The agenda will also act as a record for incomplete homework and the parent's compliance or non-compliance

- **Enlisting extra help**. Although ultimately homework is the student's responsibility, most elementary school children require some parental support. Inquire whether the parent(s) are able to oversee the child's work. If not, explore whether someone else might fill this role (such as a tutor or older sibling).

If parents are not following through on ameliorating the homework situation, this is likely a symptom of a larger issue in the home.

The importance of unstructured time

Unstructured time is not easy for children with poor executive functioning skills. Recess, for instance, features an increase in stimulation, a lack of clear boundaries, and the opportunity to socialize with peers (with all the unpredictability that implies). As Judy Gradinger, one of the psychologists working in the Jewish General Day Hospital Program says, "Some children fail recess and lunch." Difficulty at recess or lunch interacts with (or leads to) difficulty in class; an episode in the playground can derail the child's whole day.

What looks like poor classroom behaviour at 11:00am may be a continuation of an altercation in the schoolyard at 10:00. The child who acts out after recess requires an adult to intervene as soon as possible to ascertain where the child's coping skills began to break down and to help the child come up with a plan for handling similar experiences in the future. If the full recess or lunch period is too much at first, the child may need to begin with a shorter span of time and increase it in stages. Can the child function successfully outside in the playground for the last five minutes of recess/lunch?
Once the child has mastered this time frame, increase the amount of time by small increments—five minutes or so. With each success, discuss with the child what they thought worked. Conversely, when things don't go well, discuss with the child what they think went wrong and how they could approach the same situation differently.

Over time, diminished incidents at recess and lunch will very likely improve behaviour and focus in the classroom.

Executive Function Skills (also know as cognitive controls) are more strongly associated with school readiness than are intelligence quotient (I.Q.) or entry level reading and math skills.

Blair & Razza, 2007

Strategies for helping children relate to others

Don't assume every child needs friends
Friends are wonderful assets for most children and adults—but it is worth pausing to consider whether the child you are dealing with wants or needs friends. Many children, such as those on the autistic spectrum, may be quite happy in the playground wandering around on their own. For these children, time alone can be an appropriate way to unwind from the stressors interacting all day in class.

If the child wants friends, help him or her to understand and overcome barriers step by concrete step
If the child does seek companionship but fails, the solution often has at least two parts: addressing the child's history with his or her peers, and developing strategies for building new relationships.

- **Addressing the past:** A child who has been in treatment and whose behaviour was previously troublesome may have a history with his or her peers that is likely not forgotten. Help the child to understand how their past behaviour affects their present relationships. Be concrete. Give examples. Talk about how you would feel in the peer's position. Discuss what the child needs to do to gain back the peer's trust.

- **Building new relationships:** Discuss ways in which the child can establish new relationships. Break this process down into steps, considering the mechanics of initiating contact. Who do you choose to play with? How do you get a peer's attention? What do you say to begin the conversation? What if the other child says, "no"?

The Evidence on Peer Relationships

Research indicates that the quality of children's peer relations in elementary school forecasts school avoidance, disruption and failure during adolescence; friendships can act as shock absorbers against life's pot-holes.

Ladd, 1990

Children with mental health issues often suffer from poor social skills, affecting their ability to make and keep friendships.

APA, 2000; Kutscher 2006

These children may have few friends and consequently be deprived of a context that fosters skill development and meets emotional needs. Friendships satisfy innate needs for affection and attachment; they foster feelings of self worth, and serve as prototypes for intimate relationships later in life.
Helping to support and connect these children with others is a key goal of our work. Interventions aimed at reducing peer rejection need to focus on both promoting positive social behaviours to enhance likeability, and reducing problem behaviours that are contributing to a lack of acceptance by peers.

Bierman, 2004

CASE ILLUSTRATION

Stephen*, 10 years old, was referred to Child Psychiatry at JGH due to autism-related behaviours: anxiety, sensory and auditory problems, aggression, poor social skills, oppositional behavior, and academic delays. He received the diagnosis of autism while in treatment.

After treatment, Stephen remained socially isolated but was not singled out or bullied, as he had been prior to treatment. The Transitional Care Team focused on increasing Stephen's independence and organization skills.

Although Stephen made tremendous gains in containing his frustration and aggression, he sometimes reverted to immature and resistant behaviours both at school and at home. His parents reported that he would sometimes, out of the blue, become defiant in public settings and could have outbursts that were embarrassing. Stephen and his parents would remain challenged, especially as adolescence approached.

The Transitional Care Team helped the parents to seek a support group in the community. The Team also helped Stephen's family find activities that were safe spaces where he could practice prosocial behaviours and use cognitive skills to compensate for his inability to comprehend emotional cues from peers and adults.

