

Changing Academic Support in the Home for Adolescents with ADHD

IT2A Provider Manual: May 2015

**Aaron Hogue, Molly Bobek, & Alexis Nager
CASAColumbia**

**Steven W. Evans
Ohio University**

**Chris A. Zeigler Dendy
Consulting LLC**



TABLE OF CONTENTS

INTRODUCTION	1
Adapting the Protocol for Adolescents with Absentee Caregivers	5
Module 1: Motivation & Preparation	
Home Academic Environment.....	6
1a: Review Clinical Profile of ADHD Symptoms and School Functioning	6
1b. Adolescent Engagement Interventions for School Problems	8
1c. Reframing Interventions for ADHD-Related School Problems	10
1d. Relabeling Interventions and Linkage of ADHD to School Problems	12
Module 2: Behavior Change	
School Attendance & Homework Plan	16
2a. Behavior Contracting and Incentives for School Attendance	17
2b. <i>Homework Management Plan</i> Intervention	18
2c. <i>Schoolwork Organization System</i> Intervention	24
2d. Promotion of Home-Based Tutoring and/or Organizational Skills Training.....	30
Module 3: Collaboration	
Therapist-Family-School Partnership	31
3a. Family Consultation on Special Education Rights and Services.....	31
3b. School Visit to Establish Collaborative Educational Plan and School-Based Supports.....	33
Primer on Special Education Policy and Resources	35
Fidelity Monitoring Checklist.....	43
Homework Management Plan Worksheet	45
CASH-AA: SCHOOL MATERIALS SUPPLIES LIST	49
CASH-AA: Bookbag Organization System Checklist	50
Assignment Planner	51
CASH-AA: Assignment Notebook Checklist.....	52
CASH-AA: BOS and ANC Tracking Sheet	53
Additional Resources	54

INTRODUCTION

ADHD Prevalence in General and Clinical Adolescent Populations

ADHD is a chronic childhood mental health condition that persists across the developmental span of adolescence and into young adulthood. Recent national prevalence data indicate that among children aged 14-17, 19% of boys and 10% of girls have received an ADHD diagnosis at some point in their lives, making ADHD the most prevalent behavioral disorder among teenagers. ADHD is also highly prevalent among adolescents in behavioral treatment settings, affecting between 20-50% of those enrolled in outpatient mental health and substance use services. These are conservative estimates given that ADHD is significantly underdiagnosed in adolescents and is frequently undetected when it co-occurs with other disorders for which teens are typically referred: oppositional defiant and conduct disorder, anxiety, depression, and substance use. There are approximately 2.8 million adolescents enrolled annually in outpatient specialty mental health care, along with 125,000 enrolled annually in outpatient substance use treatment; based on these estimates, the outpatient behavioral care system treats between 750,000 and 1.5 million teenagers with ADHD on a yearly basis.

ADHD in Adolescents is Linked to Impaired School Functioning

Adolescents with ADHD have well-documented behavioral deficits in attention, self-regulation, and social competence. These behavioral symptoms typically cause school behavioral problems that include inconsistent attendance, poor grades, disruptive classroom behavior, time management and planning deficits, and a disorganized approach to academics. Youth with ADHD also suffer a high rate of learning difficulties of several kinds. Like ADHD, learning disabilities are considered chronic conditions that require intensive intervention and ongoing management. These ADHD-related behavioral and learning problems together lead to greater incidence of grade retention, dropout, and need for in-school support services. Research has also begun to map neurocognitive risk factors associated with childhood ADHD that routinely persist into adolescence, particularly executive functioning deficits in planning, cognitive flexibility, working memory, and processing speed. Executive functioning deficits exacerbate, and may underlie, behavioral and learning problems experienced by youth with ADHD, and they affect social as well as academic functioning. Overall, the combination of poor attention and self-regulation, learning difficulties, and executive deficits compromises school performance and complicates treatment planning for adolescents with ADHD.

Medication is Often Not Enough to Address School Problems for Adolescents with ADHD

Many professionals recommend stimulant medication as a first-line treatment option for ADHD in adolescents. There is solid evidence that rapid-acting stimulants such as methylphenidate (Ritalin) are effective in reducing ADHD symptoms in teens, and recent data suggest that extended-release stimulants such as OROS-MPH (Concerta) are also safe, well tolerated, and effective in reducing ADHD symptoms for this age group. However, stimulant medications are not a panacea for treating adolescents with ADHD, for a variety of reasons. ADHD medication compliance declines precipitously from childhood through adolescence, likely due to the inconvenience, stigma, and side effects of medication, combined with decreases in adult monitoring and increases in adolescent autonomy and self-care. Many parents tend to prefer behavioral interventions to medication as a treatment option. A recent study found that adolescents could not reliably discern whether they were taking active ADHD medication or

placebo and rarely attributed behavioral effects to the given pill. Also, families of teens with ADHD frequently have trouble accessing medication services in behavioral care settings.

Most importantly, there is little consistent evidence that, beyond symptom reduction, ADHD medications improve school or social functioning in teens. The landmark Multimodal Treatment of ADHD study found that children assigned to a stimulant medication regimen who were still taking medication 6 to 8 years later showed virtually no significant advantages in academic functioning over study youth who were no longer taking medication, with the exception of math achievement scores. More broadly, a recent analysis of multiple longitudinal studies found that ADHD medication produced minimal gains in standard scores and negligible effects on school grades and retention/dropout rates across the age span. Thus for teenagers with ADHD, medications alone have not proven to be acceptable, accessible, and effective enough to reliably boost academic or social outcomes.

Childhood Behavioral Management Interventions Do Not Translate to Adolescents

Behavior management (BM) is intended to lead to behavior change by manipulating contingencies in the target environment. BM has been a well-established approach for childhood ADHD for over two decades and includes strong empirical support for several BM models, notably behavioral parent training, behavioral classroom management, and behavioral peer interventions (usually in the form of intensive summer programs). By definition, behavioral classroom management targets school problems in school settings; behavioral parent training and behavioral peer interventions also routinely target school-related issues as either primary or secondary treatment goals.

The evidence demonstrating BM effectiveness for ADHD symptom reduction and improved social and school functioning is restricted to elementary school children between 4 and 12 years of age. No randomized trials of the BM models have focused on adolescents. Given the many developmental changes that occur as children transition through puberty and into young adulthood, the effectiveness of BM for children cannot be generalized to teens in the absence of adolescent-specific research. Moreover, BM interventions for adolescents face steep implementation barriers in both home and school settings: teens are monitored by adults less closely than children; there are challenges associated with identifying salient behavioral rewards for adolescents; and numerous teachers interact with teens throughout the school day, with individual teachers seeing students for relatively brief amounts of time. It therefore appears doubtful that BM can be readily adapted to address school functioning in the older group.

Training Interventions are a Promising Approach for Treating School Problems in Teens

Training interventions (TIs) improve individual skills and, in some cases, provide reinforcement and punishment in the training setting for behavior change that occurs outside of that setting. TIs include social skills training programs, which have been tested in various formats for decades, as well as emerging interventions in the form of cognitive enhancement training (neurofeedback, working memory training) and organization skills training. Although early efforts at social skills training were not generally successful, recent TI models aimed at cognitive enhancement and organization habits show promise, although to date only organization skills training can be considered well-established. Unlike BM, TIs are individual skills-based interventions they do not rely on adults in the home and school environments to implement modified contingencies. This represents an obvious advantage in feasibility and flexibility for adolescents in various care settings.

TIs have been used in a few studies focused specifically on adolescents, with promising results for social and organizational skills training but no evidence yet supporting cognitive enhancement training. Almost all TI studies have occurred in school settings, a natural choice given that adolescents are difficult to engage in outpatient clinical settings and benefit from having services in easy reach as school-day or after-school programming. School mental health professionals in middle and high schools have implemented TI models by training students to organize their school materials, track and monitor assignments, and plan evening homework completion. Multimodal TIs that target impairments related to organization, academic skills, and social functioning have been implemented as both in-school and after-school programs in secondary schools and have produced improvements in academic and social functioning.

Need for a Family-Based Clinical Protocol to Improve School Outcomes for Adolescents

As stated above, TI programs located in school settings enjoy great leverage for targeting academic and behavioral outcomes among matriculating students with ADHD. However, behavior therapists working outside school settings also need to have effective tools to address school performance deficits in adolescent clients with ADHD. This manual describes one such tool, a modular protocol that combines evidence-based family interventions and TIs for adolescents with ADHD: Changing Academic Support in the Home for Adolescents with ADHD (CASH-AA). A family-based approach to academic interventions is well suited for overcoming limitations in the clinical reach of school-based TIs. First, clinical family interventions can directly target caregiver and youth motivation for school involvement among teens who are enrolled in outpatient care but disconnected from school. Second, they are an excellent vehicle for intervening in the family processes and home ecology of teens with ADHD in order to engineer more productive homework routines and stronger family-school connections. This includes incorporation of selected BM interventions (e.g., behavior contracting) as needed to promote school attendance among truant teens. In this manner, clinical family interventions can help prepare the home soil so that TIs take proper root among adolescents with ADHD.

Evidence Base for the Two Primary Components of the CASH-AA Protocol

CASH-AA integrates components from two evidence-based behavioral approaches: (1) family therapy models for adolescent conduct and substance use problems, and (2) TIs for adolescents with ADHD. The protocol is intended to supply research-proven tools for addressing school-related impairments that are highly prevalent among youth with ADHD and often non-responsive to pharmacological intervention.

Clinical family interventions to enhance school investment. Early research on family-based treatments to reduce parent-child conflict among families of adolescents with ADHD generated modest evidence of reliable treatment effects. Rather than targeting family conflict, CASH-AA clinical family interventions are designed to increase family motivation to make meaningful changes in school functioning. These interventions are drawn from empirically supported family therapy models for adolescent behavior problems. First, *adolescent engagement interventions* specifically address adolescent investment in working on school-related issues in therapy by (a) developing a personally meaningful treatment agenda for school functioning in which teens can be motivated participants and (b) (re)moralizing teens by generating hope that school-related problems can and will improve. Second, family motivation and change planning interventions are used to link adolescent school problems to family processes and create positive expectations for change. Specifically, *reframing* and *relabeling*

techniques are used to launch an ongoing therapy dialogue on connections among ADHD symptoms, family involvement in school performance, and family commitment to improve school outcomes. Third, *family-focused case management interventions* are also used to facilitate stronger connections between family members and school personnel to establish a school-located advocate for the teen's academic needs and foster improved school functioning.

Training interventions to improve academic performance. CASH-AA training interventions have two foci: homework planning skills and organizational interventions for managing school materials. Controlled studies across multiple school settings have demonstrated that these TIs result in long-term benefits for many adolescents with ADHD in non-academic outcomes (ADHD symptom reduction and enhanced social functioning) and academic outcomes (improved organization of materials) that are related to improved classroom performance and grades.

CASH-AA Protocol: Brief Overview

CASH-AA is a family-based clinical protocol intended for use in outpatient care with adolescents diagnosed with ADHD as either a primary or secondary disorder. Each module contains specific treatment aims and behavioral interventions that might be implemented in a single session or as a continuous intervention sequence across multiple sessions. It follows that the length of time needed to complete each module will vary greatly depending on the profile of the given family, practice habits of the provider team, and progress of the case. The Appendix contains the **CASH-AA Fidelity Monitoring Checklist**, which lists the 3 treatment modules and their respective interventions components.

CASH-AA is designed to be a resource for this difficult-to-treat population that packages research-proven clinical family interventions and training interventions that can be readily implemented in a variety of outpatient care settings. The protocol contains several features intended to heighten its compatibility and sustainability within the everyday working conditions of behavioral care. It can be utilized as a stand-alone intervention for ADHD, or as an adjunct to other interventions for co-occurring disorders and referral problems. It can be delivered in conjunction with family-based treatments or with individual-based treatments that allow inclusion of caregivers in multiple sessions. It contains treatment modules that can be initiated and completed at any point in treatment based on individualized treatment planning. Importantly, the protocol does not require clinical resources or training beyond what is contained in the treatment manual or otherwise widely available to treatment practitioners. And because CASH-AA interventions are fundamentally psychosocial rather than educational in nature, they are easy to adopt and implement by most behavior therapists who are experienced with adolescent clients.

