# Medication Integration Protocol (MIP): Provider Manual

**May 2015**

**Aaron Hogue, Molly Bobek, & Alexis Nager**
**The National Center on Addiction and Substance Abuse at Columbia University**

# TABLE OF CONTENTS

# INTRODUCTION

The Medication Integration Protocol (MIP) is a team-oriented protocol intended to create a collaborative integration of pharmacological interventions and behavioral interventions for adolescents diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) in addition to co-occurring mental health and/or substance use problems. MIP will typically involve a team of providers: (1) Assessor who completes the intake assessment of the adolescent and family at the beginning of treatment enrollment; (2) Psychiatrist (or other Prescriber) who completes the diagnostic interview and/or medication consultation, and when indicated, oversees medication management for the adolescent; and (3) Therapist (aka Clinician) who conducts the outpatient behavioral health treatment of the adolescent and family. Of course in some circumstances one person may fulfill two or all three of these functions.

MIP is a semi-structured, flexibly delivered intervention composed of five modular Tasks:

- **MIP Task 1: ADHD & EF Intake Assessment and Medication Consult**
- **MIP Task 2: ADHD Psychoeducation and Client Acceptance**
- **MIP Task 3: ADHD Symptoms and Treatment Planning**
- **MIP Task 4: ADHD Medication and Family Decision-Making**
- **MIP Task 5: Medication Management and Integration Planning**

MIP Tasks are considered *modular* because they are designed to be administered in any order that seems clinically indicated based on the status and progress of the case. The exception is Task 1, which should be implemented first overall. MIP is structured according to *Tasks* rather than sessions because each Task contains several **Task Goals**, **Guiding Therapeutic Principles**, and **Subtasks** that might be achieved in a single session, during a continuous intervention sequence across multiple sessions, or staggered across several sessions and/or interspersed with interventions from other Tasks. The length of time needed to complete each Task will therefore vary greatly—from a partial session to parts of several sessions—depending on the profile of the given family, practice habits of the provider team, and progress of the case. MIP is considered *semi-structured* because all Subtasks for each Task should be completed at some point during treatment for virtually every case. However, MIP is also *flexibly delivered* because the priority and sequence of the various Subtasks will vary both within and across Tasks, subject to provider judgment. The provider team will also determine, based on the procedures of the treatment clinic and the needs of the given family, whether the psychiatrist or the therapist will implement the Medication Module (Task 4b) and at what juncture of treatment it should be completed.

## How to use this Manual

The five MIP Tasks, along with their respective goals and guiding principles, are described below. This Manual is designed to (1) present the targeted client outcomes and main intervention goals of each Task; (2) describe the core Subtasks of each Task; (3) discuss the utilization of MIP psychoeducational materials that have been developed specifically to supplement MIP Task completion; and (4) identify adjunctive interventions that might prove useful for completing a given Task or Subtask.

Therapists should familiarize themselves with the *Fidelity Monitoring Checklist*, goals for each task, and guiding principles for each subtask. The ***Fidelity Monitoring Checklist*** presents the tasks as activities that can be checked off when they are completed (e.g., 'Completion of ADHD Style Index'). The **Task-Specific Goals** explain what should be accomplished in the family as the result of successful completion of a given task (e.g., 'Family understands that ADHD is a common, lifetime condition based in brain chemistry'). The **Guiding Therapeutic Principles** of each subtask provide specific instruction about how the therapist should proceed, and/or what they should attend to, when completing the subtask (e.g., 'Link a history of school problems to specific EF deficits').

## Adapting the Protocol for Adolescents with Absentee Caregivers

MIP is fundamentally a family-based protocol, in that it contains interventions that directly target family understanding and acceptance of ADHD, family relationships, and family decision-making about ADHD medications. For therapists utilizing individual-based treatment for a given adolescent, MIP 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 MIP 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 the therapist to explore and validate the expected difficulty of making important changes without the caregiver participating in therapy.

## Therapists' Frequently Asked Questions

*Is ADHD over-prescribed and are kids overmedicated?*

Despite some popular media reports, rigorous studies suggest ADHD is underdiagnosed and undertreated, especially among adolescents.

*Is ADHD medication over-prescribed in minority groups?*

There are actually negative health disparities for ADHD treatment: A smaller percentage of minority groups who would potentially benefit from medication actually receive medication.

*My teenage ADHD clients have all been on medication for too long, when will it stop?*

Teenagers who are currently using medication should be reviewing medication continuation with their prescribing physicians on a regular basis. There are no known side effects or complications to stopping ADHD medication.

*How can we avoid imposing medication on kids and families?*

A well-informed, family-based decision-making process is the best method for bringing the teen, caregiver, and therapist to agreeable consensus on decisions about starting a medication regimen. This manual presents a structured protocol for reaching such consensus.

*Why should I treat ADHD when it is not my client's biggest problem?*

ADHD medication is an evidence-based treatment that can have immediate positive effects on a set of symptoms that tend to interfere with or complicate multiple areas of functioning. ADHD medication often provides an excellent foothold for making progress in other areas of therapeutic work.

*Why should I treat ADHD when the problem is not with the ADHD symptoms themselves, but with learning disabilities and/or issues with school engagement?*

If a teen has ADHD, his or her behavioral and executive functioning problems will continue to impede progress in multiple areas of school functioning if left untreated. Medication can help in these areas so that other interventions for learning or school engagement problems can gain better traction.

*If a family is difficult to engage, how can I responsibly promote a medication option that will require commitment to lengthy medication titration and long-term monitoring?*

> Engagement comes first, and medication is simply an option to review and consider in treatment, assuming the family is on board.

*There are several non-pharmacological approaches to treating ADHD (mindfulness, nutrition, etc.) that have weak or inconclusive empirical support but are nevertheless popular among many families and providers. How do I speak with families about these other options that they may be interested in exploring instead of medication?*

> There are many available approaches for treating ADHD, some of which can complement medication and some which are meant to replace it. A client-centered approach needs to balance responsible family psychoeducation about available empirical evidence with the knowledge base and preferences of the given family.

## MIP TASK 1: ADHD & EF INTAKE ASSESSMENT AND MEDICATION CONSULT

The starting point for MIP work is confirmation of an ADHD diagnosis for the adolescent. **A diagnosis of ADHD is valid only if approved by a credentialed assessor**. Diagnostic procedures include administration of a validated diagnostic interview based on the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013) or a comparable diagnostic instrument. Many of the MIP psychoeducation materials developed for use in MIP Task 2 (see below) are based directly on DSM diagnostic criteria.

DSM criteria also stipulate that a diagnosis of ADHD be given only if it is determined that the observed symptoms are **not directly attributable to another disorder**, such as a disruptive behavior disorder (e.g., Oppositional Defiant Disorder, Conduct Disorder), mood disorder (e.g., Major Depression, Dysthymia), or anxiety disorder (e.g., Generalized Anxiety Disorder, Posttraumatic Stress Disorder). It should also be ascertained that the observed symptoms are not attributable to Bipolar Disorder, as stimulant medications, which are the most common evidence-based intervention for ADHD, are contra-indicated for youth with Bipolar Disorder.

Finally, we strongly recommend that clinicians gather assessment data directly from school personnel. This enables clinicians to make a confident and specific diagnosis, to obtain reliable data on the history and current standing of school performance indicators (including enrollment in educational support services), and to set the stage for assessing clinically significant improvements in school functioning.

## Task 1 Goals

- Teen & family have undergone assessment for ADHD and executive functioning deficits
- Family understands how ADHD is diagnosed (i.e., based on behavioral evidence from multiple sources rather than on biological markers)
- Family and prescriber have discussed the diagnosis and potential need for ADHD medication (whether or not a decision to begin medication has been made)

Task 1 consists of the following subtasks:

- Task 1a: Consultation with intake assessor and/or psychiatrist on results of ADHD assessment
- Task 1b: Consultation with psychiatrist on family interview about ADHD medication prescription
- Task 1c: Preparation of EF assessment feedback for delivery to the family during Task 2

### Task 1a: Consultation with intake assessor and/or psychiatrist on results of ADHD assessment

**Guiding Therapeutic Principles:**

- Meet with the assessor and/or psychiatrist to review the ADHD diagnosis and EF deficits determined by the assessment
- Educate the family about how ADHD is diagnosed (e.g., use of behavioral information in assessment, rather than biological markers or paper tests)

## Educating the Family: ADHD Diagnoses are Behavioral

Caregivers (and when appropriate, adolescents themselves) should be informed that there are no biological markers of ADHD that definitively identify the ADHD diagnosis. Instead, a positive diagnosis is based on a confluence of behavioral evidence supplied by families and schools (and sometimes attention tasks; see below). Keep in mind that it can be hard for families to accept a diagnostic label if they believe it has been decided or applied too casually or quickly. A comprehensive analytical approach is recommended in which other social and psychological explanations (including learning problems) are systematically ruled out, in consultation with the caregiver and teen, before making a definitive diagnosis.