*The name of the child in the case illustration has been changed.

Building trust

Teaching, managing, and supporting children with mental health issues is all made easier if you can build a relationship of trust with them.

Trust is a big issue for the child who has had limited success in school. Hurt by their inability to function in class, these children can sometimes seek to limit their vulnerability by giving up. With that possibility in mind, it is easier to see signs of hope and potential when a child acts out and gets "in your face": these are attempts, however misguided, to be acknowledged and to connect. The child wants to engage on some level with the adult he is challenging. By contrast, the child who is entirely passive and withdrawn is more difficult to reach.

Bear in mind that these children can be more sensitive than they let on and that their aloofness may be purely for self preservation. Where possible find an "in" with the child, a point of reference. Humour can work well if the child is able to understand it and use it. Knowing a little about the child's personal life can also be an opening. Remember, children returning from treatment may not necessarily feel loveable, so your motives may be questioned. Keep your interactions simple and genuine and the child is likely to open up in time.

For the hard-to-reach child

- **Find out** what interests the child. "I heard you play hockey." Talk about it and be an attentive listener. "Hockey is a fun sport." Ask questions. "What position do you play?" Answer your own questions if you have to. "You look like you play forward." Describe what you see and make a statement. "I bet you're a fast skater." " It must be hard to catch up to you!" Keep it short, simple and move on but know you have been heard. The child who has been hurt or disappointed has no reason to trust that you have their best interest at heart. This will take time and you will have to earn it.

- **Connect** with a child through their interests. Engaging in a sport or activity the child is interested in puts less stress on the relationship. Over time the child will likely open up on more personal matters.

For the child with whom you do not have a relationship

- **Look for connections** the child may have with others. Fostering a relationship the child already has with someone in the school can sometimes help develop a relationship with the child and gain his/her trust.

CASE ILLUSTRATION

A brief example to illustrate the use of an existing relationship to intervene in a child's negative behaviour.

On an initial visit to the school of a referred grade-two student, a Transition Team member observed the child running in and out of the classroom and hiding in the school hallways. When the students in the child's class were instructed to be seated, the child would roam around. If the work became too challenging, the child would quickly regress, throwing papers and all his school supplies. The Transition Team staff member did not have time to build a relationship with the child, but was able to learn about the child's patterns and his existing supports, which included several weekly visits to the school's resource staff.

Reading was a classroom activity that often caused trouble for the child. He preferred to colour. Resource allowed the child to colour as a reward for reading. With the support of resource, Transition Team staff suggested the child make a story to accompany each of his pictures. Eventually the child was encouraged to make his story into a "book" which he was invited to read to kindergarten and first grade. The child went on to write and illustrate several more books, all of which were shared with the younger grades. Instead of saving up all the stickers he earned to give his little brother, the child was now able to take his stories home to read to his younger sibling. In this case, the Transition Team worker did not have time to develop a relationship with the child but intervention was needed immediately as the child's behaviour in class was falling apart. Transition Team staff worked initially with the teachers and support staff to stop the child's non- compliant classroom behaviour. Once the behaviour was under control, Transition Team staff profited from the relationship the child had with resource, using it as an "in" or entry point to help foster the child's esteem with self-published books.

WHEN TO CONTACT YOUTH PROTECTION SERVICES

If you are thinking about whether to report a child's situation to Youth Protection Services, the circumstances are probably serious enough to warrant that action. Before making a signalement, unless the situation is obviously urgent, you will want to have as much documentation as possible. This includes:

- **the agenda/communication book** you use to communicate with the family about homework, medication, and other issues
- **a record** of absences and late arrivals
- **a record** of the child's physical condition with time and dates
- **a record** of concerns expressed to you by the child with time and date,
- **a record** of conversations of concern with the parent with time and date and/or an account of the lack of correspondence with the parent(s).

Signalements can be handled in one of two ways. It will likely be clear based on the circumstances which is appropriate.

I) You can sit down with the parent and propose calling youth protection together with agreement on the reasons for requesting this assistance for the family and child, presenting this as a way for the family to receive help. If the parent(s) agree(s), this will have the best outcome. It is likely that the case will be picked up if the parent is asking for help with clear reasons concerning their child's high risk issues. You will be involved in the intake process and you may have the parent(s) on your side in future efforts.

2) You can also call Youth Protection unbeknownst to the family. Your call will be taken by an intake worker at the department of youth protection and kept anonymous. You will need the above documentation and/or a list of your concerns to make a case. Generally speaking, you will not receive feedback from Youth Protection services regarding the outcome of your signalement but you can follow up with a call if your concerns increase and no involvement is forthcoming. It is important to discuss concerns that might result in a signalement by school personnel so that the principal has clarified a safety plan.