Adapting the Protocol for Adolescents with Absentee Caregivers

CASH-AA is fundamentally a family-based protocol, in that the three modules contain interventions that directly target caregiver motivation about school performance, caregiver monitoring of school attendance and homework, and family relations with school personnel. For therapists utilizing individual-based treatment for a given adolescent, CASH-AA will be maximally effective if caregivers can be included in those sessions during which protocol elements are delivered.

However, it is commonly the case in adolescent behavioral healthcare that caregivers are inconsistent or unavailable for inclusion in therapy sessions, for any number of reasons. In such cases, most elements of the CASH-AA protocol can be effectively delivered with some degree of adaptation. Clearly, interventions that directly target caregivers will not be feasible. Instead, for some protocol elements the therapist may be able to indirectly achieve caregiver or family-wide goals by working exclusively through the adolescent.

Throughout this manual, information is provided on strategies to consider when working with adolescents alone; this information is highlighted at the end of each relevant Subtask in boxes titled “Working with Adolescents Alone.” In addition to employing these strategies to adapt the protocol, it is important for therapists to explore and validate with teens the expected difficulty of making important changes without the caregiver participating in therapy with them. And as teens make changes in their academic approach, it is useful for therapists to revisit caregiver absenteeism, potentially leveraging the teens’ success as impetus for invigorating caregiver participation.

Module 1: Motivation & Preparation: Home Academic Environment

The clinical aims of this module are to engage adolescents as active participants in therapeutic activities aimed at improving their investment and performance in academics; launch an ongoing therapy dialogue on connections among ADHD symptoms, academic involvement, and family commitment to change; assess specific home environment characteristics that support and impede school involvement; and determine caregiver and adolescent readiness to make changes in the home setting to support academic activities.

Specific intervention components of Module 1:

- 1a. Review clinical profile of ADHD symptoms and school functioning
- 1b. Adolescent engagement interventions for school problems
- 1c. Reframing interventions for ADHD-related school problems
- 1d. Relabeling interventions and Linkage of ADHD to school problems

1a: Review Clinical Profile of ADHD Symptoms and School Functioning

Diagnosing ADHD in Adolescents

The starting point for CASH-AA work is confirmation of an ADHD diagnosis for the adolescent by a credentialed practitioner. Determining whether an adolescent meets diagnostic criteria for ADHD can be quite challenging because: (1) Caregivers and teens often have (very) different perspectives on the presence and severity of the various symptoms; (2) Caregivers may have difficulty sorting out normative (or nearly normative) behaviors that reflect developmental maturation from those that are symptomatic; (3) ADHD symptom expression may change dramatically over the course of development (e.g., from hyperactive behavior in childhood to fidgety/restless behavior in adolescence), such that they are not easily recognized by family members as part of the same “condition”; (4) Caregivers may not be acute in distinguishing ADHD symptoms from other behavioral problems (particularly oppositional behavior) that frequently co-occur with ADHD; (5) The school context may not be familiar to caregivers, so behavior likely to occur only there (e.g., inhibition required in a classroom setting) may be challenging for them to identify. (6) By the time teens reach high school age, they and/or their caregivers may have become so accustomed to the ADHD symptoms and their impact that they are perceived as part of teen’s personality or temperament—syntonic to who they are—and as such, they need not or cannot be treated.

Collecting School Performance Data

The vast majority of teens with ADHD have long histories of academic problems ranging from moderate to severe, depending on the level of academic support and interventions during earlier years. School behavioral problems, academic underperformance or failure, and truancy issues are common among adolescent clinical populations with ADHD. These and related issues typically appear on the list of primary referral problems for teens with ADHD and are usually assessed during routine clinic intake procedures. Thus, this type of clinical information is easily obtained for treatment planning purposes.

However, family self-report of school problems, though invaluable, is not sufficient. *The CASH-AA protocol stipulates that therapists should communicate directly with school personnel to gain a full understanding of the depth and breadth of the adolescent's academic problems, as well as the available solutions and supports at the given school.* There are three reasons for this stipulation. First, this information is required for confident diagnosis. Moreover, it is required for a specific diagnosis: What exactly is the problem? Especially among teenagers, multiple other disorders—*anxiety, mood, conduct*—can singly and collectively induce symptoms that mimic or cause attention deficits and behavioral excesses, particularly among adolescents and families who experience a routinely high degree of life stress. Because comorbidity is the rule rather than the exception for ADHD, it is critical that providers obtain school-source information on potential ADHD symptoms during school hours—inattention, restlessness, impulsivity, emotional volatility—that corroborates the accuracy of the ADHD diagnosis. Second, only school personnel can provide highly reliable data on the history and current standing of grades, test scores, behavioral issues, school status, and when indicated, options for special education services. These data are essential for designing effective, personalized interventions within the CASH-AA protocol. These data also present potential treatment goals that (can) have immediate value to the teenager and can be easily measured and monitored to gauge the practical success of interventions. Third, assessment-focused consultation with the school sets the stage for Module 3 activities aimed at developing a strong working partnership among family members, involved school personnel, and therapists.

Assessing Family Attitudes and Experiences with School Achievement

In order to properly contextualize the school performance of the adolescent, as well as fully understand the existing home academic environment, the therapist should carefully assess the educational experiences of the primary caregiver(s) and other family members who live in the home. This includes the highest level of education achieved by close family members, history of failed or otherwise negative school experiences, and current expectations for the teen's school performance. These and related issues will help illuminate the degree to which the caregiving system is invested in education and prepared, both motivationally and experientially, to provide tangible support toward meaningful change in academic and behavioral success. Note that in many families with relatively high stress levels and modest coping resources, teens will be encouraged to succeed but expected to independently set and reach goals that lead to that success. Assessing these contextual factors is essential for designing feasible and sustainable changes in the home environment.

Working with Adolescents Alone

The therapist can query the adolescent regarding the educational experiences and expectations of caregivers and other adults living in the home. The teen's own perceptions of the "educational context" in the home can provide a great deal of insight into what academic interventions are needed and what barriers and boundaries to treatment planning exist.

1b. Adolescent Engagement Interventions for School Problems

Adolescents with ADHD often have a constellation of additional behavior problems: oppositional behavior in the home and school, school achievement problems, school failure and truancy, compromised relationships with family and friends often associated with childish or impulsive social behaviors, and sometimes more severe problems such as conduct disorder and substance misuse. These problems create multiple obstacles for the adolescent in relating to family members and being invested in therapy. Also, the adolescent's inattention, emotional immaturity, restlessness, and irritability are frequently interpreted as laziness, selfishness, and manipulation by frustrated and overwhelmed caregivers. As a result, adolescents often arrive for treatment warily, feeling embarrassed, misunderstood, blamed or scapegoated.

Also, many adolescents with ADHD enter treatment feeling ineffective and hopeless about positive change in the school domain, wherein most have experienced a long history of difficulties, disappointments, and failures of varying degrees. They have often given up on being successful in school, being recognized as talented or hard-working in non-conventional ways, and obtaining concrete rewards or personal satisfaction within the school context. Consequently, one of the therapist's primary tasks is school (re)moralization: generating hope within the adolescent that school-related problems can and will improve. To this end, therapists can present themselves as potent allies for teens, capable of helping them set personally meaningful school goals and make tangible strides toward accomplishment.

Formulating Personally Meaningful Treatment Goals for School Performance

Effective therapy involves the definition of specific treatment goals. The therapist uses the adolescent's concerns and complaints in order to craft school-related treatment goals that are personally meaningful to the teenager. Also, therapists want adolescents to feel that therapy is a context in which their unique concerns can be met, so that therapy will be considered personally worthwhile. Therapists are called on to assure teens that treatment will not only address their caregivers' complaints but will also attend to their own viewpoints, concerns, and aspirations. For example, therapists might say, "Your mother thinks that you don't succeed in school because you're lazy. I know it's more complicated than that. There's probably a lot your mother doesn't understand about what is going on with you. One of the most important parts of this therapy is going to be helping your mother hear your side of the story". Therapists make the point that treatment is not going to be just about getting teens to listen more to their caregivers; instead, it will also be a place where teens can voice their fears, frustrations, and needs. Once school-focused treatment goals are formulated, therapists periodically check in with teens to ensure that they endorse and are invested in these goals (e.g., "Does this sound like it is still worthwhile working on?"). Furthermore, at various junctures in treatment therapists will assist teens in the identification of new or revised goals as indicated.

Establishing Adolescent Investment in School-Related Treatment Goals by Making Them a Collaborative Venture

Emphasis is placed on building and then maintaining the teens' personal commitment to the process of working on school issues in treatment, thereby making these treatment goals a collaborative venture that is equally shared between therapists and teens. This process involves helping teens become actively involved in working on these issues (e.g., "This is a place for you to express your concerns about school") and building on the therapeutic relationship (e.g., "I'm

here to listen to your side of the story, I'd like you to trust me with it"). Therapists accomplish this by presenting the enhanced value of a "team" effort, fostering a "we" bond with teens, instilling hope, and sustaining a joint vision of goals and problem-solving strategies. Ideally, therapists will begin to build adolescent investment in this domain by first meeting alone with teens to access (relatively) candid attributions and goals, then meeting conjointly with caregivers to cement this investment and negotiate a concrete working agenda for addressing the problems during treatment. As needed, the teens' personal investment in the treatment process, and explicitly collaborative contract with therapists, is reinforced over time.

Addressing Real or Perceived Apathy Towards School-Related Goals

As discussed above, a history of school failures may lead teens to feel or present as apathetic towards school success. Facing a legacy of not meeting teachers' expectations and not having positive experiences of learning and being rewarded for that learning can lead teens and caregivers to become disinvested from school success. Even if a teen has not "given up" entirely on school success, it may feel easier to present as apathetic rather than appear as trying and failing. Two approaches can be used to mitigate the problem of apathy, and both steps can be categorized as a part of building an alliance with teens. The first step is validation: meaningfully understanding and reflecting the origins of the teens' apathy, and why it "makes sense" given their personal history. Therapists are eager to respect, listen to, and care about teens' experience of school as too challenging or not engaging. Therapists can also understand and validate caregivers' experiences of school as being demanding or intractable. In order to promote school success in the future, therapists must believe it is important to elicit teens' personal story of school successes and failures, and attend to the teen and caregiver needs and complaints about school.

The second step in responding to apathy is identifying, encouraging, and facilitating the growth of motivation. The main question to address is not why a given teen is unmotivated; the more productive question is, "For what is this teen motivated?" Therapists seek to elicit hope and a renewed sense of possibility for the teens' school career. Therapists' own hopefulness is critical to this effort, as well as understanding long-term goals that teens may harbor, and then supportively connecting those goals to specific, realistic, and achievable school and treatment goals. Therapists coach and encourage teens in developing specific goals for school and praise their efforts in this regard. When therapists sincerely praise these efforts, they are also modeling for caregivers a way to support teens who are working to make meaningful changes in school. Reframing school success for teens with ADHD is also an important part of encouraging motivation, for example, recognizing that the markers and standards for judging grade achievement for teens with ADHD may be very different from those applied to peers or siblings without ADHD. Effort and specific successes are important for therapists to track and bring attention to. Importantly, positive change in one aspect of school functioning can be used to prompt and bolster change in others.

In addition to demonstrating hopefulness and optimism about change, it is important to also be realistic.

Therapists must help define **clear expectations** for caregivers and teens about **what can be realistically accomplished, and on what timeline**, with regard to improving homework management and school performance—for teens with ADHD in general and for the given teen in particular.

There are points in a school year for some students when they have already failed to a degree that they cannot pass a given course regardless of what they do. It is important to know when that is the case; caregivers and teens are not always reliable sources for this type of information. Obtaining a release of information from caregivers that can be used to contact teachers can be very helpful to confirm teens' status in their classes. Although some teens may be unable to pass some of their classes due to poor performance, they usually have at least one other course that they can pass. Focusing teen and family efforts and hopes on these classes can allow therapists to maintain optimism within realistic parameters.

1c. Reframing Interventions for ADHD-Related School Problems

Principles of Relational Reframing of School Problems for Families with an Adolescent with ADHD

Families who come to therapy are usually focused on the problematic behavior of the adolescent. They expect therapy to do more of the same. Part of the therapist's job is to expand and redefine the purpose of therapy. Reframing interventions focus on (1) the ways in which family interactions influence, and are influenced by, the individual adolescent's symptoms; and (2) emphasizing that the relational bond between parent and teen is a key "solution" to problems related to adolescent symptoms. A benefit of this reframing strategy is that it circumvents battles over "right" and "wrong" and generates dialogue about interpersonal strengths, weaknesses, failures, and potential repairs.