Determining whether an adolescent meets diagnostic criteria for ADHD can be quite challenging for a number of reasons:

(1) Caregivers and teens often have (very) different perspectives on the presence and severity of symptoms
(2) Caregivers may have difficulty sorting out behaviors reflecting normative (or nearly normative) developmental maturation from symptomatic behaviors
(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), so that symptoms are not easily recognized by caregivers as part of the same "condition"
(4) Caregivers may not be acute in distinguishing ADHD symptoms from behavioral problems (particularly oppositional behavior) associated with other disorders that frequently co-occur with ADHD
(5) Caregivers may not be as familiar with the school context, so it may be very challenging for them to identify behavior likely to occur only there (e.g., inhibition required in a classroom setting)
(6) By the time the teen reaches high school age, he and/or his caregiver may have become so accustomed to the ADHD symptoms and their impact that they are perceived as part of the teen's personality or temperament, syntonic to who they are, and therefore need not or cannot be treated

Input from both caregiver and teen may be better encouraged by conducting the assessments separately.

Administering a Continuous Performance Task (CPT)

CPTs are computer-based measures that utilize monotonous tasks to test for sustained focus (inattention), and counter-intuitive (aka implicit) decision tasks to test for self-regulation (impulsivity). A variety of CPTs are available that are brief, easily administered, and appropriately normed for children and adolescents. There are many potential benefits to including a CPT as part of the standard diagnostic battery for all adolescents.

For those suspected of having ADHD, including a CPT allows for a fully triangulated ADHD baseline assessment consisting of caregiver and adolescent self-report, school report/records, and an objective performance task. CPTs also provide some "hard data" that may be useful for justifying an ADHD diagnosis with families, presenting a measureable yardstick for the degree of severity, and idiographic tracking of medication effects via pre-post testing.

Although CPT data are informative, they are not definitive as either "rule in" or "rule out" thresholds for diagnosing ADHD. Families may also be prone to reifying the CPT data and/or pathologizing the adolescent based on performance score, something the treatment team should carefully avoid when introducing the test and presenting test results.

## Working with the ADHD-Naïve Family

It is very important to exercise caution when introducing the concept of ADHD to families who have not previously considered their teens in this light, as they may be especially sensitive to terms like "disorder" and even "condition." If families become overly alarmed by labels or by premature discussions regarding medication, this could jeopardize their retention in treatment.

A more gradual approach is first to normalize the ADHD spectrum, as in: "Everyone falls along a continuum of attention/organization and self-regulation, but about 1 in 20 people have weaknesses in these areas that negatively impact some important aspect(s) of their day-to-day functioning. These folks may need to make some adjustments and accommodations to achieve the successes they seek." Such language substitutes "normalization + adjustment" for medicalization but still allows for recognition that ADHD issues are (1) longstanding and not likely to spontaneously remit and (2) can be accommodated and minimized with the work of behavior therapy.

As a general principle, **the therapist should recommend that the psychiatrist not begin to discuss medication immediately** after making and presenting an ADHD diagnosis, especially for medication-naïve clients. Brief mention of medication as one common intervention for ADHD is warranted and non-alarming, but a more in-depth discussion about mechanisms and side effects is usually better left until after the first three psychoeducation tasks have been completed. At that point, the therapist/psychiatrist can initiate Task 4 (ADHD Medication and Family Decision-Making), with a more informed and hopefully less alarmed family. This way of working represents a shift in typical treatment, during which assessment and medication recommendations happen during the first (and often only) meeting with the psychiatrist.

### Task 1b: Consultation with psychiatrist on family interview about ADHD medication prescription

**Guiding Therapeutic Principles:**

- Meet with the psychiatrist to review any medication recommendations to be made based on the intake assessment
- Encourage the psychiatrist to allow time for completion of the MIP protocol before he/she makes any specific medication recommendations to the family

Once an adolescent has been diagnosed with ADHD, a medication consult with a credentialed physician is needed to determine if and when an ADHD medication regimen will be prescribed.

If the consulting physician is also the person who completed the ADHD diagnostic interview, then the medication consult will often occur in the same session.

> For MIP, the medication consult should always take place as a **family interview** that includes both the caregiver and teen. This is essential because MIP is grounded in a family-based approach to making decisions about starting medication as well as a family-based approach to monitoring titration and compliance for families who accept medication.

During the medication consult, psychiatrists may choose to utilize some or all of the MIP psychoeducation materials in the Medication Module (see Task 4b). As is true for all MIP modules, psychiatrists will use their own discretion in determining which aspect of the Medication Module (if any) to administer to any given family.

As part of the diagnostic process and medication consult, other diagnoses may emerge that typically also benefit from pharmacological intervention, for example, depression and anxiety disorders. The Texas Medication Algorithm, a decision tree medical formulation, may provide technical assistance in these instances. Cross-diagnosis medication issues arise in highly comorbid populations, and there are also the cross-symptom benefits of stimulant meds.

> In some cases the psychiatrist and therapist might decide to jointly interview the family during the initial medication consult. This would facilitate an integrated approach to treatment from the very start, as well as allow the therapist to begin to formulate ADHD-relevant treatment goals with the family at the outset of treatment. If this approach is used, it preempts the need for separate completion of Task 1b, and possibly Task 1a as well.

**Task 1c: Preparation of EF assessment feedback for delivery to the family during Task 2 (when applicable)**

**Guiding Therapeutic Principles:**

- Review the assessment findings on the adolescent's executive functioning and develop an individualized portrait of the adolescent's deficits in this area

Getting a Handle on Executive Functioning (Dendy, 2011)

Executive functioning (EF) generally refers to the brain's ability to manage learning activities and behavior. The term "executive" refers to the organization and management functions of these cognitive skills. Executive skills are particularly needed in situations that are (1) new or less familiar and (2) complex or have multiple parts/steps. Youth with very strong basic cognitive skills and overall intelligence can nevertheless struggle in school or other social contexts that place a premium on executive functions such as organization and emotional control.

EF characteristics include:

- *Working memory and recall*: information processing, holding facts in mind, accessing facts, time awareness
- *Inhibition*: inhibiting speech and actions, thinking before acting/speaking
- *Activation, arousal, & effort*: getting started, staying alert, finishing work
- *Emotional control*: frustration tolerance, sensitivity to criticism, mood stability
- *Internalized language*: "self-talk" that helps guide and control actions
- *Analysis and reconstitution*: taking an issue apart, analyzing it, putting it back together, or assembling it in a new way
- *Shifting*: adjusting to new situations, transitioning from one context to another, flexibly solving a problem
- *Planning & organizing*
- *Monitoring*: paying attention to ongoing tasks, perceiving one's impact on others

Research indicates that a large percentage of youth with ADHD also have some deficits in executive functioning. Moreover, EF deficits (e.g., poor analytic skills, weak working memory) are often more debilitating than ADHD behavioral symptoms (e.g., poor concentration, restlessness) in school settings. In fact, ADHD teens who do not have any significant EF deficits do not usually have major problems in school achievement, though they often find themselves in trouble due to immature behavior.

The combination of ADHD and EF deficits usually generates significant school problems starting in the middle school years, when there are significant increases in (1) maturity and independence expectations and (2) the complexity and long-term planning demands of the work itself. These increased demands spell double trouble for ADHD teens with EF difficulties and explain why many ADHD youth make reasonable progress in the elementary school years only to "hit a brick wall" starting in middle school, *even if their hyperactivity and impulsivity behaviors remain stable or decrease.*

## Assessing for Executive Functioning and Learning Deficits

It is strongly recommended that intake assessment batteries for adolescents with suspected or confirmed ADHD include measures of EF in addition to diagnostic measures of ADHD symptoms. Several self-report questionnaires and performance tasks are widely available to assess various aspects of EF.

Adolescents with confirmed ADHD should also be assessed, at intake or during a later point in care, for the presence of learning disabilities, which often co-occur with ADHD and create significant challenges for school performance. Both the pharmacological and behavioral treatment components of MIP can have positive effects on school investment and school performance. It is therefore important for MIP providers to be knowledgeable about clients' potential learning problems and comfortable in tracking these issues throughout treatment.

## MIP TASK 2: ADHD PSYCHOEDUCATION AND CLIENT ACCEPTANCE

The goal of this task is to increase families' understanding of ADHD and the teens' acceptance of their ADHD diagnosis. This includes reviewing the results of the assessment to identify the individual teen's ADHD symptoms and executive functioning challenges, along with reviewing the Basic Facts Module (Task 2a) and the Executive Skills Module (Task 2b) of the ADHD psychoeducation slides.

Together, the therapist and family will also complete the ADHD Style Index, School Problem Scorecard, Family Problem Scorecard, and Peer Problem Scorecard. Completing the Scorecards is essential to adolescent ADHD assessment and treatment planning, as they are the means by which generic psychoeducational information is personalized for a given client.