What to look for and report

- **Physical** evidence such as unexplained marks and bruises are important to note.
- **If you suspect** sexual abuse, make note of inappropriate behaviour of the child towards their peers and/or adults.
- **In the case** of neglect, document how this inhibits the child's daily functioning. For instance, note whether the child frequently falls asleep on the desk, comes to school without lunch, or wears the same dirty clothes.

Youth protection personnel may ask if you know of any outside support the family is receiving such as CLSC involvement and the like.

Remember you are taking this action not just for the welfare of the child but for their family. Do not worry if you feel you do not have all the information/facts. Your call is important and while it may not be enough to warrant an investigation, it will be kept on file and may serve to support other calls regarding the family in the future.

CASE ILLUSTRATION

Ben*, aged 8 years old, was admitted to the Child Psychiatry Day Hospital due to his aggressive acting out with children and adults, difficulty with peers, and difficulty with transitions. He was oppositional defiant at home and school and extremely aggressive and violent. In addition to exhibiting poor mood regulation and high impulsivity with a lack of accountability, Ben made suicidal threats.

Ben spent a year in the Child Psychiatry Day Hospital, during which he made considerable progress. After this period, he was re-integrated into a community school—but not the school he had attended prior to treatment, as his parents were concerned that his history and reputation at his old school would cause problems.

The first months of re-entry were successful, with no major incidents. Ben's new school was very sensitive to his needs. The regression happened in the third month of his return to full school days. During a field trip, Ben aggressively attacked a teacher after flying into a rage. He was inconsolable, and was later suspended for a week.

School and home were very concerned about this regression and found it difficult to know how to hold him accountable. Although Ben was very capable, he was not pushed academically because of teachers' concerns about his behaviour and his emotional dysregulation (irritability and headstrong attitudes). Despite strategies implemented at school and home, Ben's behaviour continued to deteriorate, impairing his capacity for cooperation with school rules and social interaction. By the end of the Transitional Care Team's six-month contract, Ben continued to be violent toward children and adults and continued to test authority. His diagnosis of oppositional defiance continued despite treatment and support.

The Transitional Care Team reconsulted the child psychiatrist at JGH and adjusted Ben's medication, which did not help his behaviour. The team had to re-refer to a Centres de santé et de services sociaux (CSSS) crisis team and then involve youth protection. At this time, Ben's mother had great difficulty assessing the risks Ben presented to himself and others. She had difficulty making decisions about her own safety and was tolerant of violent and risky behaviors. She was distressed by the involvement of youth protection, since her family had had negative experiences with youth protection in the past. Youth Protection involvement made Ben's mother feel hopeless about Ben's prospects. The Transitional Care Team was able to provide critical support to her. She was able to use the support of the team to feel less guilty and more empowered. She remained engaged with her son while linking herself with other community resources (including CSSS and youth protection). The transition team was able to effectively bridge the services of the school board, CSSS, child psychiatry, and youth protection, building an alliance to the new team.

*The name of the child in the case illustration has been changed.

Typical timeline of the Transitional Care Program, as practiced by The JGH Transitional Care Team

This timeline indicates typical contact between JGH, the Transitional Care Team, the school, and the family. The combined knowledge of JGH staff and staff at the community school can do a great deal to support the child's transition.

MONTH 1

- **Child Psychiatry unit engages Transitional Care Team, refers family of child**
- **Transitional Care Team meets internally** to discuss what caused child's admittance to Day Hospital, what progress child made there, which approaches were successful in improving the child's condition and behaviour, which strategies to employ as the child reenters community school and what goals remain.
- **Transitional Care Team and the JGH staff convene a case conference with the child's school staff including the student services or psychologist from the school board if need be, for a discharge meeting on the unit**. Group exchanges information about what has worked and what hasn't during child's time at JGH. N.B. Teachers should make every effort to attend this meeting, which is generally extremely helpful to all parties; we find that principals are very willing to facilitate teacher participation in this meeting. Coding letters, testing, IEPs or other information important to the parent-child-school triad should be reviewed as needed.
- **Transitional Care Team meets parents/caregivers to discuss upcoming transition**, listen to concerns; parents/caregivers sign consent form permitting child's participation.

Anticipating problems: these early meetings with parents and school staff help to establish areas of concern and help the Transitional Care Team to anticipate problems. Some factors to establish during this period are:

- Is the child looking forward to returning to school? Have they been properly prepared for reentry to meet peers and their new teachers if it is the start of a new academic year?
- Is the school prepared for the child's return? What are the school's concerns?
- Does the child have a reputation at the school? Does he or she have friends?
- Does the school understand the child's diagnosis?
- Is there consensus at the school about how to manage the child, or do staff members disagree about how to proceed?
- If the child has learning difficulties, how severe are these?
- What resources does the family have for managing this transition (time, money)?