For families of teens with ADHD, the overarching goal of reframing school-related problems is to guide families away from discussions that cast ADHD-related school deficits as individual problems and recast them as family-wide concerns. To accomplish this, clinicians engage families in describing (1) how school problems affect the emotional valence and everyday functioning of the home and (2) how families respond to (and perhaps exacerbate) these problems on a regular basis. Of course the intention is not to broaden or deepen negative attributions about teens or the school problems themselves. On the contrary, clinicians hope to make family members more aware of how they affect one another, which relieves teens from bearing the exclusive burden of the issues and opens the door to working on the family-centered resolutions contained in the remainder of the CASH-AA protocol. By shifting focus away from complaints about individual teens and toward the solutions and accommodations that can be enacted by families as a whole, clinicians look to take the heat off teens, lower defensiveness and reduce the likelihood of hostile exchanges or escalating negativity in session, and prompt (renewed) investment from all parties in changing how the family and home environs support teen school achievement.

Relational Reframing for Adolescents with ADHD: Exemplar Therapist Statements

“Right, he won't listen, he can't focus, he doesn't seem to care about school at all—so you've given up on trying to help. But that leaves him with no anchor in the house at all, no one to hold things in place and help him set course.”

“Everyone walks on eggshells around him, not wanting to trigger an explosion—and maybe someone triggers him on purpose sometimes, to get back at him.”

“So when Thomas stays out late, dad begins to lecture, they both start to yell—and Thomas is out the door again.”

“Tiana’s school failures are very frustrating to you, but also very scary—that kind of worry can wear you down, weigh down the whole family, which makes it even harder to know what to do.”

“If he’s going to get through this, to make the changes required to get back on track, he’s going to need you to be there for him at every step—he can’t get far without you.”

Motivating Families to Make Changes to the Home Academic Environment

Reframing school deficits as family-wide problems with family-centered solutions also creates the opportunity to collaboratively assess the (1) the motivation of caregivers and teens to make needed changes in the home academic environment and (2) the capacity of caregivers to be involved in reconfiguring the home academic environment, which involves a realistic appraisal of the routine availability and commitment of caregivers to actively support and monitor their teens’ academic activities at home. Building motivation and capacity to upgrade the home academic environment is excellent preparation for the success of Module 2 interventions, particularly homework management planning.

Teens with ADHD often have difficulty structuring and managing time at home in order to complete all homework assignments along with chores and other activities. Teens may spend a great deal of time each evening watching television, interacting on-line, or playing video games. They may also have caregivers who are minimally involved in structuring homework time and providing consistent behavioral guidelines. Ultimately, poor time management may result in poor grades, reduced academic self-efficacy, and increased family conflict. Therefore it is important for therapists and families to conjointly establish the motivation/rationale for good time management in the evening: benefits such as completed homework and less hassle from caregivers/teachers; and avoidance of consequences such as missed assignments, poor grades, and general stress/anxiety. As described in Module 2, the Homework Management Plan relies on a structured evening routine to assist teens with time management by designating intervals of time during which they will complete certain activities. That intervention also requires family cooperation and caregiver monitoring to help ensure that teens follow the schedule.

Reframing and Home Environment Change: Tips for Working with ADHD Clients

- Because ADHD symptoms are chronic, even with medication in place, it is essential to devise a *family* solution to *individual* school problems.
- Because ADHD is essentially an individual and chronic condition, therapists and families can be less concerned about the appearance and expression of ADHD-related symptoms, and more concerned with how family dynamics contribute to the observed pattern, severity, and maintenance of school-related problems in the home and school settings.
- Caregivers of kids with ADHD often experience greater caregiving challenges in the home and outside the home—thus there is additional stress and pressure on the

caregiving system. It can be reassuring for caregivers of ADHD youth to have their difficult (often painful) experiences with the teens' school performance normalized, and their previous efforts to support teen school success validated, by therapists.

- Some common ADHD symptoms present particularly large barriers to school success (e.g., severe distractibility, impulsivity). Therapists should engage families in describing (1) how particular ADHD traits affect the emotional valence and everyday functioning of school and home academic environments and (2) how schools and families respond to (and perhaps exacerbate) these symptoms when they arise. This can lead to discussion of how families may interact differently when these symptoms are addressed, and hopefully moderated, by interventions such as those contained in the CASH-AA protocol.
- When assessing family motivation to improve the home academic environment, therapists can help families make the connection between suboptimal home support and school problems. For example, failure to effectively manage time often leads to incomplete or missing assignments, failure to study adequately for tests and quizzes, and caregiver-teen conflict over neglected school and home responsibilities. At the same time, therapists can prompt discussion about practical changes to the family routine that would better support academic success, with an eye toward the Homework Management Plan interventions of Module 2.

Working with Adolescents Alone

Reframing interventions will likely have modest impact without the ability to assess and engage caregivers directly in making emotional and behavioral shifts in family processes. But therapists can still leverage individual motivational work with teens in order to establish a strong rationale for making meaningful changes in how they restructure their personal environment at home. Indeed teens can be empowered to act as the main (or sole) impetus for change in this area: “You can accomplish so much for yourself! And I’ll do my best to help you figure out how to make it work.” If teens are successfully engaged in therapy without a caregiver, they are already demonstrating a capacity to make positive changes in their own lives in an independent way.

1d. Relabeling Interventions and Linkage of ADHD to School Problems

Principles of Relabeling for ADHD Families: ADHD Acquittal and Rewards

Family members of adolescents with ADHD typically enter therapy with strong negative attributions about the teen's ADHD-related school deficits, invoking labels such as lazy, irresponsible, and disruptive. In such cases, the therapist can help set the stage for long-term change by actively working to change the perceived meaning—or the perceived “motivation”—underlying ADHD-related behaviors that affect school performance, such as inattention, impulsivity, disorganization, immaturity, and mood lability (i.e., temperamental behavior). This involves a kind of cognitive intervention known as *relabeling*: altering negative attributions about a given behavior by emphasizing the heretofore unrecognized or mislabeled cause of the behavior. In general, therapists attempt to relabel a perceived negative behavior in order to

change the meaning or value of that behavior by casting it in a more benign light. Relabeling techniques are effective to the degree that they successfully (1) suspend the automatic negative thinking and response patterns in families; (2) require family members to actively search for new explanations of problematic behavior; and (3) offer a new perspective allowing for more effective and less painful communication and expression of feelings.

For adolescents with ADHD, relabeling can be used to decrease negative and blaming attributions about ADHD-related school problems by articulating either: (1) how those problems are directly linked to the teens' ADHD, a neurochemical condition that is not (wholly) controlled by the given teen; or (2) how several "problem" behaviors may also have positive or adaptive features. To set the stage for relabeling interventions, therapists can emphasize the following basic facts about ADHD in teens: ADHD-related characteristics are chronic (i.e., persist to some degree throughout adolescence and young adulthood), neurochemical (i.e., primarily outside teen control), and adaptive in some contexts (i.e., has social benefits for teens and others).

The first kind of relabeling intervention, called *ADHD Acquittal*, takes the following form: recasting or excusing a negative behavior for which adolescents have been deemed "at fault" by pointing out the ADHD characteristic(s) that underlie or give rise to the behavior. This kind of relabeling moves families away from a negative attribution (ascribing a blameworthy behavior that is under teen control) and toward a benign attribution (accepting a common ADHD characteristic that is part of a psychological condition). For example, "lazy" can be recast as inattentive or distractible, "irresponsible" → poor sense of time, "disruptive" → impulsive, and so on. Of course adolescents with ADHD can also be lazy, irresponsible, or disruptive. The importance in ADHD acquittal is identifying which behaviors are part of a given teen's personal ADHD profile—and thus aspects of a chronic neurochemical condition—in order to steer the therapeutic focus away from blame and towards targeting specific behaviors for ADHD treatment. It is important not to take responsibility for improving one's own behavior away from adolescents, but to convey an understanding of the additional challenges that teens experience associated with ADHD. For example therapists might explain, "You are inattentive at times because of your ADHD, AND at other times you may be lazy. This makes paying attention difficult, but there are things you can do to get better."

The second kind of relabeling intervention, called *ADHD Rewards*, takes a somewhat different form: Emphasizing the rewarding or prosocial aspects of an ADHD-related behavior that has been previously cast in a purely negative light. This kind of relabeling underscores the often overlooked fact that there are two sides of the coin for most ADHD characteristics: annoying/maladaptive qualities counterbalanced by endearing/adaptive qualities. For example, hyperactive = energetic; slow to mature = young at heart; impulsive = funny and quick witted; and so on. While the challenges associated with ADHD are very real and can present large obstacles to school achievement, even introducing the idea of a positive relabel to a family can foster a less judgmental discourse for teens who may be cast in a negative light most of the time. Generally speaking, if relabels of ADHD-related school problems can be credibly established, it will facilitate productive family conversations about devising acceptable interventions for the ADHD characteristics and making other important changes in families to reach treatment goals regarding school achievement.

Cognitive Techniques to Enhance Relabel Interventions

- **Non-blaming:** Blocking the tendency to cast blame on any individual family member can lower defensiveness among all members, and also allow individuals the possibility of changing without being forced to admit fault or previous difficulties.
Examples:
“I know everyone is angry, but I want to help you all be a part of the solution, which we can do without blaming anyone.”
“We aren’t going to decide who is most at fault because I don’t think that will help anyone. Your family can work together to make things better for everyone.”
- **Positive focus:** Requiring family members to state aspects of family life that are working well and that they do not want to change in therapy, or asking members to recall happier times or instances of pleasant events and family activities that emphasize strengths, can help motivate families to re-establish positive relationships and raise expectations that family life can be rewarding.
Examples:
“When do you guys get along the best?”
“What is the best thing about your daughter? When is your mom the most helpful to you?”
- **Shifting Perspective:** Encouraging family members to consider that the desirability of ADHD behaviors may change over the lifespan or in different contexts. Characteristics that are not valued in teenage years and school settings may be highly valued in adult life and the working world. Similarly, behaviors that might be annoying, tiresome, or outrageous to one person or group might be considered charming, enlivening, or creative to another.
Examples:
“How do you think having a mind that works really fast might be good once Alex is an adult?”
“Alex, are there times when you like being impulsive?”

An additional option for relabeling ADHD behaviors that many families find intriguing is presenting the “evolutionary context” of ADHD. Our ancestors 8 million years ago were nomadic, roaming the earth to avoid predators, find new food sources and shelter, respond rapidly to multiple threats, and adapt to frequently changing environments. In this context, certain ADHD-related characteristics—fascination with novelty, alertness to stimulus change, adventuresome spirit—may have served hunter-gatherers quite well. By looking through a wide lens of human evolution, the therapist can again seek to promote an understanding of ADHD that is non-blaming while also recognizing that many ADHD-related behaviors are especially challenging and often self-defeating in the context of contemporary social expectations and working environments. That is, caregivers and teens alike can be sympathetically reminded that certain modern contexts—sedentary classrooms featuring a passive learning approach!—are uniquely ill-suited for persons with ADHD. Indeed, this is all the more reason for students with

ADHD to embrace the benefits of working to bolster their organization skills and structure the home academic environment to be as supportive as possible for the individual ADHD learner.

Directly Linking ADHD to School Problems

Relabeling interventions can also extend to the primary reasons for treatment referral. Most adolescent referrals for outpatient behavioral health counseling do not center on inattention or hyperactivity problems. Yet, the disruptive behavior problems for which teens are regularly referred—oppositional and aggressive behavior, conduct problems and delinquency, school and learning problems, family conflict, substance use—commonly co-occur with ADHD. This includes school underperformance in the domains of poor school achievement, unruly or disorganized behavior, or both. It is well known that many teens referred for school problems and/or learning disorders carry an undiagnosed ADHD condition. Moreover, ADHD predates the emergence of the school deficits and is invariably a significant risk factor and contributor to their emergence. When caregivers and teens are made cognizant of the link between (latent) ADHD and the (manifest) school problems, it facilitates two positive developments in treatment: (1) Reduced negativity and blame surrounding the school issues, similar to the reattribution effect obtained by relabeling the ADHD characteristics themselves; and (2) Increased willingness to adopt ADHD-specific treatment goals and accept ADHD-specific interventions that target improved school performance, notably those in the CASH-AA protocol.