## Task 2 Goals

- Family understands that ADHD is a common, lifetime condition based in brain chemistry
- Family has articulated and accepted ("owned") the particular ADHD profile of the teen
- Family has defined the teen's unique profile of EF deficits
- Family understands that EF deficits affect, and are affected by, stress and performance challenges at home and school, and that accommodations are needed to bring about improvement
- Therapist has completed copies of the ADHD Style Index and all 3 Scorecards: Family Problems, School Problems, Peer Problems

| Instant ADHD Information and Community: The CHAAD Website |
|---|

An invaluable resource for both the therapist and family is the CHAAD website, a consumer-driven information warehouse stocked with resources aimed at counselors, school personnel, family members, and media. The easy-to-navigate website contains caregiver-to-caregiver and teen-to-teen psychoeducational resources that may be highly interesting and informative to families with basic internet skills, opening the door to a large and highly supportive community of ADHD families. The materials on the website can also serve as foci for therapeutic discussions on all varieties of ADHD-related topics.

Task 2 consists of the following subtasks:

- Task 2a: Review of ADHD intake data and Presentation of Basic Facts Module
- Task 2b: Review of EF intake data and Presentation of Executive Skills Module
- Task 2c: Completion of *ADHD Style Index*
- Task 2d: Completion of *Family Problem Scorecard*
- Task 2e: Completion of *School Problem Scorecard*
- Task 2f: Completion of *Peer Problem Scorecard*

**Task 2a: Review of ADHD intake data and Presentation of Basic Facts Module**
In this task the therapist presents the results of the teen's assessment and provides psychoeducation about the symptoms, prevalence, and neurobiological underpinnings of ADHD.

**Guiding Therapeutic Principles:**

- Support the adolescent and caregiver in recognizing ADHD as a lifelong biochemical "condition" ("disorder" may be too stigmatizing and/or misunderstood)
- Educate the family about prevalence rates and deliver a strong anti-stigma message: ADHD is not unusual, and the adolescent is not alone/weird/damaged
- Educate the family about the two dimensions of adolescent ADHD: Inattention/Disorganization, Impulsivity/Restlessness/Volatility
- Educate the family about the multiple symptoms and common impacts of ADHD, but also, that ADHD "looks different" in every teen
- Encourage the adolescent to recognize ADHD in him/herself and to take ownership of his/her ADHD condition: I have it, and it impacts my life in important ways
- Encourage the caregiver to accept that his/her teen has this condition, acknowledge the stress it creates in everyday caregiver/family life, and attribute some portion of the history of teen/family problems to ADHD issues
- Set the stage for introducing the importance of medication: ADHD stems from problems in brain chemistry (primarily: neurotransmitters)

DSM-IV Symptoms ("How do doctors diagnose ADHD?" slides)

"These are what doctors use to diagnose ADHD. This doesn't mean you have all the symptoms that are listed, but you and your caregiver reported that you do have many of them, and that they cause you some problems in your everyday life."

How do we know that you have ADHD? ("Am I an ADHD teen/Am I the caregiver?" slides)

- No single test confirms the diagnosis—the doctor(s) review a lot of information
- Underachievement in school is key—you are smart but not living up to your potential
- The symptoms show up in at least 2 different settings (home, school, peers)—evidence that it's not them, it's you!

"Attention and impulsivity can be understood as existing on a spectrum; it is not as much of a binary "yes/no" diagnosis as maybe we'd like it to be. Your symptoms and history lead us to believe you're on this, clinically significant, end of the spectrum."

Hyper-Focus: The Attention Paradox ("What is the core issue? Interest Deficit" slide)

Caregivers are often puzzled by or skeptical of a newly confirmed diagnosis of ADHD because they witness their teens demonstrate the ability to be hyper-focused—totally absorbed and non-distractible—during activities that fascinate them (video games, reading a favorite book, movies/music). "He can pay attention when he wants to!" is a common refutation of the diagnosis.

Explain to caregivers that **ADHD brains have no trouble paying attention to things that are exciting and stimulating**—things that keep interest high and neurotransmitters flowing steadily. In fact, ADHD teens can often focus on novel or exciting experiences for a longer period of time than others. However, their attention span and level of concentration (i.e., ability to block out distractions) is **LOWER** for ordinary experiences and **MUCH LOWER** for experiences that they find boring or routine.

The Neurobiology of ADHD: Finding the Right Metaphor

One of the biggest challenges facing those who offer psychoeducation to ADHD teens and their families is usefully describing the underlying cause of the observed behavior—that is, the brain neurochemistry associated with the condition—without communicating directly or indirectly that the ADHD brain is somehow "disabled": damaged, underperforming, or poorly constructed. The "disability" metaphor is not wholly accurate, and can also (for obvious reasons) be highly demoralizing to the family. A metaphor with similar pitfalls is the "wiring" metaphor. There is considerable risk that informing a teen "Your brain is wired differently" provides an implicit judgment about defectiveness, or at the least, poor craftsmanship. Even the seemingly informative statement "Your brain has fewer neurotransmitters" relies on the concept of "absence" or "lack" as its central metaphor.

**"Your brain works fast—sometimes a bit too fast"**

This "speed" metaphor has several virtues:

(1) It is not grounded in a deficit metaphor—in fact it suggests a kind of compliment

(2) It lines up well with the life experience of most ADHD teens (being always on the go, impulsive, prone to quickly switching attention, rapidly engaging their imagination when bored)

(3) It is congruent with the neurobiological facts of ADHD—"Your brain is very fast at clearing out (using up) the neurotransmitters that allow for sustained attention."

(4) It feeds directly into a potentially non-threatening explanation of the benefits of medication: "Medication is designed to slow down how quickly your brain uses up its neurotransmitters, so that you have them available longer for paying attention."

This metaphor may prove particularly compelling to those teens whose ADHD type includes the Hyperactive/Impulsive dimension.

Cognitive Distortions and Cognitive Repair *(Robin, 2006)*

3 Common Types of Cognitive Distortions about ADHD:

- **Ruination**: "Having ADHD means I'm disabled/defective"
- **Autonomy**: "Having ADHD means I am not in control of my behavior"
- **Perfectionism**: "Having ADHD means I can't do what I want/need to do"

How to address Cognitive Distortions using Cognitive Restructuring techniques:

1. Gently identify the distorted belief
2. Provide a logical challenge or counterexample
3. Suggest a more reasonable belief that is respectful of the original sentiment
4. Help collect evidence that favors the more reasonable belief

Here is an exemplar of repairing a cognitive distortion:

**Adolescent**: I guess because of ADHD I'm just not right, my brain doesn't really work right

**Therapist**: So now that we've identified and discussed your ADHD a little, you believe you are defective or broken, like you have a disability?

**Adolescent**: Yeah

**Therapist**: I wonder if that is 100% true. I know there are ways in which you AND your brain work really well. You have great skills on your skateboard and you have an awesome sense of humor. You agree with me about that?

**Adolescent**: Yeah, maybe

**Therapist**: I wonder if a better way to think about it would be, there are ways your brain works really well, and there are a few ways in which you need some support to help your brain work differently, more efficiently.

**Adolescent**: Ok fine

**Therapist**: So we will think together about ways you need help to work better, and also make sure we pay attention to what works well for you and your brain.

Rejecting the ADHD "Label": Tackling Stigma Head On (*Kellison et al., 2010*)

Many adolescents and caregivers will be reluctant to accept the diagnosis of ADHD due to the social stigma of being "labeled" with a mental health disorder in general and/or with ADHD in particular. Many ADHD teens will have been previously diagnosed and possibly treated for ADHD in a counseling setting, and these experiences may have generated (often legitimately) negative attitudes toward the ADHD label. Adolescents may also have been previously diagnosed with ADHD or tagged with a related label (e.g., "emotionally disturbed") during Individualized Educational Program (IEP) assessments and planning meetings at school.

It is essential for the therapist to review any such previous experiences with the family so that grievances and dissatisfactions can be properly aired, success stories noted, and stigma-related anxieties fully explored. **Psychoeducation can help correct misunderstood facts and misperceptions about ADHD, but it is usually not sufficient by itself to allay stigma-related concerns**.

Adolescents (and often caregivers) typically harbor three types of stigma-related concerns associated with accepting an ADHD diagnosis:

(1) **Negative self-image**: teens may develop negative attributions about themselves such as feeling damaged or impaired, apart or isolated, or not as valuable/strong/good as others.
(2) **Concern with public attitudes**: teens may believe that others will discriminate against them, ignore or reject them, ignore or overlook their good qualities, blame the teen personally for having ADHD-related problems, or subtly distance themselves socially.
(3) **Disclosure concerns**: Teens may feel anxious about the burden of keeping the diagnosis a secret, and may expect to suffer serious repercussions, additional unwanted scrutiny from teachers or school staff, or regrets once others are purposefully or accidentally informed.

Other Points to Emphasize

- ✓ ADHD is not a choice or a moral failing—it's a matter of innate brain chemistry
- ✓ ADHD is not a disease or disability—it's a matter of differential brain chemistry
- ✓ ADHD is very common—some teens feel embarrassed (shame) or unfairly labeled (stigma), but the fact is: About 1 out of every 10 teens have some form of it
- ✓ Many successful athletes and entertainers have ADHD (list available)
- ✓ Hyperactivity in childhood typically converts to fidgetiness and restlessness in adolescence

**Task 2b: Review of EF intake data and Presentation of Executive Skills Module**

In this task the therapist presents the results of the teen's executive functioning (EF) assessment and provides psychoeducation about how executive skills deficits can impact school performance as well as everyday life.