MONTH 2

- **Child has returned to school full-time**

- **Transitional Care Team requests appointments to observe child** (in class and during unstructured activities). After the observation, the educator may decide to meet privately with the child to discuss the integration process, or choose to postpone this meeting. Many of these children have had close relationships with the staff at the hospital and welcome the opportunity to hear of them, and to be reminded that the child's success is important to them. The Transitional Care worker may offer the child the opportunity to send a message, note, or drawing back to JGH staff. The child's connection to the JGH program/staff is important as it gives the Transitional Care worker a way to develop a relationship with the child.

- **Transitional Care Team meets to discuss case**

- **Weekly telephone contact between parent and Transitional Care Team begins**. Typically, first telephone session begins by reviewing the program in the home, discussing what has transpired since discharge, evaluating how the child's first full week at school has gone, and determining whether the communication booklet between home and school is being used. Parents are encouraged to discuss problems and difficulties with following through on the program.

MONTH 3

- **Educator continues to observe child at school**
    - any emerging issues?
    - is school following through on recommendations?
    - are family and school both using communication booklet well?

- **Weekly telephone contact continues**

Three months post-discharge is a high-risk period for regression. Transitional Care Team monitors closely at this point and convenes meeting with family, school, JGH psychiatry staff as necessary.

MONTH 4

- **Weekly telephone contact continues**

- **In-school monitoring continues**

MONTH 5

- **Weekly telephone contact continues**
- **In-school monitoring continues**
- **Discussions about and preparations for end of six-month follow-up period begin**

MONTH 6

- **Weekly telephone contact continues**
- **In-school monitoring continues**
- **Transitional Care Team discusses child's progress with family and school**
- At the conclusion of the six-month follow–up period, the Transitional Care Team discusses (internally) whether an extension to follow-up would be beneficial for the child and his/her family. If so, this extension is offered provided the family has been cooperative, following through on recommendations and treatment.

Guide to Appendices

Appendix A – Transitional Care Team information form. This form outlines information that should be gathered at the beginning of the follow-up process, as the child is first transitioning from the Day Hospital back to community school. The Transitional Care Team may not be able to gather all the information outlined in the form; teams should gather as much as possible. This information may be collected at or in advance of the initial team meeting. (See **page 20**).

Appendix B – List of mental health disorders. A list of diagnoses commonly diagnosed among children and pre-teens admitted to the Child Psychiatry Day Hospital of the Jewish General Hospital. The names of the disorders are as they appear in the American Psychiatric Association's DSM-5.

Appendix C – Behaviour contracts (3 examples). Contracts can be used to make explicit the behaviours expected of the child, and the consequences of enacting those behaviours or failing to enact them. (See **page 18**).

Appendix D – Guide to online resources. Links to useful websites.

Appendix E – Case Study of Transition Program participant.

Appendix F – References. Works cited in this document and further reading.

Child Psychiatry Transition Care Program

Name: _____	D.O.B.: _____	TCT ID #: _____
JGH program: _____	Admission: _____	Discharge: _____
Primary worker: _____	Ext: _____	Email: _____
JGH teacher: _____	Ext: _____	Email: _____
Family Therapist: _____	Ext: _____	Email: _____
School: _____	Phone: _____	Grade: _____
Address: _____	Teacher(s): _____	
Principal: _____	Contact: _____	Email: _____
CLSC: _____	Phone: _____	Email: _____
Consultant: _____	Phone: _____	Email: _____
Other: _____	Phone: _____	Email: _____
Follow-up start date: _____	Follow-up end date: _____	
Plan: 1) _____	Plan: 1) _____	
2) _____	2) _____	
3) _____	3) _____	
Mother: _____ Home: _____	Cell: _____	Email: _____
Father: _____ Home: _____	Cell: _____	Email: _____
Siblings/age: _____	_____	

Comments: _____

_____

_____

_____

APPENDIX B - List of mental health disorders

The various disorders listed below are those that are commonly diagnosed in the children and pre-adolescents the Transitional Care Team accepts to monitor post discharge from the Jewish General Hospital's Child Psychiatry Units. The names of the disorders are as they appear in the in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders - DSM-5. (American Psychiatric Association, 2013).

Anxiety Disorders

Anxiety disorders in children and adolescents include separation anxiety, phobias, generalized anxiety disorder, obsessive compulsive disorder, panic disorder and post traumatic stress disorder (American Psychiatric Association, 2013; Carr, 2009). Children with anxiety disorders typically experience intense fear, worry or uneasiness that can last for long periods of time and significantly affect their lives (Carr, 2009). Repeated absences from school, impaired relations with peers, low self-esteem, problems adjusting to transitions, and anxiety disorder in later adulthood may all be a facet of the disorder.