Working with Adolescents Alone

Adolescent relabeling interventions can proceed as described, though their impact will be limited by the absence of caregiver input about which labels are most common or carry greatest emotional weight. To compensate, therapists can employ a version of the “empty chair” technique with teens to elicit content that might otherwise go untapped: “If your mother were here now sitting in that chair, what are some of the phrases she might use?” Teens may also be able to call to mind other important people in their family or life for these exercises.

Module 2: Behavior Change: School Attendance & Homework Plan

The clinical aims of this module are to initiate family-centered interventions designed to boost school attendance (as needed) and homework quality. Two school-based training interventions (TIs), *Homework Management Plan* and *Schoolwork Organization System*, were adapted for clinic-based use under the guidance of their developer, Dr. Evans. Home-based monitoring of the teen's organizational and study habits are incorporated into the homework planning interventions. Therapists and families also conjointly design and implement developmentally calibrated behavioral contracts and incentives for school attendance and homework completion, and they oversee ongoing family negotiation and problem-solving about reaching academic goals.

“Caregiver Triage”

The therapist's experience with the family during Module 1 activities, or in other contexts, may cast doubt on whether the caregiver can function as an appropriate monitor and support for Module 2 interventions. Broadly speaking, it may not be possible to work effectively with a caregiver who is **excessively impulsive** and/or **harshly negative** with the teen, or who has **inadequate motivation or resources** to invest in Module 2 activities. In such cases, therapists can consider proceeding as if working with an absentee caregiver (see instructions throughout Module 2: “Working with Adolescents Alone”).

Working with Adolescents Alone

TIs such as those described below in Module 2 were originally designed for implementation in individual or group settings. Thus whereas the family-based approach of CASH-AA confers certain advantages for delivering TIs to clinical populations, extensive caregiver involvement is not strictly required for TIs to be effective. The TIs included in CASH-AA can be adjusted ad hoc for delivery to teens alone (or with minimal family involvement), assuming they are sufficiently self-motivated to participate consistently. This adjustment may be needed when caregivers prove to be unhelpful monitors and/or unreliable treatment participants, or when school attendance and performance are not a family priority.

Specific intervention components of Module 2:

- 2a. Behavior contracting and incentives for school attendance
- 2b. *Homework Management Plan* intervention
- 2c. *Schoolwork Organization System* intervention
- 2d. Promotion of home-based tutoring and/or organization skills training

2a. Behavior Contracting and Incentives for School Attendance

For teens who skip school classes or days sporadically, routinely, or in extreme cases altogether, it may be necessary to develop a behavioral contract for school attendance in collaboration with the family prior to initiating homework and other organizational interventions. The first step in this process is establishing the importance of the adolescent's school attendance for all members, particularly the teen. Adolescent engagement interventions (see Section 1b) can be applied to promote teen investment in school attendance. School attendance can be either *intrinsically contingent*—wherein the teen values the tangible (e.g., progress towards a degree) and intangible (e.g., positive regard from adults/mentors, ego boost from “proving them wrong”) benefits of regular attendance and/or is guilty or disappointed about truancy—or *extrinsically contingent*, wherein caregivers or other authorities make school attendance personally rewarding (e.g., incentive plan for improving attendance) or school absences punishing (e.g., pre-specified negative consequences from caregivers or school/justice authorities).

Behavioral contracts and their incentives need to be tailored to each family. Still, there are three basic principles of behavioral contracting that enhance the odds of success for most teens. **First**, teens should be physically present during most/all phases of the construction of the contract (allowing for pre-contract meetings with caregivers or teens alone that are intended to boost the productivity of contract negotiations), either (1) actively involved in the form of direct contributions to its content and some degree of investment in the contingencies that it contains or (2) passively involved as a silent or contrarian witness to the contract's construction who can then independently articulate its important details. **Second**, the language and contingencies of the contract should be as simple (versus legalistic or overly conditional) as possible, and the language of the contract should be couched in purely behavioral terms that are readily observed (e.g., “Sean will leave the house by 7:40 am”) rather than in terms that evoke cognitive/emotional states (e.g., “Sean will try harder to arrive at school on time”).

Third, for maximum behavioral effectiveness the contract should contain a mix of both positive incentives (rewards/privileges) and negative incentives & punishments (current privileges revoked, new restrictions incurred). As with any behavior plan, the incentives and disincentives should be moderate in strength (not too much or too little) and retain personal value/meaning to the given teen. Also, although the behavioral terms of a given contract can remain the same for months or longer, the (dis)incentives may need to be rotated or changed periodically to retain their personal and developmental salience. Finally, for teens who may be subject to external consequences for school absenteeism due to monitoring by the school system or juvenile justice system, these consequences can usually be balanced by adding voluntary rewards/privileges as part of the treatment plan without compromising the effectiveness of the external consequences. Most schools have personnel responsible for monitoring school attendance and communicating with families when attendance or lateness becomes an issue. An important part of the attendance contract is identifying who this person is at the teen's school and establishing regular communication, both to provide the therapist with accurate attendance data and also provide the teen with more support as he/she works to make improvements in attendance. Therapists may be able to utilize email to make this task more efficient, or online portals that schools provide for ongoing family monitoring of attendance and assignments.

Regular attendance is a prerequisite for the remaining interventions. If regular attendance cannot be achieved, then the Module 2 and Module 3 procedures are not appropriate until regular attendance is re-established.

Working with Adolescents Alone

In families with absentee caregivers, these interventions do not directly apply. Of course therapists will use their preferred methods for supporting increased school attendance, which may include some form of agreement-making directly with teens as well as key adults in the teen's life.

2b. Homework Management Plan Intervention

Overview

The Homework Management Plan is designed for teens with ADHD who demonstrate problems keeping track of, completing, and turning in homework (HW) assignments on time. The Plan targets family management of HW completion. It provides a starting point for developing good study habits and for decreasing caregiver-teen conflict over HW completion. Therapists work with families to establish a routine HW schedule and a reasonably distraction-free home environment to support homework completion. The Plan is reviewed when report cards are released and renegotiated at those times.

Intervention Goals

Teens will complete academic work at home for a designated period of time in a distraction-free setting every evening that precedes a school day (Sunday through Thursday). As a result, s/he will be better able to keep track of, complete, and turn in all school assignments on time. In addition, the family should experience a decrease in conflict (if any exists) associated with HW completion. See the Appendix for a template and example of the form used to create a contract.

Intervention Introduction

Therapists should clearly state that the success of the Homework Management Plan (HMP) depends on joint cooperation between caregivers and teens to adhere consistently to a fixed HW routine and to monitor HW performance on a daily basis. Caregivers and teens should understand the following details of the intervention before they begin:

- ❖ Therapists should emphasize that the HMP focuses on establishing a HW management routine, and therefore, consistency is essential for its success.
- ❖ The amount of time allotted to HW per evening should be renegotiated at the end of every grading period based on the grades received.
- ❖ When beginning the HMP, and for as long as necessary thereafter, caregivers should be prepared to monitor and/or check-in with teens throughout the allotted HW time to help them stay on task (though NOT to help with the homework itself; see below).

Intervention Methods

The HMP is used to train teens to develop good study habits while decreasing family anxiety and conflict over homework completion. The foundation of the HMP involves helping caregivers accept things they can no longer control (e.g., knowing the homework assignments each day, understanding all of the content of the academic subjects) and making a renewed effort to influence things they can (e.g., ensuring teens spend time on schoolwork each evening). Helping caregivers accept new limits on how much they can assist with schoolwork may be quite

difficult for those who were able to boost their child in elementary school by being very involved in daily assignments. In contrast, for caregivers who have been minimally or uninvolved in homework routines, the initial stages of the HMP focus on establishing the motivation and basic monitoring habits needed to support homework scheduling and completion. For all families, initial sessions involve meeting with caregivers to discuss this new approach, identifying the parameters of what is negotiable, and determining how homework sessions can best fit within the routine evening schedule.

The ultimate goal of the HMP is to increase the amount of time teens spend on schoolwork each evening. Caregivers and teens negotiate an amount of time and establish contingencies for adherence. A common framework for the HMP is that teens are allowed full privileges until a certain time in the evening (e.g., dinner). After this time, they have no privileges until they spend the negotiated time on schoolwork. The privileges withheld should be as comprehensive as possible and include computer time, video games, cell phone use, leaving home, having friends at the house, and television. As soon as the full amount of time allotted for schoolwork is completed, all privileges are returned. If teens claim to have no schoolwork, then caregivers assign something such as writing a summary of a book chapter, newspaper story, or magazine article. Because high school students always have assignments or test preparation that they can do, caregivers can be confident that teen claims about having nothing to do is inaccurate. For most caregivers, they only need to assign this “busy work” for a few days before teens find schoolwork to complete.

A challenging aspect of the HMP is that caregivers must avoid closely monitoring the schoolwork itself. *Caregivers should make sure teens are doing schoolwork, but should not check to see if work is being done correctly or completed.* The goal of this intervention is to help caregivers establish some time each evening during which their teens attend to schoolwork. For this to be successful, they cannot concern themselves with issues related to the quality of work or the completion of all assignments.

The Homework Management Plan is outlined in a caregiver-teen contract that is negotiated in therapy sessions (see template in Appendix). The table below provides a detailed outline of the specific HMP interventions to be delivered across each of the 5 Parts of the HMP. Typically the 5 Parts are implemented in five separate and consecutive sessions, but in some cases it may be advisable to implement more than one Part in a given session; or, a Part may require more than one session to complete. The table also includes (a) who is expected to participate in each HMP Part and (b) detailed examples of specific procedures and recommendations for successfully completing each Part.

Working with Adolescents Alone

We recommend that therapists working with teens alone start with the Bookbag Organization System (BOS, described in 2c), as this intervention involves only teens. Once progress has been achieved in the BOS, therapists must then decide whether teens have potentially sufficient motivation and organizational resources to improve homework habits if supported by HMP resources. If therapists believe this might be the case, then they should proceed to draft the HMP directly with teens. In doing so therapists should adopt the following framework for guiding HMP interventions (perhaps sharing these ideas with teens, if indicated):

(1) Teens will need to “self-monitor” the study habits required to make (gradual and incremental) improvements in homework completion, which can be accomplished with support from therapists; (2) Teens will need to “self-enforce” the conditions required to minimize distractions and work productively; and (3) Treatment sessions will be used as a weekly touchstone for gauging HMP progress and making needed adjustments.

The HMP table below identifies which aspects of the intervention are delivered with teens; these will be the focus of work. Therapists will need to decide what HMP information usually designated for caregivers—e.g., it is important to be concerned with quantity not quality—should be shared directly with a given teen. If teens are willing to attempt the HMP, and further show some initial progress, therapists can then consider adding Assignment Notebook Checklist (ANC) interventions as an adjunct to HMP work. ANC interventions are primarily focused on teens only and should be able to proceed as designed, assuming that the given teen remains committed to completing assignments and at least partially successful in creating conditions in the home—or other designated workspace—to continue making progress.