**Guiding Therapeutic Principles:**

- Explain that due to EF deficits, ADHD teens typically have serious problems at both home and school that go beyond poor attention span and being hyper
- Link a history of school problems to specific EF deficits
- Underscore the fact that the school context—the work environment and productivity demands—is difficult for most ADHD teens, who are neither "lazy" nor "disabled" but are often labeled as such by school personnel
- Reinforce the idea that for ADHD teens with EF deficits, significant accommodations at both home and school are needed—"business as usual" caregiving and teaching will not be enough

Disorganization is Not (Entirely) the Teen's Fault

Like ADHD, EF deficits are themselves linked to brain chemistry and function, and the vast majority of ADHD teens have deficits (of some magnitude) in more than one EF domain. Thus some behaviors that appear to be entirely under the control of the adolescent—planning ahead, being organized, being accurate/precise, keeping track of time—are in fact very challenging to an ADHD brain. This doesn't mean that ADHD teens can't be organized, just that most will require (much?) more external structure than the average teen to learn and practice organizational skills, *even when the teen is motivated and "trying her best" to be organized*.

School Achievement ("3 Influences on School Performance" slide)

ADHD symptoms interfere with school achievement, and separately from that, EF deficits interfere as well. Thus teens with difficulties in both domains have the deck stacked against them with regard to school success. However, an ADHD teen can still leverage his/her intelligence, motivation, and effort in school to overcome these challenges and achieve success, IF: (1) the teen retains some degree of investment in school and hope about achieving educational goals AND (2) the teen receives the necessary supports and accommodations at home and school.

> **Many ADHD teens become disconnected and hopeless about school, and their caregivers lose the confidence and motivation to reconnect them.** *For such families it may be an uphill struggle—and perhaps even counterproductive to achieving other treatment goals—to focus extensively on school issues.* For these families, it may be helpful to focus on vocational goals, or look forward to the different kinds of educational environments available to them in the future.

EF Deficits Affect Everyday Life, Not Just School (Dendy, 2011)

It is important to emphasize with both the caregiver and adolescent that EF deficits impact not only *learning*—i.e., the school context—but also *coping*—i.e., the everyday context. Teens with EF deficits may have particular problems with self-direction and coping under the following conditions: when information in tasks is new, in stressful situations, when planning ahead for the future, and/or when tasks are complex and require multiple steps.

> Psychoeducation pertaining to the school context could be largely rejected or tuned out by teens who are disconnected from or highly anxious about school. **Emphasize in equal measure that EF deficits also explain why ADHD teens sometimes have difficulties coping in every life situations, including family/home.**

This message about the challenge of coping with everyday life is congruent with a related message contained in the Basic Facts module: ADHD is not only about behavioral symptoms, but also about attention and maturity challenges.

Other Points to Emphasize

- ✓ ADHD is not related to intelligence
- ✓ Caregivers cannot control or easily influence the school environment, but they CAN make important changes in the school & homework support system that operates at home
- ✓ Whereas it is true that almost everyone, including ADHD teens, can perform better when they are motivated to work harder, it is also true that is it both exhausting and anxiety-provoking to "try harder" over a long period of time. ADHD teens need functional supports, positive encouragement, and teen-specific accommodations for the vast majority of times when they, like everyone else, "try regular".

**Tasks 2c, 2d, 2e and 2f: Completion of *ADHD Style Index, Family Problem Scorecard, School Problem Scorecard,* and *Peer Problem Scorecard***

In this task the therapist and family complete the ADHD Style Index, School Problem Scorecard, Family Problem Scorecard, and Peer Problem Scorecard. Completing the Scorecards is essential, as they are the means by which generic psychoeducational information is personalized for a given client. After the scorecards are completed, the therapist and family will be well positioned to identify problem areas and treatment goals, making ADHD symptoms and related problems an area to be targeted directly for intervention.

**Guiding Therapeutic Principles:**

- Anchor the psychoeducational language about ADHD symptoms and EF deficits to client-specific, highly personalized characteristics and problems identified by the family
- Generate a client-specific, non-blaming, explanatory narrative for challenges and problems in the adolescent's everyday functioning
- Cement the adolescent's self-identification ("ownership") of specific ADHD-related characteristics, challenges, and problems—this also will help pave the way for a concrete and need-focused discussion regarding medication
- Build a direct link between the most significant endorsed problems and treatment goals, such that treatment goals are perceived as high priority and also personally relevant for the adolescent as well as the caregiver
- Identify positive characteristics of ADHD that the teen can readily endorse

<u>Priming Families for the Scorecard Process</u>

Upon completion of Basic Facts and Executive Skills modules, the adolescent (and caregiver) should be properly primed for the Scorecard process. Teens should be positioned to assert:

- I understand what ADHD is
- I accept that I have ADHD
- It is important to think carefully about how ADHD affects my life (i.e., to "personalize" my ADHD in terms of personality factors, challenges, and specific problems)
- I can recognize the impact of ADHD in many areas of my life: family, school, friendships

Script for Introducing the Scorecards to the Adolescent and Caregiver

- [To Adolescent] "Let's think together about how ADHD creates challenges and problems in your life. This will help us determine what the most important problems are, and what we can do in therapy to address them. I'll read them all out loud, and afterwards we'll talk about them as much as you want, and [to Caregiver] it would be great to hear your ideas also. After that, [to Adolescent] I'd like you to rank them in order from the biggest problem—give that problem a rank of #1—to things that are not problems at all. Now let's take a look at this scorecard of _____ problems. On the left is a box that describes characteristics of ADHD that commonly impact the _____ area: [Read the characteristics]. On the right is a listing of several common problems. Keep in mind that you may have only a few of these problems or many of them—every person is different! Now, I'll read the problems aloud….."

**<u>Points to Emphasize when Completing Scorecards</u>**

- ✓ These problems are directly related to ADHD—though ADHD may not be the only, or even the main, cause of the problems
- ✓ These problems are all very common among teens with ADHD
- ✓ The adolescent is not absolved of responsibility for addressing these problems just because s/he has ADHD—the problems can be addressed and improved if the family is motivated to do so and realistic about how to approach it

- ✓ For many/most of these problems, there will need to be ADHD-specific accommodations by both the adolescent and caregiver to create improvements—business-as-usual coping (by the teen) and caregiving will not likely lead to change

Linking the Style Index and Scorecard Responses to the Treatment Plan

Completing the ADHD Style Index and Scorecards presents an ideal opportunity to establish ADHD as a key treatment goal, something that will be a major focus of the work, and something that will need targeted interventions: family interventions, school-related interventions, and possibly medication. Thus, completing these materials provides the impetus for getting the caregiver and perhaps the teen to sign on board specifically to make ADHD a forefront area of concern. It can also establish the urgency needed to raise the issue of medication, which for many families is a large and intimidating step.

- For most families, **Index/Scorecard responses should be immediately linked to treatment implications**, which then lead immediately to contracting about ADHD-specific treatment goals and planning (see Task 3).

Options for Scorecard Administration

- One strategy is first to solicit simple checkmarks for any positive responses, and afterwards return to checked items to solicit rankings for each
- The scorecards can be administered under different conditions of endorsement: (1) items endorsed as problematic by the teen, and (2) items considered problematic by others
- Scorecards can be administered prior to discussing any other psychoeducation materials to gain the accord of the teen that there are relevant personal problems related to ADHD. That is, the identification of multiple ADHD-related problems can promote acceptance of the ADHD mantle itself
- The School Problems scorecard can be introduced by framing the exercise as an attempt to identify expectations that are difficult to meet, rather than asking the teen directly to endorse that he is deficient in given area. Doing so might more efficiently usher in medication as a possible solution. This also touches on the issue of *ownership* versus *externalization* of the symptoms: "I am ADHD" versus "ADHD makes things hard for me"

Working with Adolescents Alone

Completing the ADHD Style Index and Scorecards can proceed as described; however, it will be necessary to rely entirely on the adolescent's report. In order to solicit a more detailed picture of the teen's ADHD style and related challenges, the therapist can ask the teen to identify which items might be endorsed by caregivers, other family members, teachers, or friends/peers.

Other Points to Emphasize

- ✓ **Be careful not to pile negativity on top of the adolescent or allow the caregiver to dominate the conversation with complaints**—the Scorecard exercises are aimed at identifying how ADHD impacts the teen's life, not exacting a laundry list of bad behavior.
- ✓ **Avoid increasing emotional negativity and/or disconnection between caregiver and teen**—if the energy in the room is not investigatory and constructive, scorecard review can easily become counterproductive. Scorecard creation and review should support, not undermine, the overarching family therapy goal of clarifying and strengthening family relationships. Completing the family scorecard may also create an opportunity to understand how ADHD is hereditary and shared by family members.
- ✓ **For anxious/depressed youth, it may be difficult to review the Scorecards, especially the Peer checklist, as this may feel like piling on and/or spur highly negative emotions.** Also, ADHD teens may not have a very accurate viewpoint on problems in the Peer arena. Thus it may be best in many cases to solicit caregiver reports only.
- ✓ **Avoid using phrases that contain the word "kid"**. Instead of "Other kids that I see also have ADHD…" say "Other *teens* that I see…" The word "kid" can conjure imagery of 6 year olds, especially in an ADHD context.