Generalized anxiety disorder is characterized by unrealistic worry about everyday life activities. Children worry unduly about academic performance, of being on time, or feelings of self-consciousness. Typically these children will feel tense, and will have a strong need for reassurance. They may complain of physical aliments like stomach aches or headaches.

Separation anxiety disorder is usually seen as a difficulty in leaving parents to attend school or sleep away activities, or in being alone. Often these children cling to their parents and have trouble falling asleep.

Obsessive compulsive disorder (OCD) refers to a condition where individuals are trapped in a pattern of repetitive thoughts and behaviours. Even though the individual may recognize that his or her thoughts or behaviours may seem senseless and distressing, it is a very hard pattern to stop. Compulsive behaviours may include hand washing, rearranging objects, and/or repeated checking.

Panic disorder is a condition of repeated "panic attacks" without an apparent cause. Panic attacks are periods of intense fear accompanied by a pounding heartbeat, sweating, dizziness, or feeling of imminent death. Children with this condition may go to great lengths to avoid situations that may provoke an attack. This may be seen as a school related situation or a separation from parents.

Phobias are unrealistic and excessive fears of certain situations or objects. The disorder typically centers on animals, storms, water, heights or being in enclosed spaces. Children will understandably try to avoid the objects or situations they fear, greatly restricting their lives.

Post traumatic stress disorder Children develop post-traumatic stress after they experience events such as physical or sexual abuse, being a victim of or witnessing violence, or living through a disaster such as a hurricane or bombing. The incident may trigger re-experiencing the event, strong memories, flashbacks or other troubling thoughts. As a result individuals may overreact when startled, have difficulty sleeping or avoid any associations with the trauma.

Attention deficit hyperactivity disorder (ADHD)

ADHD is currently the most commonly used term for a syndrome characterized by persistent over-activity, impulsivity and difficulties sustaining attention (Barkley 1997). It is well established that ADHD has a neurological basis, affecting some 6 percent of the population (Barkley 1997; Kutscher 2006). At the core of ADHD is the inability to inhibit distractions, to stay focused on the task at hand, accompanied with organizational difficulties that make a child "absent minded" or forgetful. A list of some of the behaviours or symptoms exhibited by children with ADHD are:

- inconsistent work and behaviour
- poor frustration tolerance
- excessive emotionality
- feeling frequently overwhelmed
- trouble with transitions
- poor organizational skills and poor sense of time
- angers frequently and quickly
- inflexible and explosive
- trouble paying attention to others, and often with poor reading and social cues
- lying, cursing, stealing and blaming others
- pushes away those who want to help
- trouble learning from mistakes
- live in the moment with possible thrill seeking

Children with ADHD are deficient of inhibition, of being able to slow down the process and evaluate the options before reacting. ADHD individuals have problems with executive functioning, such as planning, problem solving, and shifting attentional focus. Children with ADHD can be hard to live with – ask any parent, teacher or family member.

Attachment Disorder

Known medically as **Reactive Attachment Disorder** it is a markedly disturbed and developmentally inappropriate social relatedness beginning before age 5 years. For our purposes we use a broader term intended to describe a spectrum of overlapping categories. This would include problems with mood, behaviour and social relationships that arise from a failure to form normal attachments. This behavioural pattern is sometimes seen in children who have experienced numerous relational separations and changes in caregiving arrangements during infancy or were brought up in institutions or multiple foster homes (Brisch 2002).

The term refers to the absence or distortion of age appropriate social behaviours in the lack of social bonds with others. For example, children may endanger or injure themselves and are frequently involved in accidents that appear to have been flagrant risk-taking behaviour. These children do not reassure themselves in dangerous situations with a glance back at their attachment figure, the way a securely attached child would do in an anxiety-provoking situation. These children may seem driven in their behaviour, and fail to learn from their painful accidents (Brisch 2002). They may also organize their attachment relationships around physical and/or verbal aggression. This is their expression of a desire for closeness to their attachment figure. In school these children are "troublemakers" and often are oppositional and defiant (Brisch 2002). Their desire for attachment is understandably often misunderstood.

Infant attachment insecurity is a risk factor for a range of adjustment problems in later life (Carr 2009).