Procedures and Examples for the Homework Management Plan

HMP Part	Tasks	Tips and Examples
Part 1 Caregiver & Teen	<ul style="list-style-type: none"> ● Explain the purposes of the HMP: <ul style="list-style-type: none"> ○ To establish evening schoolwork routines to help teens complete work on time and improve test and quiz scores ○ To create a written agreement between caregiver and teen outlining the evening schoolwork routine ● Review the contract template 	<ul style="list-style-type: none"> ● Caregivers and/or teens sometimes express concern that the other will not agree to a “reasonable” plan. We have found it helpful to express confidence that an agreement can be achieved. ● It can be helpful to note that ultimately caregivers can implement and enforce most aspects of the HMP without direct agreement from their teens.
Part 2 Caregiver	<ul style="list-style-type: none"> ● Make sure caregivers understand that their job is to monitor and enforce the negotiated amount of time—not the quality or completion of schoolwork. ● Help caregivers establish their approach to negotiation: <ul style="list-style-type: none"> ○ Discuss the minimum amount of nightly HW time that is acceptable. We recommend that this take into account the teen’s current study habits and be only slightly higher. ○ Choose a starting point for negotiation. This should be higher than the minimum so that caregivers are prepared to compromise. ○ Prepare caregivers to present their case for the initial amount, and to consider their teens’ counterarguments before they agree to a compromise. 	<ul style="list-style-type: none"> ● Many teens in treatment do not do any school work in the evening. Starting at 15 minutes per evening is very reasonable for these teens. ● If 15 minutes is the minimum, starting the discussion at 45 minutes is reasonable to <u>allow for compromise</u>. ● It is sometimes difficult for caregivers to accept the rule of not monitoring quality or completion of assignments; it can help to remind them: <ul style="list-style-type: none"> ○ of the critical developmental aspects of this age pertaining to autonomy and self-reliance: getting too involved in homework is one way to undermine teen development of emotional maturity and self-regulation ○ if teens receive poor grades, then caregivers will have all the leverage needed to increase the daily study time after report cards are released
Part 3 Caregiver	<ul style="list-style-type: none"> ● Before proceeding with Part 3: <ul style="list-style-type: none"> ○ Check in with caregivers about any concerns or revisions to the approach outlined in Part 2. ○ Make sure caregivers’ concerns are addressed and confirm their readiness to negotiate. 	<ul style="list-style-type: none"> ● If caregivers reconsider their positions, help re-solidify their approach—even if this requires another session. ● Remind caregivers that the HMP contract is renegotiated at every report card, based on the reported grades. ● Two caregivers in the same family need to be on the same page. If they disagree about important aspects of the HMP, point out that their negotiation on this involves compromise—just like they hope to solicit from the teen.
Part 3 Teen	<ul style="list-style-type: none"> ● Meet with teens alone to prepare them for the negotiation: <ul style="list-style-type: none"> ○ Explain that negotiation includes compromise: Teens should be prepared to agree to some things that are personally undesirable. 	

Part 3 Teen (cont.)	<ul style="list-style-type: none"> ○ Recommend offering an amount of time less than the teens' ideal, to leave room for negotiation. ○ Help teens understand the value of having a good rationale for their position. 	<ul style="list-style-type: none"> ● Preparatory discussions with teens may be brief but <u>very</u> important to help them: <ul style="list-style-type: none"> ○ understand that they have input (not control) over the contract ○ learn to negotiate effectively ○ understand that the HMP is intended to help them succeed
Part 3 Caregiver & Teen	<ul style="list-style-type: none"> ● Go through the HMP contract template item by item. ● Help caregivers and teens negotiate the information that goes in the blanks. ● Fill in the blanks of the template; have caregivers and teens sign the agreement; therapists keep one copy and provide another to families. ● Determine when the HMP will take effect; this should be as soon as possible. 	<ul style="list-style-type: none"> ● At least 15 to 20 minutes are required for negotiation. Adequate preparation is key to completing the contract quickly, though this can require several sessions. ● Therapists should work to facilitate negotiation by: <ul style="list-style-type: none"> ○ interrupting arguments ○ helping family members rephrase points ○ asking directly what one person thinks about a specific point made by another
Part 3 Caregiver	<ul style="list-style-type: none"> ● Call caregivers within 48 hours of when the HMP will take effect to provide encouragement, reassurance, and answer any questions; calls increase the likelihood that families will implement the plan consistently. 	<ul style="list-style-type: none"> ● It is crucial that therapists not be seen as taking sides. ● Remember: Whatever is decided in the initial negotiation is simply a starting point.
Part 4 Caregiver & Teen	<ul style="list-style-type: none"> ● Review the initial implementation of the HMP: <ul style="list-style-type: none"> ○ Discuss concerns; answer questions; resolve disputes. ○ Remind families that the agreement is set until the next report card, when it can be renegotiated as needed. ○ Remind families that a key to HMP success is consistency, and that any changes will diminish the likelihood of success. ● Continue to check in with caregivers at subsequent sessions; continue problem-solving as issues arise. 	<ul style="list-style-type: none"> ● Changes should be strongly discouraged overall ● Small practical revisions may be necessary <ul style="list-style-type: none"> ○ For example: A change in the days or times of a sports practice would require a corresponding shift in the homework time. ○ An unacceptable change is an increase in time spent each evening because caregivers discover how behind their teen is academically. ● PATIENCE AND PERSISTENCE is the key phrase for success with the HMP!
Part 5: After Report Card Caregiver & teen	<ul style="list-style-type: none"> ● Take the family through the same process outlined in Parts 1-4 ● Emphasize that good grades mean that the stipulated amount of time worked, and therefore should be maintained. ● Emphasize that poor grades are evidence that the amount of time was inadequate, and therefore should be increased. 	

“Home Triage”

Although CASH-AA is committed to improving academic support in the home, for many teens it may be most sensible for the **teen to do homework in a different environment**, such as a **library, after-school program, or relative/friend’s home**. In such cases therapists can collaborate closely with families to identify suitable conditions for homework completion in the given setting (when, for how long, and with what measures to minimize distractions) and a plan for teens to communicate with caregivers **on a daily basis** about homework activities at that site. Although this leaves room for only “second-hand” adjustments to Module 2 activities—via teens reporting to caregivers on HW activities—in some cases it may present the best available option. To boost chances of success, families and therapists can look to identify resource persons at the site who can cheerlead, and even provide secondary monitoring of teens on site, also providing periodic reports to caregivers.

For Consideration

- Intense conflict between caregivers and adolescents, caregivers’ rigid beliefs that teens should not need their help, intense defiance by teens, and other exceptional situations may make the HMP impractical or inadvisable for certain families.
- Another situation at home that contraindicates HMP use is the inability of a caregiver to usually monitor the teen’s evening behavior when the HMP is supposed to be in effect.
- When therapists believe that a negotiated HMP is not appropriate or feasible, it may be advisable to first address those situations that are barriers to the implementation of more feasible HMP procedures/features.
- Many school systems now offer on-line grade portals that provide families constant access to grades updated on a regular basis in every subject, including separate performance indicators for tests, homework, and class participation. These can be informative, but often they include inaccurate information, as not all teachers keep the information current. Caregivers should be discouraged from discussing this information with their teens. It is likely to cause arguments and raise issues that are not relevant to the implementation of the HMP. In contrast, therapists are encouraged to have students access this information to remind themselves about what schoolwork they can do during their evening HW time.
- Changes in teen behavior may not occur until after four to six weeks of consistent implementation. Therapists should focus on consistent HMP implementation by caregivers, and not on whether the HMP is working. The outcomes of interest will be on the upcoming report card, and at that point revisions to the HMP can be systematically negotiated.
- Caregivers should avoid having arguments or applying strong pressure or punishments to the student about adhering to the HMP. Caregivers can provide reminders, encouragement, and praise when appropriate. Their role is to consistently stick to the parts of the HMP to which they are committed—monitoring adherence to HW time, limiting/accessing privileges.

2c. Schoolwork Organization System Intervention

Overview

Teens with ADHD often have a difficult time maintaining efficient and reliable organization of school materials and assignments, which has a negative impact on their ability to record, remember, and locate school assignments. By helping teens take the relatively small step of organizing their school materials—bookbags, binders, and HW tracking systems—therapists will not only facilitate completion of the Homework Management Plan, but also initiate student progress toward the larger goal of better overall organizational and self-management skills.

Intervention Goals and Materials

The goal of the Schoolwork Organization System (SOS) is to introduce a highly specified, research-proven system for organizing school materials and keeping track of assignments. To do this, teens will need to bring their bookbags into treatment sessions on a weekly basis for several sessions until teens and therapists are satisfied that the newly installed organization system has taken root. Also, therapists will need to supply teens, or ask families to purchase, a specific list of organizational materials. These materials are inexpensive, easily found in any stationery store, and essential for successful installation of the SOS. See the Appendix for a list of suggested materials and supplies. Not all adolescents will need all items on the list. Before purchasing the materials, therapists and teens should decide on a basic organization system. Some teachers require specific types of folders or binders for their classes, and therapists should inquire about these requirements prior to determining an organization system. In addition, the preferences of the adolescents should be considered (especially high school students). Young adolescents (e.g., sixth and seventh grade students) should probably start with the default system, with the only revisions being teacher-required modifications. After determining the basic framework of the organization system, then materials listed in the School Materials Supplies List (see Appendix) should be purchased.

Intervention Introduction

Some teens will already be using a school materials organization system with which they are comfortable, sometimes mandated in whole or part by the school itself. Teens often believe that these systems are effective and do not need to be changed. If an adolescent is having significant school problems, in particular deficits with completing assignments, then it is likely that his/her materials organization system is inadequate. If there are aspects of the adolescent's current system that are operating well, then these may be integrated into the SOS. Most students with ADHD will probably need to adopt the SOS system in its entirety.

Note that it is usually preferable to conduct SOS activities with teens alone in session, to avoid situations in which caregivers are critical, negative, or dismissive of teens' organizational habits. The intervention steps are presented below. Once the full SOS is established—both the Bookbag Organizational System and the Assignment Notebook Checklist (see Appendix)—maintaining them will take only a few minutes of each session. The first three Parts, in which the new systems are introduced, can take 30 minutes or more (if implemented consecutively), but subsequent Parts can be as short as five minutes.

Procedures and Examples for Schoolwork Organization System

Part 1 Step 1: Review the Current System

Start by acknowledging the challenges of managing materials required for high school and keeping track of assignments, and inquire gently about the system currently used by the teen.

- *High school students generally get tons of school papers and worksheets every day, how do you manage to keep track of everything?*
- *How about homework—how do you know what your assignments are when you leave school, and when you get home each day?*
- *Do you write your assignments down, or do you remember everything on your own?*
- *Where do you record homework assignments?*
- *How do you know what materials to bring home each day?*
- *Is your caregiver involved in helping you with homework in any way?*
- *Do any of your teachers have specific requirements for how they would like your materials organized for their class?*

After these initial inquiries, investigate the bookbag and its contents with the teen. Go through school binders/folders to examine them firsthand, review the teen's assignment notebook, and offer praise/encouragement while also noting areas that could be improved.

- *Wow, you are really consistent in writing assignments down in your assignment planner, but I know your caregivers mentioned you still have several missing assignments. I noticed that that you had a folder in your binder, and it looked like it had papers from a bunch of different classes. How might having separate folders for each class, and a folder specifically for homework, help with assignment completion?*
- *It's great to see you are already using a binder. What have you found to be beneficial about using the binder?*
- *I didn't see a place in the binder for you to record your assignments. Where do you typically do that?*

As teens describe their organization system, inquire about how it is working for them. If teens express challenges, capitalize on those moments to build the importance of the intervention. If teens report that everything is going well, try to facilitate teen understanding of the potential connections between organization and academic problems

Thanks for letting me take a look at your bookbag and binder, how's your system working for you?

Therapist: That's a horrible feeling when you get somewhere and realize you don't have something you need. You're recognizing that there are still some issues that your current organization system is not addressing.

Student A: I mean, it's okay I guess. Sometimes I get to class and realize I don't have a paper I need, or I've forgotten my homework.

One of the things we can do in our work together is see if we can tweak some of the things you're already doing to help ensure you will always have the materials you need to be prepared for class.

Student B: I think it has been working really well for me.

Therapist: Great, I'm glad to hear it has been working well. What helps you to know that it has been working?

Student B: Well, it's easy, I just keep all my papers in this folder.

Therapist: Hmm, so on one hand this system is easy for you to manage, and you like that, but I remember last time we met you mentioned your caregivers were really getting on you about your grades in math and science. How willing would you be to try making a few small adjustments to your current organization system, to see if that might help your grades, or to show your caregivers the effort you are putting in?

Offer to help teens revamp or fine-tune the existing system and ask them to bring their school materials to the next treatment session.

Part 1 Step 2: Introduce the BOS

Review the Bookbag Organization System (BOS) Checklist as an example of an organization system (for younger teens, therapists should just introduce the BOS as the new organization system). The needed supplies are detailed in the Appendix: School Materials Supplies List.

Discuss a system that is (a) simply the BOS as it is written; or (b) a hybrid of aspects of the teens' current system that are working, combined with BOS. It is important to keep in mind that there is no one perfect system; any system that is practical, efficient, and achieves organization of materials will likely work.