# ADHD Style Index

## Daily Life

- ☐ Independent/pushes limits
- ☐ Stubborn/willful
- ☐ Easily frustrated or discouraged
- ☐ Willing to try new things
- ☐ Energetic
- ☐ Daring/sensation seeking
- ☐ Creative
- ☐ Night owl/morning zombie
- ☐ Enthusiastic
- ☐ Bouncing off the walls
- ☐ Leaps before looks

## Academic

- ☐ Puts off work to last minute
- ☐ Has difficulty planning ahead
- ☐ Imaginative
- ☐ Restless/easily bored
- ☐ Daydreams
- ☐ Good at presenting an argument
- ☐ Can't get good ideas on paper
- ☐ Curious
- ☐ Has difficulty with facts and figures
- ☐ Good communication skills
- ☐ Has poor handwriting
- ☐ Is a slow reader

## Social

- ☐ Late for everything
- ☐ Likes to argue his/her point
- ☐ Good leader
- ☐ Has difficulty tuning in
- ☐ Charming/good at persuading others
- ☐ Intrusive/nosy
- ☐ Has a short fuse
- ☐ Interesting/unpredictable
- ☐ Fidgety/restless
- ☐ Funny/charismatic
- ☐ Sensitive to needs of others

# Family Problems Scorecard

**Inattentive**

**Impulsive**

**Easily Frustrated**

**Independent**

- Disrupts/ruins family activities ☐
- Hard to discipline ☐
- Always challenging/pushing limits ☐
- Always fighting with siblings/sets poor example ☐
- Angers or frustrates one or more caregivers ☐
- Doesn't contribute to household upkeep ☐
- Ignores or forgets responsibilities ☐
- Doesn't listen or communicate ☐

# School Problems Scorecard

**Inattentive**

**Disorganized**

**Easily Frustrated**

- [ ] Completed work is rushed, messy or incomplete
- [ ] Loses track of time
- [ ] Constantly talking or blurting out
- [ ] Can't get started
- [ ] Slow reader
- [ ] Impatient or never proofreads
- [ ] Daydreams in class/Slow to respond
- [ ] Loses homework or forgets responsibilities
- [ ] Can't sit still or wait turn
- [ ] Can't plan or finish complicated projects
- [ ] Gives up too soon on new or hard work

# Peer Problems Scorecard

**Inattentive**

**Impulsive**

**Hyper/Silly**

- Not tuned in/Spacey ☐
- Doesn't think about perspective of others ☐
- Interrupts or dominates conversations ☐
- Doesn't get the joke or vibe ☐
- Seems insensitive or insulting ☐
- Seems self-centered ☐
- Invades others' personal space ☐
- Always changing or can't maintain friends ☐
- Always late or unprepared ☐

## MIP TASK 3: ADHD SYMPTOMS AND TREATMENT PLANNING

MIP is a "family-based" protocol insofar as it (1) depends on the participation of both caregiver and adolescent and (2) adopts the premise that integration of medication and behavioral interventions will be easier to achieve if the teen's ADHD characteristics are framed in a relational (rather than purely individual) manner. Task 3 therefore anchors this integration within the larger therapeutic context of the family therapy approach.

> Why family-focused?
>
> Although ADHD symptoms legitimately "belong to" the individual teen, it is also true that the precipitation, exacerbation, immediate impact, and long-term consequences of those symptoms are associated with the family's relational dynamics in significant ways. Moreover, successful medication acceptance and compliance among adolescents depend to a large degree on family involvement.

The main objective of Task 3 is to communicate to the family a fundamentally relational approach to understanding ADHD and its treatment. This is done by: reframing the ADHD characteristics in a relational context; changing the family's negative attributions about the teen's ADHD characteristics and referral problems; and helping the family to identify the most significant areas for improvement and to develop family-focused treatment goals to address those areas. Task 3 culminates with the family and therapist agreeing to add ADHD-specific treatment goals to the overall treatment plan, using the Our Goals for Treatment worksheet.

## Task 3 Goals

- Family has adopted a non-blaming and cooperative attitude toward ADHD characteristics
- Family understands the specific, relational impact of ADHD on all family members
- Family understands how ADHD is related to the primary reason(s) for referral and accepts that addressing ADHD directly will improve coping among all members
- Family and therapist have identified high-priority family and school problems to target
- Family and therapist have specified family-focused treatment goals to address these high-priority problems, and completed the Our Goals for Treatment worksheet

Task 3 consists of the following subtasks:

- Task 3a: Presentation of relational reframe for ADHD-related behaviors
- Task 3b: Presentation of ADHD relabeling and Linking ADHD to referral problems
- Task 3c: Completion of the Our Goals for Treatment worksheet

### Task 3a: Presentation of relational reframe of ADHD-related behaviors

In this task the therapist helps the family reframe the ADHD characteristics in a relational context by articulating how they affect and are affected by family characteristics and processes.

**Guiding Therapeutic Principles:**

- Evolve the therapeutic focus from a person-centered description of the adolescent's ADHD profile toward a (1) relational description of caregiving and family processes affected by the ADHD and (2) a cooperative family-based solution to referral problems
- Encourage the family to understand and embrace the distinction between (a) genetic neurochemical characteristics that are experienced but not chosen by the teen (e.g., inattention, impulsivity, poor sense of time) versus (b) interpersonal behavior and family characteristics that are affected by ADHD but can nevertheless be improved with diligent work in therapy
- Evoke an articulated, non-blaming understanding of how family context can precipitate and/or exacerbate problems related to the teen's ADHD, with the ultimate goal of discovering efficient ways to moderate the negative impact that ADHD characteristics and family processes exert on one another

Principles of Relational Reframing for ADHD Families

The goal of relational reframing is to guide the family away from discussions that cast ADHD behaviors as individual problems and recast them as problems that affect the interactions and emotional climate of the entire family. Therapists emphasize the relational nature of ADHD behaviors by (1) identifying longer sequences of behaviors involving multiple family members that are antecedents and consequents of ADHD behaviors and (2) focusing directly on the impact that the ADHD behaviors have on the actions, thoughts, and feelings of other family members.

> Of course the intention is not to broaden or deepen negative attributions about the teen or the ADHD symptoms themselves. On the contrary, **the therapist hopes to make family members more aware of how they affect one another**, which relieves the teen from bearing the exclusive burden of the problem, opens the door to working on family-based resolutions, and prompts renewed investment from all family members in changing how the family supports the teen's development.

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."

Relational Reframing: Tips for ADHD Clients

- Because ADHD symptoms are chronic, even with medication in place, it is essential to devise a *family* solution to this *individual* problem.
- Because ADHD is essentially an individual and chronic condition, the therapist and family can be less concerned about the appearance and expression of ADHD symptoms, and more concerned with how family dynamics contribute to the observed pattern, severity, and maintenance of symptoms—and how changes in the family can alleviate some of the symptom-related problems.
- Caregivers of ADHD kids are always more challenged in the home and outside the home—thus there is additional stress and pressure on the caregiving system. It can be reassuring for ADHD caregivers to have their difficult history with the teen normalized, and their previous caregiving efforts validated, by the therapist.
- Some common ADHD symptoms are particularly difficult and/or noxious to the caregiving/family system (e.g., impulsivity, emotional lability). The therapist should engage the family in describing (1) how these particular ADHD traits affect the emotional valence and everyday functioning of the family and (2) how the family responds to (and perhaps exacerbates) these symptoms when they arise. This can lead to discussion of how the family could respond differently if these symptoms were to be moderated, though not fully eliminated, by medication.

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 the therapist can leverage individual motivational work with the teen in order to establish a strong rationale for making meaningful changes in how he/she restructures his/her personal environment at home. Indeed, the teen 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 a teen is successfully engaged in therapy without a caregiver, they are already demonstrating a capacity to make positive changes in their own life in an independent way.

**Task 3b: Presentation of ADHD relabeling and Linking ADHD to referral problems**

In this task the therapist uses relabeling interventions to help change the family's negative attributions about the teen's ADHD characteristics. The therapist also descriptively links these characteristics to other co-occurring behavioral health issues, with ADHD framed as a condition that typically predates, exacerbates, and may be an underlying cause of, the referral problems.