Autistic Spectrum Disorders

Autism Spectrum disorder (ASD) is a category including a range of complex neurodevelopment disorders characterized by social impairments, communication difficulties and restricted, repetitive and stereotyped patterns of behaviour (National Institutes of Health 2010). The autistic spectrum disorders previously were categorized as pervasive developmental disorder or PDD(nos), autism disorder, and Asperger's syndrome, but in the DSM - 5, the categories are: Social (pragmatic) Communication Disorder and Autism Spectrum Disorder

Social (pragmatic) Communication Disorder

Includes persistent difficulties of using communication for social purposes, impairment of the ability to change communication to match the context or the needs of the listener (such as shifting from classroom to playground settings, adult to child communication), difficulties following conversation or narratives, and difficulty understanding social inference, non-linear or ambiguous meanings which are part of every day communication.

Diagnostic criteria for ASD now outlines:

1. Persistent deficits in social communication and social interaction across multiple contexts, manifesting with impaired social-emotional reciprocity, deficits in non-verbal communication behaviours, and deficits in developing, maintaining and understanding relationships. Severity is based on social communication impairment and restricted repetitive patterns of behavior

2. Symptoms must be present in early development

3. Symptoms must cause clinically significant social, occupational or other functional restrictions.

4. These disturbances cannot be explained by intellectual disability (intellectual developmental disorder) or global developmental delay though these disorders may be co-morbid to ASD and could also include catatonia or associated medical or genetic conditions such as **Rett's syndrome**.

Conduct Problems

About one-third of children with childhood behaviour problems develop conduct problems, which is a pervasive and persistent pattern of disregard for rules and antisocial behaviours that extends beyond the family into the community (Carr 2009). Lack of self-regulation skills, problematic parenting practices, and extra factors such as high stress and low social support all contribute to maintaining conduct disorder (Carr 2009; Kutscher 2006). All of the disruptive behaviour (oppositional defiant disorder, conduct disorder, or child and adolescent anti-social disorder) are of concern because they may lead to co-morbid academic, emotional and relationship problems, and in the long term to adult adjustment difficulties (Carr 2009). These conduct problems are relatively common (Carr 2009).

The DSM-5 has added a category for **Callous and unemotional (CU)** traits which apply to a subgroup of conduct disorder children and adolescents who display distinct emotional and behaviorial traits showing no remorse and are less sensitive to punishment cues. Critics of this category maintain that there is yet little evidence to categorize younger children as psychopathic or having a stable diagnosis in this category.

Oppositional defiant disorder (ODD)

ODD is the least severe of the three types of disruptive behavioural disorders. ODD is marked by a pattern of aggressive, negativistic, hostile and defiant behaviour. There is a persistent pattern of actively refusing to follow requests, of over-reactions, losing one's temper, blaming others, angry, resentful and vindictive actions. Children with ODD may deliberately annoy others, and are likely to be argumentative with adults. ODD is rarely seen in isolation, rather its behaviour is usually a symptom complex resulting from some other underlying disorder of the syndrome mix.

About 5-15% of school age children meet criteria for ODD. As infants or toddlers, the ODD child may display irritability, stubbornness, rigidity, aggression, intense reactions, and tantrums. Sometimes these reactions are worsened by inconsistent or excessively harsh parenting techniques, or by family stresses. By school age, symptoms spill over to affect teachers, peers and other adults. The behaviours of the ODD child lead to increasing rejection and attention seeking behaviour (Kutscher 2006). Often the negative behaviours tend to improve with the treatment of the underlying problem (Carr 2009; Kutscher 2006).

There is evidence that oppositional defiant disorder embraces three subdivisional developmental trajectories of irritability (affect dyregulation), headstrong and hurtful behaviors which diverge from age 8 to 16 (Whelan et al. 2013). Aggressive acts in early childhood respond well to multimodal treatments and have good outcomes (Castellanos-Ryan et al. 2013, Tremblay et al., 1995) according to the literature. Dysregulated affect (irritability) with headstrong traits have higher risk when developmental trajectories are followed into adolescence.

Conduct disorder (CD)

Children with **CD** are more frequently overly hostile and aggressive, law breaking, with a lack of remorse. These children violate the rights of others, bully, threaten, and can display physical cruelty with people and animals.

Depression

The American Psychiatric Association makes the distinction between a major depressive episode, which is severe, versus dysthymia, a latent condition. Mood disorders can appear differently through the lifespan, especially as children may be unable to verbalize their sadness. The symptoms caregivers may see in children are irritability, getting into fights, or avoidance (Kutscher 2006). Alternately, children may present with physical symptoms such as headaches or stomach aches (Kutscher 2006). Older children may present with more typical symptoms such as sadness, loss of energy, low self-esteem and a lack of motivation (Kutscher 2006).

Children may be unable to put words to their feelings; therefore it is important to keep an eye out for a broad range of symptoms. Problems with sleep, problems with appetite - eating too much or too little, withdrawal or lack of interests, irritability, concentration problems, thoughts of death. The current literature indicates that medication with SSRI fluoxetine is approved for the treatment of significant childhood depression.