Important elements of any effective system include:

- a place to record assignments for each class
- a place to store homework for each class
- a place to store materials needed for class (e.g., pencils, pens, calculator)
- a place to put papers that should be saved but are not new work that needs to be completed

Acceptable Modifications to the Standard BOS

- *The science teacher requires that students have a separate binder for science class. The binder is reviewed by the science teacher on a weekly basis.* *Instead of having the science folder and notes in the main binder, those materials would be stored separately in the science binder. Use any organizational criteria set by the science teacher to evaluate the science binder. If the science teacher did not specify an organization system, agree on an organization system for the science binder similar to the main binder (e.g., notes attached by 3 rings in order from oldest to newest, followed by a science folder, with no loose or unrelated papers present).*
- *The student refuses to use a binder.* *Work together to develop an alternative organizational system. For example, a notebook for each class with a folder for class-related papers, organized in order from oldest to newest. Notes are written in the appropriate notebook in order from oldest to newest. The student also has a homework folder and an agenda. The agenda is stored in the outer pocket of the bookbag.*
- *The student has an assignment planner, but the planner does not have holes that allow it to be attached by three rings in the binder.* *Agree on an alternative location where the assignment planner will be consistently stored (e.g., front pocket of the binder).*
- *The student has non-school notes or drawings that s/he wants to keep handy, but they are problematic because they are loose in the binder.* *Agree that the student's non-school materials will be kept in a specified location in the binder, such as a folder or zipper pack in the binder.*

Unacceptable Modifications to the BOS

- *The student does not want to use any folders.*
- *The student does not want to have a place to document assignments.*
- *The student wants to keep all class materials in the same folder.*

Part 2: Introduce the ANC

Review the Assignment Notebook Checklist (ANC—see Appendix). Integrating the ANC into the teen’s organization plan establishes a routine that helps teens record daily homework assignments accurately and plan for quizzes, tests, and projects.

The key components on the ANC are recording:

- (a) each assignment for every class, written accurately with sufficient detail
- (b) the total number of assignments expected

Assignments are recorded for the core classes (Science, Social Studies, Language Arts and Math) and any additional classes if necessary. Teens and therapists should agree on what teens will write if there is no homework for a given class (e.g., N.H.; None).

It is also critical to establish a method for verifying assignments.

At the end of Part 2, come to an agreement about (a) the planned organization system to be used (BOS, whole or modified) and (b) the system to be used to record homework assignments (ANC). Make a plan for how any new organizational materials will be obtained.

Prior to the next Part, (a) compose a typed version of the agreed-upon checklist for the ANC and (b) teens agree to bring their school materials (bookbag, binder, and assignment notebook) to all subsequent treatment sessions.

Examples of ANC Methods that Can be Used to Verify Assignments

- *Teacher signatures/initials*
- *Online websites that list homework assignments (e.g., Infinite Campus)*
- *Record assignments in a Google doc to which teachers also have access; at the end of the school day, teacher(s) sign off on the Google doc.*

Part 3: Build the SOS

With the teen, organize the new school binder as prescribed by the individualized BOS. Therapists may also assign teens the task of putting together all materials according to the plan developed. Therapists should provide teens with the written checklist of the system to use at school, keeping a copy for reference during subsequent sessions.

Part 4: Implement the SOS

Use the BOS checklist to check the bookbag and binder, and use the ANC checklist to check the assignment notebook. At first, therapists do the checking while teens correct identified errors. The data recorded on the BOS and ANC tracking sheets (see Appendix) should reflect the status of the materials when teens arrive at session (i.e., no credit given for making required corrections in session). When checking the assignment notebook, therapists should have a separate entry on the ANC for each day that school was open. This part should occur over the course of 2-3 consecutive sessions. When checking materials, therapists should give teens age-appropriate validation when criteria are met, and should maintain a neutral, matter-of-fact tone of voice when criteria are not met.

Part 5: Evaluate the SOS

Observe and record the data on the BOS and ANC tracking sheet while teens complete the two checklists. Prior to Part 6 occurring, let teens know that their caregivers will be joining the next session, during which the two checklists will be completed.

Part 6: Introduce Caregivers to the SOS

Teens, caregivers, and therapists meet together. Therapists introduce the BOS and the ANC that teens have been working on, in doing so validating the teens' progress. Teens then complete the two checklists, and therapists record the data. During this, therapists explain the procedures to caregivers. At this point therapists share that because the teens have made progress, and in order to help maintain progress after their work together on HW organization is complete, caregivers will watch teens complete the two checklists once per week at home prior to the given week's therapy session, and then the information will be reviewed by therapists and teens at the following session.

For Consideration

- Once teens have mastered the BOS or the ANC (i.e., received perfect or near-perfect scores on the given Checklist for three weeks in a row), therapists can periodically re-examine school materials for continued quality assurance.
- Therapists and families may decide to institute a reward for successful installation of the BOS/ANC and/or successful system maintenance (i.e., ongoing excellent scores on the Checklists). Furthermore, if progress is not observed after 2 weeks of implementation of either checklist (BOS or ANC), therapists should initiate and lead the establishment of a reward system in order to spur progress.

2d. Promotion of Home-Based Tutoring and/or Organizational Skills Training

The interventions described above may not by themselves be sufficient to support academic success for adolescents with ADHD, particularly for teens with significant executive functioning deficits and/or specific learning problems. Additional academic supports can often be found in the schools, particularly for youth who are formally identified by the school as needing supportive services for emotional or learning problems. These issues are discussed below in Module 3. However, for various reasons—the given teen does not qualify for school supports, appropriate and/or effective school supports are not available, and so forth—families may need to acquire supports outside the school setting. These supports usually fall into one of two broad categories: (1) tutoring services that provide didactic instruction and practice in specific areas of academic weakness; or (2) self-organization training that provides individualized assistance in monitoring and enhancing how students prepare for, track, and complete school assignments and requirements, often utilizing standardized checklists or software technology that promotes graduation toward teen self-reliance. Tutoring and organizational skills training services are sometimes available via community-based agencies or contracts with individual specialists. Therapists can assist families in locating and evaluating the potential benefits and costs of appropriate services that are available to the family, with the urgency that additional home-based academic supports sometimes represent the critical margin of difference between strong versus moderate/weak academic confidence and achievement for adolescents with ADHD.

Working with Adolescents Alone

Therapists can attempt to work directly with school counselors and special education personnel to arrange for appropriate services to be delivered in the school setting.

Module 3: Collaboration: Therapist-Family-School Partnership

The clinical aim of this module is for therapists to establish and maintain a partnership among therapist, family, and school personnel to serve the educational interests of the teen, in line with evidence-based principles of family-school collaboration for youth with ADHD. The **first clinical task** occurs during treatment sessions, wherein therapists confer with families about special education rights available to adolescents with ADHD. There are materials for caregivers available on the New York State Department of Education webpages. Also, the Clinical Resources and Protocol Adaptations section of this protocol (see below: “A Primer on Special Education Policies and Procedures”) outline information pertaining to special education procedures (typically falling under “Individual Education Programs” [IEPs]) and available classroom supports under “504 Plans” that can be accessed by students with ADHD without applying for a full IEP. Therapists will be most helpful to caregivers if they are familiar to some degree with the special education laws and procedures as they apply to adolescents with ADHD and co-occurring learning problems. The **second clinical task** requires therapists to complete at least one on-site school visit in order to solidify partnership with an appropriate school advocate and construct a mutually determined plan for tailored educational services. Therapists can then assist caregivers in developing the skills and habits necessary to work closely with school personnel to monitor and revise the educational plan over the course of the teens’ school experiences.

Specific intervention components of Module 3:

- 3a. Family consultation on special education rights and services
- 3b. School visit to establish collaborative educational plan and school-based supports

3a. Family Consultation on Special Education Rights and Services

The first aim of Module 3 is to confer with families regarding special education rights and school-based services available to adolescents with ADHD. Services can include *accommodations* (i.e., changes to school practices that hold a student to equivalent expectations but provide a differential boost to mediate the impact of the disability [e.g., extra time to take a test]), *modifications* (i.e., changes to school practices that alter, lower, or reduce expectations to compensate for a disability [e.g., fewer/shorter homework assignments]), or *interventions* (changes made through a systematic process to improve knowledge, skills, behaviors, cognitions, or emotions [e.g., remedial instruction]). Several professional resources have been compiled to guide clinicians in educating families about school policies for students with behavioral challenges—as federally stipulated in the Individuals with Disabilities Education Improvement Act of 2004—and helping families secure appropriate services for youth diagnosed with ADHD. Services are often available even for students with passing grades, so that practical options for enhancing school-based supports can be explored with caregivers and teens.

Helping Families Understand and Critique ADHD Accommodations/Modifications (A/Ms)

Unfortunately, at this time there is very little empirical evidence to support the effectiveness of A/Ms. On the one hand, several A/Ms have been shown to provide modest boosts to some students with ADHD. Also, many educators and counselors strongly support A/Ms of various kinds based on their professional experiences with students. On the other hand, the empirical evidence supporting the benefit of any of these potential A/Ms to students is based on very small samples—almost none of them focused specifically on adolescents—and on very few studies overall. Furthermore, there is evidence that some A/Ms are not effective (e.g., extended time), along with concerns by many experts in the field that they can actually be detrimental to student progress. Overall, there is no convincing evidence to indicate that any A/M reliably reduces the impact of ADHD problems for adolescents.

Choosing Between Interventions versus Accommodations/Modifications

It is important for therapists to help families understand the differences between interventions versus A/Ms, and the reasons for preferring interventions in most cases. The goal of A/Ms is to reduce the expectations or requirements of students so that they can succeed without the full set of skills or competencies. For example, sometimes students with ADHD are not required to take notes in class or may not be penalized for submitting work late. There are interventions, in addition to the ones in this manual, that can successfully train students to take high quality notes in class and to submit their assignments on time. If teachers eliminate the expectation for taking notes and submitting work on time, students are never likely to learn how to do these things. In this manner, A/Ms can inadvertently extend the impact of the disability. In addition, they may lead students to adopt a position of entitlement that they should not be required to do things that are expected of others, nor be responsible for learning how to improve their work habits. This could be a very counterproductive lesson to students and lead to frustration in the workplace where competent performance is required of all employees. For these reasons, many recommend that A/Ms be provided for students only when all available interventions (including medication) have failed. In contrast, the goal of interventions is to improve the competencies and skills of students with ADHD so they can meet age-appropriate expectations at school and in the community.

Working with Adolescents Alone

It is doubly important to establish direct communication with school personnel whenever caregivers are not participating in treatment. Teens typically have only a rudimentary understanding of their special education status and the service options available to them. For teens experiencing serious behavioral/academic difficulties, or those with an active IEP, therapists should contact the appropriate teacher or guidance counselor directly to ascertain status and advocate as needed. It is also useful to hear from the school about how much caregivers are connected to school affairs, as this can inform therapist decision-making about when and how to get involved.

3b. School Visit to Establish Collaborative Educational Plan and School-Based Supports

The second aim of Module 3 is for therapists to complete at least one school visit to solidify partnerships with appropriate school advocates (e.g., teacher, guidance counselor, special education specialist) and, as indicated, to construct a mutually determined plan for tailored educational services. Therapists then assist caregivers over time to develop and maintain the skills needed to work in conjunction with school staff to monitor and revise the educational plan over the course of the school experience. Therapists can also provide case information to caregivers and schools throughout treatment (as consented) and troubleshoot caregiver advocacy efforts once they are underway. School visits can also be vital for alliance building with teens, caregivers, and school personnel. Therapists demonstrate commitment both to helping teens in broad systemic ways by visiting schools, and teachers and guidance counselors can see they have an ally in their goals for teens.

The overarching goal for school visits is to identify and cultivate a shared set of goals and supports for the given teen and family. Each system (family, school, clinic) will naturally have its own set of target behaviors and goals for teens; the more overlap and cooperation that exists between systems, the more likely that good outcomes will result. Of course orchestrating a school visit normally requires a great deal of time and effort; the potential payoff is that the information gleaned from on-site visits can make the tasks of therapy more efficient and thus more rewarding as well as successful. Broadly speaking, therapists should look to identify ways in which the school is currently supporting teens in addressing the challenges of ADHD, and also how schools might improve the amount and/or effectiveness of their support. Therapists can share these observations with school personnel when appropriate, and also assist caregivers in continuing to advocate for their teens in the identified areas. In this manner therapists can serve as both direct advocates and as models for caregivers on how to advocate teens' needs. Therapists can also gain invaluable data about the culture of the schools, the style of particular school personnel in managing the challenges of ADHD, and an understanding of how teens are viewed by school personnel and peers.