**Guiding Therapeutic Principles:**

- Encourage the family to understand and embrace the distinction between (a) genetic neurochemical characteristics that are experienced but not chosen by the teen (e.g., inattention, impulsivity, poor sense of time) versus (b) behavior that is affected by ADHD but can nevertheless be improved with diligent work in therapy
- Connect specific features of the adolescent's unique ADHD profile to the reasons for treatment referral, with the goal of expanding the family's understanding of the teen's complex treatment needs

Principles of Relabeling for ADHD Families

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 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
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 teen's ADHD, a neurochemical condition that is not (wholly) controlled by the teen; or (2) how several "problem" behaviors may also have positive or adaptive features.

To set the stage for relabeling interventions, the therapist emphasizes the following basic facts about ADHD in adolescents: **ADHD-related characteristics are chronic** (i.e., persist to some degree throughout adolescence and young adulthood), **neurochemica**l (i.e., primarily outside the teen's control), **and adaptive in some contexts** (i.e., has social benefits for the teen and others).

*ADHD Acquittal*

This relabeling intervention involves recasting or excusing a negative behavior for which the adolescent has been deemed "at fault" by pointing out the ADHD characteristic(s) that underlie or give rise to the behavior. This kind of relabeling moves the family away from a negative attribution (ascribing a blameworthy behavior that is under the adolescent's control) and toward a benign attribution (accepting a common ADHD characteristic that is part of the teen's 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 the 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.

In addition to moving the focus away from blame, ADHD acquittal can expand the family's understanding of ADHD. For example, "difficulty sustaining attention" can be recast as "low threshold for boredom."

> **It is important to still hold teens accountable for their behavior, and for improving that behavior.** Some of the challenges and negative consequences for a teen with ADHD are categorically associated with their ADHD, and some are not. For example a therapist 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."

*ADHD Rewards*

This type of relabeling involves emphasizing the rewarding or prosocial aspects of an ADHD-related behavior that has been previously cast in a purely negative light. This 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, teens with ADHD tend to be energetic, talkative, funny, sharp, quick-witted, and creative.

> Though 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 a teen 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 the family 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 adult 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?"

ADHD behaviors can also be relabeled by placing them an evolutionary context, which many families find intriguing. Eight million years ago, our ancestors 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. Looking through a wide lens of human evolution can 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.

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**. 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.

Linkage of ADHD to referral problems

Most adolescent referrals for outpatient mental 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. Many teens referred for disruptive behavior disorders, or mood/anxiety problems, carry an undiagnosed ADHD condition. Moreover, the ADHD likely predated the emergence of the referral problem and was a significant risk factor and contributor to its emergence.

Relabeling interventions can help make caregivers and adolescents cognizant of the link between ADHD and the referral problem(s). This facilitates two positive developments in treatment: (1) Reduced negativity and blame surrounding the referral problem, 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, notably medication.

Working with Adolescents Alone

Adolescent relabeling interventions can proceed as described, though their impact will be limited by the absence of caregiver input on which labels are most common or carry greatest emotional weight. To compensate, therapists can employ a version of the "empty chair" technique 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?" The teen may be also able to call to mind other important people in their family or life for these exercises.

**Task 3c: Completion of the Our Goals for Treatment worksheet**

In this task the therapist helps the family specify family-focused treatment goals for the teen's ADHD symptoms. This is done by first identifying and prioritizing the most significant ADHD challenges in need of improvement, and then collaboratively developing family-focused treatment goals to address these challenges. Remember: whereas ADHD symptoms "belong to" the teen, those symptoms impact and are impacted by the family's relational dynamics in significant ways.

**Guiding Therapeutic Principles:**

- Initiate a discussion of the most significant ADHD-related challenges in need of improvement
- Identify the expected impact of improving in these identified areas
- Identify resources and capacities of family members to support teen's achievements
- Develop family-focused treatment goals that will target the most significant challenges identified by the family
- Complete the Our Goals for Treatment worksheet with the family

## Accommodating ADHD

Because ADHD slows developmental maturity, it typically requires accommodations on the part of families, including: adjusting expectations, fine-tuning or revamping caregiving strategies, devising and maintaining school and homework support systems in the home, and encouraging behavioral consistency.

Engendering these kinds of developmental accommodations in the family requires a long-term, intensive, trial-and-error process in treatment that invariably commands multiple sessions to properly launch and to make noticeable gains. Thus, *it is beyond the scope of MIP to implement family accommodation interventions*. However, it is important for the therapist and family to devote time to identifying the client's top priorities for family accommodations to ease stress and increase coping with ADHD. To this end, the therapist helps the family to develop family-focused treatment goals.

This follows naturally from the identification of high-priority problems listed on the Family Problems Scorecard and School Problems Scorecard because these problems are the most likely to require substantial family accommodations over time.

Setting treatment goals to ameliorate the highest-priority school and family problems serves two valuable purposes:

(1) **Enhancing client moralization and motivation to work in therapy** by engendering an action-oriented and solution-focused framework for addressing ADHD-related issues in ongoing behavioral treatment

(2) **Bringing about a circumscribed set of changes in the family** by prompting a dialogue about the benefits of combining family therapy with medication, which can trigger a broad and unique set of changes in the adolescent's attention (focus and sustained concentration), self-control (behavior regulation), and mood stability (emotion regulation).

> Because the achievement of treatment goals is a long-term process, it can be therapeutically beneficial for therapists to spend time with caregivers in individual sessions or parts of sessions to both affirm their ongoing treatment efforts and provide a holding environment for their frustrations or impatience with their ADHD teens. This can help bolster caregiver commitment to ongoing interventions beyond the scope of MIP and to mitigate discouragement with the treatment process.

It's important to remember that there are many successful people—from artists, to politicians, to captains of industry—who have ADHD. These individuals are able to flourish because they have learned to 1) embrace the positive aspects of their ADHD, **and** 2) to make accommodations in their personal, professional and social environments so that their ADHD works for them and not against them.

Completing the Our Goals for Treatment worksheet

*1. List high priority problems*

The therapist begins by having the family identify which problems on the Family and School Problems Scorecards they feel have the greatest impact on them as a family and on the treatment problem. What are the problems they would most like to see improved, and why (i.e., what impact will this improvement have)? It is best to hone in on the top 2-3 problems; ideally, at least one family and one school problem should be identified to focus on in treatment. For families that have difficulty narrowing the list to 2-3 problems, the therapist should help the family to synthesize individual problems into meta/core issues that might lead to more generalizable treatment goals. Are several problems actually part of a larger issue that could be the focus of treatment? Would some problems be improved simply by improvement in other areas?

The symptom removal reframe—imagining what it would be like if a given problem were magically removed—can be a useful technique to identify how addressing a given ADHD-related challenge would impact the family.

*2. List existing family resources to address the issues*

The therapist and family next discuss how they might address each of these challenges. On the Our Goals for Treatment worksheet, identify what strengths and resources the family already has at their disposal to assist them in addressing each challenge. Family strengths could include such things as: excellent caregiver monitoring, emotional closeness, good reinforcement systems, etc.

*3. List barriers to improvement*

The therapist and family next identify and list what barriers or challenges the family faces in addressing each issue. Barriers might be: a lack of emotional closeness, lack of caregiver knowledge of academic interventions or accommodations, caregiver difficulty in setting limits, etc. These will drive the development of family-focused treatment goals.

*4. List family-focused treatment goals*

The therapist and family list the goals the family wants to focus on in treatment. Goals could include: the family learning how to establish a more supportive academic environment at home, family therapy to help caregivers establish and enforce limits, etc. **Remember**: the purpose of this activity is to clarify the family's treatment goals: *how* they achieve their goals—through individual or family therapy, school accommodations, or medication—is the work of ongoing treatment once the MIP protocol has been completed.

Although the discussion of goals should be focused around treatment goals related to ADHD and its impact on the family, where co-occurring issues are significant and intertwined with ADHD symptoms, it can be valuable to address the family's desire to set goals for these problems as well.

Working with Adolescents Alone

The identification of problems to target and existing strengths and resources can proceed as described. However, identifying barriers and challenges to addressing the given problem should be focused on barriers that can be realistically addressed in treatment with the adolescent alone, that is, without caregiver participation. Likewise for the identification of treatment goals: the focus should be on goals that are reasonable for the teen to achieve in individual therapy, without requiring the assistance of the caregiver.

# Our Goals for Treatment

Based on the Family and School problem scorecards, identify the top three ADHD-related problems you want to work on as a family. Then, list your family's resources and barriers to addressing these problems, and develop treatment goals to help manage them.

| | **Problem**<br>What are our family's biggest ADHD-related challenges? | **Resources**<br>What strengths do we have to help us with these problems? | **Barriers**<br>What gets in the way of us making these better? | **Treatment Goals**<br>What would we like to do or change to make these better? |
|---|---|---|---|---|
| Family | | | | |
| School | | | | |
| Our Choice | | | | |

## MIP TASK 4: ADHD MEDICATION AND FAMILY DECISION-MAKING

Task 4 should be completed whether or not the family has already agreed to begin medication during intake or early in treatment. Medication-eligible families who have not yet started a medication regimen will fall into one of the following categories: (a) they declined to begin a regimen when offered, (b) they remain undecided, or (c) they have not yet been counseled to begin.