Selective Mutism (SM)

Known formerly as **Elective Mutism**, it is a condition of a consistent failure to speak in specific social situations, despite speaking in other settings. Children with SM are fully capable of speech and language but are not able to speak in certain situations when it is expected of them. The disruption interferes with educational or occupational success or with social communication. They may be severely withdrawn and some are unable to take part in group activities due to their extreme anxiety. Recent immigration is an additional stressor for some of these children.

Sensory Processing disorder

Sensory processing disorder is a neurological disorder causing difficulties with processing information from the five senses, vision, auditory, touch, olfaction and taste, in addition to the sense of movement and positional sense (Kutscher 2006). For those children with SPD, sensory information is perceived but is understood abnormally. This condition can be linked to autism spectrum disorders, attention deficit disorder, Tourette's syndrome and speech delays among others (Kutscher 2006). Sensory Processing Dysfunction is being used as an umbrella term that includes three distinctions of sensory difficulties; sensory modulation disorder, sensory discrimination disorder and sensory-based motor disorder.

Each child will have differing symptoms depending upon the type of dysfunction. One child may be hypersensitive to touch and movement, while another child may be hyposensitive to these same actions. He/she may not be aware of touch, or fail to realize their touch is too aggressive and painful to others.

Tourette's syndrome

This is an inherited neuropsychiatric disorder with onset in childhood (Kutscher 2006). It is characterized by the presence of multiple physical motor tics. These tics come and go most usually during the day hours. The more common tics are eye blinking, coughing, throat clearing, sniffing, and facial movements.

The severity of tics decreases for most children as they pass through adolescence. In most cases medication is not necessary, but there are medications and therapies that can help when their use is justified as the disorder can present in severe forms in early childhood. Psychoeducation is an important part of treatment.

Behaviour Contract, Example No. 1

This Agreement was made this 8th day of September 2xxx, between _____ the Transitional Care team at the JGH and _____ who will agree to comply with the behaviours listed below. Should she fail to respect the behaviours, consequences will follow. The consequences are the minimum and can increase if the misbehaviours continue or _____does not accept her consequences.

1) I will **respect** people and property around me.
2) I will **listen** to people in authority.
3) I will **follow** the basic rules of the classroom.
4) I will do the **work** assigned to me by my teachers.
5) I will not **behave** in an aggressive, violent or threatening manner either verbally or physically.
6) I agree to **participate** in extra-curricular activities.

Consequences:

If _____does not comply with any of the above behaviours, she will lose all entertainment privileges at home (e.g. internet, TV, MP3, video games, etc)..

Should _____ hair continue to be a distracting factor, it will be modified to a suitable length.

If _____will go one week with complete adherence to the contract, her father will reward her with a bonus of her choice at the end of the week.

The following people will uphold the above agreement.

X_____ Child

X_____ Parent

X_____ Transitional Care team

This Agreement was made this 12th day of January 2xxx, by and between _____

and _____.

_____ will have the following consequence if he uses any of the below

behaviours. The consequences are the minimum and can increase if the behaviour continues or

_____ does not accept his consequences.

1) Violence: Hitting, kicking pushing, any act of aggression

- Go to your room immediately.
- In your room for a minimum of 3 days.
- Loss all privileges (TV, computer, music) for 3 days.

2) Verbally Fighting: Yelling, arguing, insulting or threatening.

- Go to your room immediately, until Mom gives permission to leave.
- Loss all privileges (TV, computer, music) for a minimum of 2 days.

3) Swearing: Using inappropriate language (As defined by Mom).

- Go to your room immediately, until Mom gives permission to leave.
- Loss all privileges (TV, computer, music) for a minimum of 1 day.

4) Disrespecting Mom: Not following instructions, talking back

- Go to your room immediately, until Mom gives permission to leave.
- Loss all privileges (TV, computer, music) for a minimum of 2 days.

5) Dishonesty: Telling a lie, not telling the whole truth.

- Go to your room immediately, until Mom gives permission to leave.
- Loss all privileges (TV, computer, music) for a minimum of 1 day.

6) Stealing: Taking anything that doesn't belong to you without permission.

- Go to your room immediately, until Mom gives permission to leave.
- Loss all privileges (TV, computer, music) for a minimum of 2 days.

The following people will uphold the above agreement.

X _____ X _____ X _____

Child Parent Transitional Care team

I, _____, understand that I cannot be rude or disrespectful to any adult or

student at _____School.

There will be a zero-tolerance for any behaviour that is insulting or demeaning to an adult or another student.