More specifically, on-site school visits can serve an invaluable therapeutic function under (at least) two scenarios. The first scenario is when the school is developing a new Individualized Education Program (IEP) or making significant alterations to an existing IEP. Therapists can play a unique role as a two-way facilitator between schools and families: (1) Helping family members comprehend and actively engage with the often bewildering amount of assessment data and service options presented in the course of preparing and finalizing the IEP; and (2) Helping school personnel select IEP services that are fully informed by the therapists' own knowledge of the families and ongoing treatment planning. Therapists have the opportunity to validate both the caregivers' and school personnel's concerns, which at times can feel at odds. This two-way facilitation can occur prior to the formal IEP meeting or (perhaps ideally) in the meeting itself.

The second scenario is when teens are at risk of, or have already incurred, serious academic or behavioral problems that threaten to derail school progress. In such cases it may be critical for therapists to make direct contact with teachers or guidance counselors who are willing to serve as an active advocate for teens, and a kind of "clinical deputy" of therapists, which might involve: (1) Checking in with teens regularly to provide motivational support and practical advice and problem-solving (i.e., keeping the given teen "on the radar"); and (2) Remaining active as liaisons for teens' interactions with other school officials (i.e., being a go-to resource

for colleagues who are “dealing with” the given teen regularly or for a given incident). In this role therapists can offer insider information and advice to school advocates in helping teens manage ADHD symptoms and the myriad problems that arise or coincide with them. Additional advantages to recruiting one identified on-site advocate are that therapists need not spend time gathering information from multiple contacts, but instead will have one centralized contact; and if school personnel are not comfortable with therapists participating in formal meetings, therapists can ask advocates to serve as proxies for therapists’ ideas and concerns.

Working with Adolescents Alone

On-site visits have great added value in these cases, particularly when teens can be present in the given conversation/meeting. Therapists can operate simultaneously as knowledgeable significant others for teens and as therapeutic mediators who help negotiate decisions and interactions to serve the best interests of all parties. On-site participation is especially valuable for IEP meetings that are not attended by caregivers. In these meetings, procedures and services are established that impact every aspect of the teens’ school life: behavioral, curricular, and extracurricular. Meeting outcomes—both decisions made during the meeting and their implementation thereafter—can be immensely improved by on-site advocacy and subsequent follow-through by therapists. In between school visits, the concrete data supplied by report cards and online school performance tracking platforms offered by many schools is vital when caregivers are not present to provide the up-to-date feedback.

Tips for collaborating with schools:

- Secretaries are great resources: they can help connect parents and therapists with teachers, administrators and school counselors
- Be proactive: clinicians must initiate and proactively follow-up on all contact with teachers—reaching out and reminding teachers of what is needed takes the burden of remembering off their shoulders
- Use email: teachers can often access email during the day more easily than talking by phone before or after school

Primer on Special Education Policy and Resources

There are several federal laws that make it possible for adolescents with ADHD to qualify for special assistance at school in order to help boost their educational performance. These laws view ADHD as a disability that impedes educational progress. There are two main types of educational assistance plans for qualifying teens with ADHD: 504 Plans and Individualized Education Programs (IEPs). IEPs require a formal evaluation by school psychologists and official designation of special needs; 504 Plans, on the other hand, can be devised based on school or family request for any needy student with ADHD.

The basic differences between the 504 Plan and IEP are outlined in the box below.

504 Plan	IEP
<ul style="list-style-type: none"> • Support is provided as a part of the teen’s regular education. • Defines disability broadly, so that more kinds of learning difficulties are eligible, including those relating to ADHD; most teens with ADHD will qualify for a 504 Plan. • No formal evaluation is legally required for eligibility, though one may still be done; sources of information regarding eligibility include caregivers, teachers, guidance counselors, and other relevant individuals (e.g., primary care physician, therapist). • No formal legal requirements for creating the 504 Plan; it will include information about the types of accommodations being provided. 	<ul style="list-style-type: none"> • Special education support is provided, in addition to support as part of the teen’s regular education. • Specific disabilities are eligible for an IEP; ADHD is considered an ‘Other Health Impairment’ under these requirements. • Formal evaluation must be completed to determine eligibility; important to include evaluation for ‘Other Health Impairments’ because ADHD is included in this category; evaluation will include gathering information from caregivers, teachers, and other relevant individuals. • IEPs are written documents that must include specific elements; goals must be set and measured, and progress evaluated regularly.

Most students with ADHD qualify for educational assistance under a 504 Plan; a smaller number are eligible for assistance through an IEP, because of the more stringent requirements for qualifying for an IEP. 504 Plans are also more quickly implemented. However, teens that do qualify for an IEP have access to more intensive services. When academic struggles are the result of not just ADHD but also other disabilities, such as specific learning disabilities or emotion/behavior disorders, an IEP should be requested.

By adolescence, many teens with ADHD will already have a 504 Plan or IEP in place. However, these plans are intended to be revised as necessary. If a teen is struggling or simply not performing to his or her full potential, it is time to revisit and potentially revise the plan.

DETAILS: The 504 Plan/IEP Process

What to expect from the 504 Plan Process:

Who's involved?

Creating a 504 Plan is a team effort; at the least, this team will include caregiver(s), a guidance counselor, and one or more of the teen's teachers.

How long does the process take?

This will vary from school to school and case to case. Because they don't require an evaluation, 504 Plans are usually developed and implemented fairly quickly once the team determines the teen's eligibility and needs.

Importantly, it is not necessary for an official plan to be in place for schools to begin providing services. If it seems as though it will take some time to formalize the 504 Plan, the caregivers and school can work together to create an informal plan so that the teen can benefit from services in the interim.

What about evaluation?

No formal evaluation is legally required for a 504 Plan, though some schools may still choose to do one; instead, information about the teen's educational challenges is collected from caregivers, teachers, and other relevant sources (e.g., guidance counselors, primary care physicians, therapists).

It is the presence or absence of a disability that determines eligibility for a 504 Plan, and determination of eligibility depends on how the teen would be performing if all existing supports (medication, tutoring, caregiver assistance with schoolwork, etc.) were removed. In other words, if the teen is coping with educational demands due to a successful medication regimen, or an excellent academic support system, that does not mean that a disability is not present, and this fact must be taken into account to determine eligibility.

Notes for New York City:

The New York City Department of Education provides a special form for requesting accommodations as part of a 504 Plan. This form can be found by going to schools.nyc.gov and then entering "Request for 504 Accommodations" into the search box.

The official 504 Plan process cannot begin until this form has been provided to the school with any additional supporting documentation from other relevant sources, such as primary care physicians. However, families can greatly benefit from collaborating with the school early and often in the 504 Plan process, even before they submit the official form, to help determine what

other documentation should be provided and what specific accommodations might be recommended for the teen.

What to expect from the IEP Process:

Who's involved?

Creating an IEP is a team effort. This team will include the caregiver(s), a guidance counselor, one or more of the teen's teachers, a special education teacher, a school psychologist (or other professional qualified to interpret the results of the evaluation), and a representative from the school district who oversees special education.

How long does the process take?

This will vary from school to school and case to case. Because of the stringent requirements governing the eligibility for and creation of an IEP, and the need for a formal evaluation, it can take up to several months to complete the IEP development process.

Importantly, it is not necessary for an official plan to be in place for schools to begin providing services. If it seems as though it will take some time to formalize the IEP, the caregivers and school can work together to create an informal plan so that the teen can benefit from services in the interim.

What about evaluation?

If an IEP is being pursued, then a formal evaluation will be required, and caregivers will be required to provide written permission for this to occur. Different types of disabilities are considered in determining eligibility for an IEP: specific learning disabilities (SLDs), other health impairments (OHIs), and emotional or behavior disorders (EDs). ADHD is included under the OHI category, so this should be included in the evaluation. Evaluators sometimes look for SLDs only, which could result in a teen with ADHD who should be eligible for an IEP being denied because OHIs were not properly considered.

Schools determine how their evaluations are conducted, so procedures vary. The evaluation will almost certainly include intelligence testing (IQ and strengths/weaknesses), achievement testing (grade-level performance), observation of the teen at school, and a review of the teen's academic records. Evaluations also include information from caregiver and teacher interviews regarding the teen's development, learning style, and academic achievement. Evaluations provide the opportunity for caregivers to present information about their teen's educational habits, organizational skills, and learning struggles.

Finally, the evaluation must consider how the teen would be performing if all existing supports (medication, tutoring, caregiver assistance with schoolwork, etc.) were removed. In other words, if the teen is coping with educational demands due to a successful medication regimen, or an excellent academic support system, that does not mean that a disability is not present. It is the presence or absence of a disability that determines eligibility for an IEP, not the teen's current academic performance.

Notes for New York State:

The first step in the formal IEP process is to request an evaluation—this can be done by the teen’s caregivers, teachers or other school personnel. Caregivers must provide written permission for the evaluation before it can take place.

What might go into a 504 Plan/IEP?

How to prepare:

1. Brainstorm what the 504 Plan/IEP should address

It is helpful to enter into the 504 Plan/IEP process with a clear idea of what areas the teen needs support for. Some of the important things to consider for teens with ADHD are:

- Inattentiveness
 - difficulty sustaining attention on things over longer periods of time
 - trouble paying attention to details
 - difficulty filtering out distractions
- Impulsiveness
 - trouble inhibiting behavior and
 - trouble regulating emotions
- Time management issues
 - being late for things
 - difficulty splitting time up between tasks
 - difficulty getting tasks done on time
- Memory deficits
 - difficulties in reading comprehension
 - difficulty writing
 - difficulty solving problems
- Planning deficits
 - making and carrying out plans
- Disorganization
 - messy lockers, backpacks, notebooks
 - poor handwriting
 - losing things
- Forgetfulness
 - not turning in assignments
 - not preparing for tests
 - not bringing the right books home to complete schoolwork
- Misbehavior (if the teen needs more lenient discipline because misbehavior is due to the disability—ADHD, or an emotional disorder—this **MUST** be included in the 504 Plan or IEP)
 - due to impulsiveness (interrupting, not staying seated, losing temper, talking back)
 - due to an emotional disorder

2. Brainstorm goals for the teen

Legally, IEPs must include measurable goals for the teen; the process for 504 Plans is less strict, but in either case it is helpful to have specific goals in mind that can be measured and tracked for the teen. This will make it easier to determine whether or not the 504 Plan/IEP is successful, or whether revision might be needed.

For example, if a teen (Amy) is struggling with organization skills and routinely forgetting to turn in homework, the goal might be: Amy will remember to turn in her homework. But a better goal would be: By the end of this grading period, Amy will be turning in at least 50% of her homework assignments without being reminded by teachers. To know whether this is occurring, it is necessary to track what percentage of homework Amy is returning. This allows the team to measure progress to ensure that the assistance being provided is, in fact, working—and to modify it if good progress is not made.

3. Brainstorm specific A/M/Is

The teen and family may have particular accommodations, modifications or interventions in mind that they would like to have considered. Knowing what these are while the 504 Plan/IEP is being created can help to avoid frustration later if they are not included. It also provides an opportunity for dialogue with school counselors and teachers, to find out what A/M/Is are usually offered and how they are provided.

As described above in Module 3:

- Accommodations are services that help reduce the impact of the teen’s disability by providing extra support so that he/she can meet the same academic expectations as the rest of the class.
- Modifications are services which change the academic expectations for the teen, recognizing the fact that his/her disability interferes with academic performance.
- Interventions are services that help the teen gain new skills or knowledge so that he/she can meet the same academic expectations as classmates.

In New York State, it is unusual in IEP recommendations for ADHD students to be granted significant modifications or accommodations, especially those that place additional burden on teachers. Much more likely are (1) minor A/Ms, such as time extensions for handing in assignments, or permission to use a school-issued computer for taking essay tests; or (2) “services” (i.e., interventions) that can include in-class support (from an aide/tutor assigned to the student for all or part of a day) and/or after-school tutoring/remediation.

Generally, interventions are preferable to accommodations and modifications, as they provide the teen with transferrable skills and knowledge that can be applied in multiple contexts—academic, vocational, and at home—now and in the future.