## Task 4 Goals

- Family and therapist have processed any previous discussions with the psychiatrist regarding medication-related issues
- Family and therapist have discussed medication stigma, and concerns about adolescent substance use
- Family understands the unique benefits of medication in general and its potential specific benefits for the adolescent in home, school, and peer contexts
- Family understands that medication has limits to its benefits, often has side effects, and requires trial-and-error titration
- Adolescent has actively participated in the medication decision-making process and the family and therapist have completed the Pros & Cons Worksheet
- Family has accepted, refused, deferred, or been declared ineligible for a medication regimen

Task 4 consists of the following subtasks:

- Task 4a: Review of psychiatric intake assessment related to ADHD medication
- Task 4b: Completion of the Medication Module
- Task 4c: Completion of the Pros & Cons for Worksheet for ADHD medication

The order of subtasks for Task 4 should be tailored to individual families. Below are examples of two different intervention sequences for Task 4 depending on the client's medication status:

**The Client Has Not Already Agreed to Start Medication**

**Task 4a:** Therapist reviews the family's experience in discussing medications with the psychiatrist, if these occurred; the therapist also reminds the family of relevant information from the assessment.
**Task 4b:** Therapist initiates the Medication Module.
**Task 4c:** Therapist will engage the family in active **decision-making about starting a medication** regimen.

**The Client Has Already Agreed to Start Medication**

**Task 4a:** Therapist reviews the family's experience in discussing medication with the psychiatrist, **focusing on decisions about the specific prescription** given to the client.
**Task 4b:** Therapist initiates the Medication Module.

**Task 4c:** Therapist will engage in family decision-making interventions to ensure that the family is fully educated about **medication, titration and monitoring**, and provides an opportunity to work through important issues such as **stigma, ambivalence** about using controlled substances for youth, **side effects**, adolescent reliability and **compliance**, and caregiver **oversight**.

**Task 4a: Review of psychiatric intake assessment related to ADHD medication**

In this task the therapist reviews relevant assessment information and solicits family members' opinions about and prior experiences with medication.

**Guiding Therapeutic Principles:**

- Remind the family of the assessment findings
- Interview the family about any previous discussions they have had with the psychiatrist regarding medication
- Encourage a discussion of the family's attitudes toward and experiences with medication

Review of intake assessment and conversation with psychiatrist

Decision-making about medication is necessarily preceded by reviewing the results of the teen's initial assessment, as this included consultation with a psychiatrist. However, the timing of the decision-making process, and thus of this task, will vary by family. Some families may feel confident discussing medication immediately after their initial assessment, while it make have taken weeks for others to reach this point.

When the decision-making process occurs separately from the initial assessment, it will be beneficial for the therapist to review with the family the assessment findings (ADHD symptoms and executive functioning challenges), and any relevant information from other modules that have been implemented so far (e.g., ADHD Style Index, Family/School/Peer Problem Scorecards).

Family attitudes and experiences relating to medication

In addition to reviewing the teen's assessment results, in this task the therapist also explores the family's attitudes about and experiences with medication. This provides the family with an opportunity to share opinions and experiences they may not have previously discussed. During the decision-making process, it will be important for therapists to keep in mind that some families may be opposed to medication, or have had bad experiences with medication in the past. It is equally important that families feel that their concerns have been heard and are valuable.

Multi-stressed families will likely have had at least one family member with a history of psychiatric treatment with medication, with varying levels of success. The differences between ADHD and other psychiatric medication are important to emphasize with these families.

**For therapists and caregivers who have concerns about teens who currently are or have a history of using substances, see section: <u>Special Arrangement for Substance-Using Teens: Caregiver as Pharmacist</u> under subtask 4c.**

### Task 4b: Completion of the Medication Module

In this task the therapist provides psychoeducation about ADHD medications and addresses the family's questions and concerns about medication.

**NOTE:** The Medication Module can be delivered by therapists, prescribers, or both (at different junctures during the intake/treatment process).

<u>For therapists</u>: This module should be implemented *only after* first implementing the Basic Facts, Executive Skills, and Scorecard materials (Task 2) and then defining family-based treatment goals that specifically target ADHD-related problems. At this point, the therapist will have established a family-based, client-specific understanding of the given family's ADHD profile, and also articulated specific treatment goals endorsed by the family, prior to initiating an in-depth discussion about medication. If the psychiatrist has already completed all or part of this Module—which the therapist will know based on completion of Tasks 1b and 4b—then the therapist will decide which Module materials to review with the client (if any).

<u>For prescribers</u>: Often there is not enough time or occasion to engage in extensive ADHD psychoeducation outside of Task 4. Therefore, each prescriber must decide which additional psychoeducation materials from the other Modules (if any) should be delivered in preparation for the Medication Module. That is, prescribers should borrow freely from other Modules, based on their personal preferences and/or the specific needs of the given case, as a lead-in or adjunct to the Medication Module materials.

**Guiding Therapeutic Principles:**

- Emphasize that medication is the ONLY known treatment for inattention, impulsivity, and hyperactivity/restlessness—behavioral treatments have not proven effective for these symptoms
- Explain that improvements in these 3 ADHD problem areas can subsequently help the teen show improvement in related executive skill areas and home/social behavior
- Educate the Caregiver and Adolescent about the three aspects of a medication prescription: Type, Dose, and Length of Action
- Underscore that medication titration requires a period of trial-and-error before determining the best prescription
- Assure the client that almost all families are (1) ambivalent about starting a medication regimen and (2) worried about stigma and harmful side effects
- Discuss the limitations of ADHD medication and also common side effects, and prepare the client that almost all teens experience some side effects to some degree

Revisiting ADHD Stigma: Medication Issues ("Don't label me with ADHD!" slide)

As described above in Task 2a (Basic Facts Module), most adolescents and caregivers will be concerned about the stigma that can result from being diagnosed with ADHD, in the form of negative self-images, concern with public attitudes, and disclosure concerns. For many families there is substantial additional stigma associated with the prospect of taking stimulant medication, above and beyond accepting the ADHD diagnosis itself. It is crucial for the therapist to raise the issue of medication-related stigma during Task 4, and for some clients during Task 2 as well. Therapists should fully explore self-image, public attitude, and disclosure concerns about medication specifically, even if these concerns have already been discussed with regard to the diagnosis itself.

Disclosure concerns are particularly germane for clients who are considering medication. It is certainly true that accidental or incidental disclosures related to medication taking are much less common now that long-acting medications are available that can be ingested in the morning only and remain effective the entire school day. That is, for the vast majority of youth it is no longer necessary to line up conspicuously outside the school nurse's office to receive an afternoon pill for being hyper.

SPECIAL TOPIC:
Information for Caregivers Concerned about Teens Abusing ADHD Medications

- Stimulant medications do not act on the brain in the same way that illegal substances do—they remain in the brain synapses for a *much* shorter period of time, and the dose of stimulant released in the brain by the ADHD medication pill is *much* lower than the dose of stimulant released by street drugs like cocaine, speed, etc.
- Stimulant medication is not addictive—there are no cravings or withdrawal symptoms when medication is stopped, even if it has been used for a long period of time
- Medications can help *prevent* substance use problems: Children with ADHD who receive appropriate medication are less likely to develop substance use problems than ADHD children who are untreated
- ADHD medication in teens can help alleviate problems and improve performance in several areas, thereby reducing stress that can cause teens to "self-medicate" with substances

**For therapists and caregivers who have concerns about teens who currently are or have a history of using substances, see section: Special Arrangement for Substance-Using Teens: Caregiver as Pharmacist under subtask 4c.**

**Task 4c: Completion of Pros & Cons Worksheet for ADHD Medication**

In this task the therapist guides the family through their decision-making by ensuring that the teen has an equal voice in the process and reminding caregivers that ultimately, the decision is up to the teen.

**Guiding Therapeutic Principles:**

- Engage the teen as an equal partner in the decision-making process
- Prepare caregiver to accept teen's decision—remember: caregivers cannot force teens to take medications
- Assist families in completing the Pros & Cons worksheet for ADHD Medication

## Decision-Making in a Developmental Context: Engaging the Adolescent

To be successful in starting an ADHD medication regimen with adolescents, it is essential to cultivate their active involvement in the decision-making process and their active agreement to take medication. Medication consultation and other forms of counseling for adolescents are invariably initiated by caregivers, schools, or other social institutions, and many teenagers are not sufficiently informed or consulted when brought for medical and/or mental health services. It is therefore natural that they may harbor resentment and be reluctant to participate in a program in which they had no choice. MIP therapists must be careful to ensure that medication decision-making is not presented in a way that is coercive, stigmatizing, or irrelevant to the target adolescent. Instead, the decision-making process must be experienced as something in which the teen can be productively invested and engaged.