If I cannot control my disrespect or rudeness towards others, I will be dismissed from

_____ School for that day.

I can achieve a check/tic for good behaviour (no rudeness or disrespect or bullying).
Until I am able to conduct myself in a respectful manner I will not attend Lunch, Recess, Gym or ERC with my class.
If I can achieve a full week of respectable behaviour, I will first be entitled to attend Lunch duty with the Kindergarten. If the positive attitude continues I will then be allowed to attend Gym, followed by ERC and finally, when I am able to achieve a positive standing with my teachers and the other students I will be able to attend lunch and outside recess. At this time, my ability to go on the school field trips will be reconsidered.

X_____ Signature: Child

X_____ Signature: Principal

X_____ Signature : Mother

Reward Schedule

- ☐ Lunch with Kindergarten
- ☐ Return to Gym
- ☐ Return to ERC
- ☐ Return to one recess
- ☐ Return to second recess
- ☐ Return to Grade 6 lunch

X_____ Signature: Teacher

Appendix D - Guide to online resources

1. A collection of links to useful online resources assembled by the Institute of Community and Family Psychiatry of the Jewish General Hospital.

http://jgh.ca/en/icfp-library-child-psychiatry-links-for-parents

2. The Offord Centre for Child Studies

http://www.offordcentre.com

3. The Canadian Mental Health Association

http://www.cmha.ca

4. Espace montréalais d'information sur la santé

http://www.cmis.mtl.rtss.qc.ca

5. Mental Health Commission of Canada

www.mentalhealthcommission.ca/the-facts/

Appendix E - Detailed Case Study

A six-year-old male child was displaying aggressivity, noncompliance and possibly ADHD. His parents were in the midst of a conflictual divorce. The school was unhappy with the child's behaviour and felt the parents were not supporting their efforts to help the child. The parents felt the school was too demanding and was not treating their son fairly or appropriately. The child was enrolled in the Day Hospital Program at Montreal's Jewish General Hospital (JGH).

The school reluctantly managed his behaviour at school during his time in the JGH program. After the child completed the JGH program, the transition team eased the reintegration of the student and his family into the school. The team helped to reestablish a relationship between the family and school staff, both teachers and administrators. To this end, a meeting with all parties, including JGH staff, was convened; clear plans for both school and family were articulated. Both parents were asked to participate in the meeting and to work together for the benefit of the child. This initial meeting was important because it enabled school administrators, teachers, and the family to feel their concerns were acknowledged and validated.

Once the family and school felt that they could work toward the common goal of student success, the transition team was able to observe the child's behaviour and make recommendations for interventions. These strategies included classroom behaviour management as well as interventions to promote positive peer relations.

In this case, there was insufficient communication and consistency between the parents and between the parents and the school. Therefore, the child received different messages from school and home, and the school felt unsupported by the family in their efforts. A communication book was created to allow the school to voice the positive and negative situations that arose during the day and to explain assignments. The parents were asked to write back to the school with pertinent information and responses to the previous day's comments.

Other behaviour management strategies included modifying and scaffolding work aimed at helping the student increase his focus and diminish his academic frustration. The transition team offered suggestions about the placement of his desk, for instance, and about which peer "neighbours" might help him thrive.

Clear guidelines for appropriate behaviour were established with the student, communicated to the parents and clearly and consistently enforced by all the teachers and support staff. These were codified in a behaviour contract. Likewise, clear and consistent rewards and consequences were established with the student, communicated to the parents and enforced by the teachers and support staff. These rewards were reexamined every two weeks to ensure that they were motivating the student to succeed.

Peer interactions were monitored closely to avoid triggering aggressive behaviour, especially outside the main classroom (gym, art class, library, lunchroom). The student was given a quiet spot in the classroom/hallway to retreat to when he felt overwhelmed or the teacher felt he was becoming overwhelmed. Deep breathing and relaxation techniques were encouraged to help avoid an aggressive episode and regulate his emotions.

The student also felt that he was able to express his feelings honestly to the classroom teacher. Although the student presented challenges, the teacher was able to discover how much to push the student without causing too much stress or fear. When explosions happened, the student understood the consequences but was not harshly reprimanded. The transition team worker was able to engage the student, and encouraged him to remember his teachers and experience at the JGH and to try to maintain the successes he had achieved in the program.

The Transition Team worker was able to provide emotional support and feedback to the school personnel. The fact that the Transition Team worker encouraged the teacher in the strategies that worked, helped fine-tune behaviour contracts, and listened to the trials and tribulations of the week made the teacher feel supported. After the school had encouraged and modeled consistency and positive communication, with support from the Transition Team, the parents began to see the improvement in the child's behaviour at school and worked to provide this stability at home.

Appendix F - References

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