Consider an example: Michael has trouble taking notes—a common problem for teens with ADHD; now that he is in high school, quizzes and tests rely more on lecture material than textbook material, and his grades have suffered. Modifications might include: (1) changing the way Michael is tested, for example replacing essay or short answer questions with fill-in-the-blank questions accompanied by a bank of correct answers to choose from; (2) grading Michael’s

test on a more lenient curve, or providing him with extra-credit questions that other students don't have. An example Accommodation would be for the teacher to provide a set of lecture notes for each day's lecture, rather than having Michael rely solely on his own notes. An example Intervention would be for Michael to receive instruction from the Special Education teacher on how to take better notes. This could include information about organizing his notes (such as using an outline, concept map, or other framework), how to make the most important information stand out so that he could easily find it when reviewing for tests, and how to take notes efficiently (focusing on the important information rather than writing down every word in the teacher's lecture).

Questions to ask

About the general process:

- What are some of the accommodations/modifications/interventions that the school offers?
- Does the school have recommendations for how to address certain types of problems?
- What school resources does the teen have access to (e.g., counselors, special education teachers, use of resource room)?
- Who can caregivers talk to? What resources are available to them if they need support in creating or implementing the plan?
- If caregivers are not involved in the teen's academic life, what additional support can the school provide?

About evaluation:

- Will an evaluation be recommended?
- When will the evaluation take place? (REMEMBER: Caregivers must provide written permission for evaluation to occur)
- What does the evaluation require from the family/teen?
- How can the therapist help with the evaluation process?
- What will the evaluation assess for? (Other Health Impairments in addition to Specific Learning Disabilities?)
- What are the results of the evaluation?
- Is the teen eligible for a 504 Plan or IEP? If so, which one, and why?

About the 504 Plan or IEP:

- How often will the 504/IEP be re-evaluated?
- What can be done if it seems the 504/IEP isn't working? Or isn't being implemented properly?
- Do the teen's teachers know how to implement recommended accommodations/modifications?
- Do the teen's teachers have experience providing this type of support for other students?

REVIEW: Chronology of the 504/IEP process

1. Recognize that there is a problem (the teen is struggling, even if a 504/IEP is already in place)
2. Interventions can begin immediately: It is not necessary for an evaluation or any kind of meeting to occur for services to begin; schools are allowed to provide early interventions without a formal plan in place
3. Evaluation (required if IEP is being considered)
4. Prepare for the 504/IEP planning/revision meeting
5. Develop the 504/IEP or revisions to the existing plan
6. Implement and continue to monitor the success of the plan

Changing Academic Support in the Home for Adolescents with ADHD (CASH-AA): Fidelity Monitoring Checklist

Client ID: _____ Therapist: _____ Date of First Intake: _____

Dates of Task Activity
(x when Task completed)

Module 1 Motivation & Preparation: Home Academic Environment

- 1a. Review clinical profile of ADHD symptoms and school functioning _____
- 1b. Adolescent engagement interventions for school problems _____
- 1c. Reframing interventions for ADHD-related school problems _____
- 1d. Relabeling interventions and Linkage of ADHD to school problems _____

Module 2 Behavior Change: School Attendance and Homework Plan

- 2a. Behavior contracting and incentives for school attendance _____ N/A
- 2b. *Homework Management Plan* intervention
 - Part 1: Orientation _____
 - Part 2: Caregiver Prep _____
 - Part 3: Caregiver Confirm, Teen Prep, Plan Negotiation _____
 - Part 4: Progress Review _____
 - Part 5: Plan Re-Negotiation _____
- 2c. *Schoolwork Organization System* intervention
 - Part 1: Review Current System, Introduce BOS _____
 - Part 2: Introduce ANC _____
 - Part 3: Build BOS _____
 - Part 4: Implement BOS (Therapist Leads BOS & ANC Review) _____
 - Part 5: Evaluate BOS (Adolescent Leads BOS & ANC Review) _____
 - Part 6: Introduce BOS & ANC Review to Caregiver _____
- 2d. Promotion of home-based tutoring and/or organizational skills training _____ N/A

Module 3 Collaboration: Therapist-Family-School Partnership

- 3a. Family consultation on special education rights and services _____ N/A
- 3b. School visit to establish collaborative educational plan and school-based supports _____

Homework Management Plan Worksheet

This contract provides a description of the procedures related to _____ completing schoolwork at home. This plan began on _____ and should be renegotiated when the next report cards are sent home which is approximately on _____. The purpose of this plan is to help _____ improve his/her grades at school by completing assignments on time and studying adequately so he/she is prepared for tests and quizzes.

We agree that _____ will spend _____ minutes per day working on schoolwork. This may include studying or completion of assignments. He/She will spend this time every day that is followed by a school day. This is typically Sunday through Thursday but the time is not required if there is no school on the following day due to holidays or other reasons. If there is school on the following day (regardless of the activity—for example, field trip, testing, assemblies), then the time should be spent on schoolwork.

_____ may have full privileges each evening that this contract is in effect until _____. At that point, if he/she has not already completed schoolwork time, then he/she is no longer allowed to do any of the following activities:

_____.

After completing the schoolwork time, all of the privileges listed above are permitted. It is OK to never do the schoolwork time as long as privileges are not available during the entire evening. Regardless of whether he/she completes the schoolwork time, all privileges are available on the following day.

_____ should inform _____ (caregiver) when he/she is beginning the schoolwork time, where he/she will be working, and when it is completed. The following locations are permitted for doing schoolwork:

_____ will check to make sure that _____ is doing schoolwork during that time, but will not check the work or try to determine how much of what was assigned is being completed. If _____ is not working on schoolwork when _____ checks, then the _____ minute time period will start over. If _____ claims to not have any schoolwork, then _____ will assign him/her something to read from a book, newspaper, magazine or some other source and a written assignment related to that reading (for example, write a summary of what was read). _____ must work on this task during the schoolwork time in order to earn the privileges.

Student Signature

Date

Caregiver Signature

Date

Caregiver Signature

Date

Homework Management Plan Worksheet

EXAMPLE

This contract provides a description of the procedures related to Jeff completing schoolwork at home. This plan began on October 4, 2015 and should be renegotiated when the next report cards are sent home which is approximately on January 15, 2016. The purpose of this plan is to help Jeff improve his/her grades at school by completing assignments on time and studying adequately so he/she is prepared for tests and quizzes.

We agree that Jeff will spend 20 minutes per day working on schoolwork. This may include studying or completion of assignments. He/She will spend this time every day that is followed by a school day. This is typically Sunday through Thursday but the time is not required if there is no school on the following day due to holidays or other reasons. If there is school on the following day (regardless of the activity—for example field trip, testing, assemblies), then the time should be spent on schoolwork.

Jeff may have full privileges each evening that this contract is in effect until 5:30 (on Sundays, Mondays & Wednesdays) and 7:00 (on Tuesdays & Thursdays). At that point, if he/she has not already completed his schoolwork time, then he/she is no longer allowed to do any of the following activities: use of a computer (except as needed to complete schoolwork), telephone, television, video games, leave the house, have others come to the house, use of any electronic device not required for schoolwork (e.g., iPad, handheld game), or any other recreation activity (board games, ping pong, etc.). After completing the schoolwork time, all of the privileges listed above are permitted. It is OK to never do the schoolwork time as long as privileges are not available during the entire evening. Regardless of whether he/she completes the schoolwork time, all privileges are available on the following day.

Jeff should inform Mom (caregiver) when he/she is beginning the schoolwork time, where he/she will be working, and when it is completed. The following locations are permitted for doing schoolwork: any location is fine. Mom will check to make sure that Jeff is doing schoolwork during that time, but will not check the work or try to determine how much of what was assigned is being completed. If Jeff is not working on schoolwork when Mom checks, then the 20 minute time period will start over. If Jeff claims to not have any schoolwork, then Mom will assign him/her something to read from a book, newspaper, magazine or some other source and a written assignment related to that reading (for example, write a summary of what was read). Jeff must work on this task during the schoolwork time in order to earn the privileges.

Student Signature

Date

Caregiver Signature

Date

Caregiver Signature

Date

Name: _____

Date Completed: _____

CASH-AA: SCHOOL MATERIALS SUPPLIES LIST
--

- ✓ School bookbag
- ✓ Large 3-ring binder
- ✓ Binder-size portable 3-hole Punch device
- ✓ 3-hole Divider with tabs to identify class names
- ✓ 3-hole Pocket Folders: labeled, one for each class
- ✓ Homework Folder: Labeled “Homework to be completed” on left pocket and “Homework to be turned in” on right pocket
- ✓ 3-hole Pouch for housing pens/pencils/erasers/sharpener
- ✓ Assignment planner
- ✓ Loose-leaf paper

Name: _____

Date Completed: _____

CASH-AA: Bookbag Organization System Checklist

BINDER ORGANIZATION	YES	NO
Binder presents legible student name and homeroom on front cover		
Assignment Planner is secured by 3 rings in front of binder		
Homework folder is just behind the planner AND correctly organized: HW to be completed in left pocket, HW to submit in right pocket		
There is a divided section AND a subject folder for each class, secured by 3 rings		
There are no loose papers or non-school materials		
All papers are in the appropriate section and the correct folder		
There is a pocket for caregiver review that contains only appropriate materials		
Notes for each subject are secured and organized <i>oldest to newest</i> in each section		
Loose-leaf paper, 3-hole punch, and Pencil pouch materials (pen, pencils, erasers, sharpeners) are all correctly placed and in plentiful supply		
BOOKBAG ORGANIZATION	YES	NO
Contains binder and all books needed to complete homework for next day		
Contains only those books needed for HW during next 3 days <i>OR</i> books for long-term assignments		
Contains metrocard in easily accessible location (if applicable)		
Contains no unnecessary clothing, loose paper, or non-school materials		

Week of: ____/____/____

Assignment Planner

class	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

Name: _____

Date Completed: _____

CASH-AA: Assignment Notebook Checklist

Assignment recorded for:	Monday	Tuesday	Wednesday	Thursday	Friday
Language Arts					
Math					
Science					
Social Studies					
Other:					
Other:					
Teacher sign-off:	Monday	Tuesday	Wednesday	Thursday	Friday
Language Arts					
Math					
Science					
Social Studies					
Other:					
Other:					

Name: _____

CASH-AA: BOS and ANC Tracking Sheet

Week 1	
Date:	
# Yes checks on BOS	# checks on ANC
Week 2	
Date:	
# Yes checks on BOS	# checks on ANC
Week 3	
Date:	
# Yes checks on BOS	# checks on ANC
Week 4	
Date:	
# Yes checks on BOS	# checks on ANC

Week 5	
Date:	
# Yes checks on BOS	# checks on ANC
Week 6	
Date:	
# Yes checks on BOS	# checks on ANC
Week 7	
Date:	
# Yes checks on BOS	# checks on ANC
Week 8	
Date:	
# Yes checks on BOS	# checks on ANC

Additional Resources

- Dendy, C. A. Z. (2000). *Teaching Teens with ADD and ADHD: A Quick Reference Guide for Teachers and Parents*. Bethesda, MD: Woodbine House.
- Dendy, C. A. Z. (2006). *Teenagers with ADD and ADHD: A Guide for Parents and Professionals (2nd Edition)*. Bethesda, MD: Woodbine House.
- Evans, S. W., Owens, J. S., & Bunford, N. (2014). Evidence-based psychosocial treatments for children and adolescents with Attention-Deficit/Hyperactivity Disorder. *Journal of Clinical Child and Adolescent Psychology*, 43, 527-551.
- Evans, S. W., Owens, J. S., Mautone, J. A., DuPaul, G. J., & Power, T. J. (2014). Toward a comprehensive life-course model of care for youth with Attention-Deficit/Hyperactivity Disorder. In *Handbook of School Mental Health* (pp. 413-426). United States: Springer.
- Harrison, J. R., Bunford, N., Evans, S. W., & Owens, J. S. (2013). Educational accommodations for students with behavioral challenges: A systematic review of the literature. *Review of Educational Research*, 83, 551-597.
- Hogue, A., Bobek, M., & Evans, S. W. (2014). Changing academic support in the home for adolescents with Attention-Deficit/Hyperactivity Disorder: A family-based clinical protocol for improving school performance. *Cognitive and Behavioral Practice*. <http://dx.doi.org/10.1016/j.cbpra.2014.07.002>
- Robin, A. (2006). Training families with adolescents with ADHD. In Barkley, R. (ed.). *Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment* (3rd ed., pp. 499-546). New York: Guilford.
- Sibley, M. H., Kuriyan, A. B., Evans, S. W., Waxmonsky, J. G., & Smith, B. H. (2014). Pharmacological and psychosocial treatments for adolescents with ADHD: An updated systematic review of the literature. *Clinical Psychology Review*, 34, 218-232.