Due to variation in the development of cognitive processes such as self-evaluative skills, some teens may be unable to recognize the degree to which their ADHD-related behaviors are problematic. Consequently, it may not be immediately evident how they can benefit from medication. However: MIP holds as a premise that *even a young teen can be educated and helped to understand why and how medication works.*

## Completing the Pros & Cons Worksheet

The therapist begins by pointing out the 4 pros and 4 cons that are pre-populated on the Pros & Cons Worksheet; then the therapist solicits additional pros and cons from the family and adds them into the blank spaces. The therapist can assist the family in identifying pros and cons tailored to the specific ADHD-related problems deemed most problematic for the teen and family, as identified in Tasks 2c-2f. Next, the therapist walks through each of the pros and cons with the family, asking the teen and caregiver to separately rate each on a scale from 1 (not at all important) to 4 (very important). The therapist should clearly explain that it is not expected that teens and caregivers will fully agree on every item, so that both parties are comfortable with discrepancies in ratings when they are first recorded. Only those ratings differing by 2 or more points should be considered truly "discrepant"; a 1-point difference is de facto agreement. Once all ratings have been completed, the therapist can point out items that show agreement, and then ask family members to revisit items with discrepancies, encouraging both parties to share their thinking and looking to foster (greater) family consensus wherever possible. Once all items have been given final ratings, the therapist presents the Worksheet for the family to review during the process of final decision-making—a process that might conclude immediately upon completion of the Worksheet or that might require much additional discussion, and perhaps several additional sessions, to complete. For extended decision-making time periods, the Worksheet can be constantly reviewed and also revised if family member opinions change over time.

Cultivating Active Involvement from the Adolescent

- The therapist begins by clearly communicating to the teen AND caregiver that the **teen's participation and viewpoints are as important as anyone's**, and that all three perspectives (therapist, caregiver, teen) are equally valuable. This may be a (relatively) new way of thinking for some families and should be carefully established.
- During the early stages of the decision-making process MIP therapists should place great emphasis on defining whether and **how ADHD medication can have personal, meaningful benefits for the teenager**. The therapist should use examples drawn from the teen's own depiction of his/her daily life to formulate individualized benefits, in active collaboration with the teen.
- When indicated, the therapist might also **gently challenge the teen to adopt new perspectives** or consider the benefits of trying new approaches, in the service of engaging him/her in thoughtful and context-specific decision-making. Depending on the sophistication and investment of the given teen, these "thought experiments" will vary in their specificity and relevance.

Adolescent engagement interventions of this kind are virtually required to ensure active teen involvement in medication decision-making and generate personally meaningfully medication benefits. Without these, teenagers have little motivation for agreeing to medication and even less motivation to follow through with medication ingestion on a daily basis. Remember the bottom line: *Caregivers cannot coerce teenagers to swallow pills*.

Working with Adolescents Alone

Parent consent is necessary for starting ADHD medication, so it is particularly challenging to complete Task 4c when caregivers are unavailable for sessions. However, because medication can be seen as a medical need above and beyond usual therapy for the teen, caregivers may be willing to attend sessions that are specifically focused on medication education and decision-making. Alternatively, caregivers may consent to initiate medication on the basis of a prescriber's recommendation independently of behavioral therapy—something the therapist may be informed about, or even help broker, via direct communication with the prescriber. In such a case, it remains vitally important to go through medication education and decision-making with the teen even if the caregiver is unable to attend the session, so that the teen can make an informed personal (versus family) choice about beginning medication, as well as being an informed patient throughout the course of taking medications if he/she decides to do so.

School Achievement as a Prime Lever

For the vast majority of families, the single most important characteristic influencing family readiness for starting an ADHD medication regimen during the teenage years is school achievement. Because many families have grown accustomed to the unmedicated teen's ADHD-related behavior over the years, simply reducing ADHD symptoms is often not sufficient motivation for starting medication.

However, new school crises typically emerge in late middle and early high school as (1) academic curricula require greater levels of organization and long-term planning and (2) greater academic autonomy and self-direction are expected. These new demands can be extremely difficult for ADHD students to satisfy, even for those who maintained steady school progress in earlier years. These new demands can quickly outstrip the teen's ability to adjust and cope, resulting in a pile-up of academic disappointments and failures. School motivation and self-efficacy often plummet in lockstep with grades and behavior marks. For ADHD students who find themselves in this relatively common predicament, medication offers the compelling possibility of immediate and potentially significant improvement in school performance. Thus, improved school functioning can be the prime lever for moving a family toward active decision-making about starting medication.

Medication Cannot Replace Family Therapy

An important element of educating families about medication is to acknowledge its limitations; caregivers may have developed unrealistic expectations about medication—they may believe that medication is the only treatment that is required. The reality, though, is that medication does not greatly help with issues of organization, academic motivation, or decision-making; nor can medication, alone, improve family relationships.

Medications do not do the work of caregivers; **they enable caregivers to do their work more effectively**.

Family Therapy is needed to focus on ADHD-related issues other than inattention/impulsivity:

- Help connect or reconnect caregivers and adolescents who have become emotionally distant and/or conflictual
- Teach and activate effective problem-solving strategies for addressing client-specific ADHD-related problems
- Define points of accommodation that will enable the client to effectively address problems presented by ADHD symptoms and EF deficits in family and school domains
- Determine how ADHD-related issues contribute to the client's other psychosocial problems and points of treatment focus

## When Medication Initiation is Deferred

There are various reasons why families may be hesitant or resistant to start medication even after the psychiatrist and therapist have made a recommendation for medication and have completed the Medication Module:

- ongoing negative attributions about medication
- worry about stigma and/or side effects
- a desire to see if therapy alone can have an impact on symptoms
- a belief that the teen's symptoms are not severe enough to warrant this level of intervention

It may also be that after completing assessment feedback and psychoeducation with the family, the therapist concludes that the level of symptomatology and/or degree of impairment from symptoms is moderate, or that the family is not well positioned to initiate and comply with a medication regimen.

When the final decision reached during Task 4 is to defer the start of a medication regimen, therapists have three ongoing duties to the family throughout the course of treatment:

1. Reassessing the teen's symptoms and their impact on the family, school and peer contexts; symptoms may abate over time, eliminating further consideration of medication, or symptoms and/or impairments may become more significant, igniting further consideration.
2. Revisiting psychoeducation about ADHD symptoms and medication.
3. Renewing family decision-making about medication.

> This approach should be followed even for families who express principled opposition to medication because: (1) Medication remains the only evidence-based approach for treating many core symptoms of ADHD, and it is sound practice to remind clients of the best available treatment for an ongoing need; (2) Family attitudes and principles may soften or change over time as they process the psychoeducation materials, and/or as the ADHD symptoms continue to create stress and impairment in multiple domains.

Considering a Transitional Option

Between the "polar" decisions of Medication versus No Intervention, there exist several midway interventions that many medication-averse families might consider pursuing (or have already tried): herbal/diet remedies, biofeedback and/or EMDR, meditation, computerized cognitive training programs, and so forth. There may be substantial value in meeting medication-averse families "partway" by discussing or even initiating these alternative interventions. In addition to any positive (placebo) effects that may result, these transitional options might open the door to gradually approaching medication experimentation, particularly if no improvements follow from attempting the alternatives.

## Initiating Medication

Developing a feasible plan for pill monitoring about which both caregiver and therapist are confident is a prerequisite for starting a medication regimen. A key issue here is that the therapist be convinced that the caregiver is a legitimate resource for the teen, and is capable of being a committed and sustained presence in medication monitoring.

Altogether, the following factors constitute a "clinical assessment" of whether the caregiver can be a productive resource for the teen.

Does the caregiver:

- ✓ regularly attend behavior therapy sessions, and have they developed a strong collaborative relationship with the therapist?

- ✓ demonstrate a positive (versus negative/toxic) relationship with the teen, such that the therapist has witnessed in treatment sessions that the caregiver can engage the teen rationally, calmly, and productively even with difficult subject matter?
- ✓ have a home schedule that permits the caregiver to be present in the morning during pill ingestion, and generally, available to ensure a basic level of monitoring?

It is therapeutically useful, as well as useful with regard to medication safety, for the therapist and family to proceed with in-depth discussion about a pill monitoring arrangement. That is, the degree to which the caregiver and adolescent are able and willing to enact a suitable pill monitoring arrangement is both diagnostically relevant and potentially an issue that is ripe for discussion and intervention.

These negotiations are an integral part of Task 4, and one that may extend for several sessions.

## Special Arrangement for Substance-Using Teens: Caregiver as Pharmacist

Cautions about possible misuse or diversion of prescribed medications are relevant for all teens but especially germane to those who misuse substances. These cautions are particularly strong for (a) teens who are frequent and/or heavy drug users and (b) teens who are suspected of being involved in drug sales.

> Careful monitoring of substance-using teens on stimulant medication is needed to ensure that the medication is not "diverted" (given away, sold) or used in a non-prescribed fashion (e.g., multiple pills taken).

For these families, the best option may be to **contract with the caregiver to act as the gatekeeper for medication distribution**. If the caregiver supervises the ingestion of long-acting medication pills each morning and also keeps possession of the pill supplies in a secure location, then the risk of diversion is minimal and the risk for misuse non-existent.

As discussed above, developing a feasible plan for pill monitoring about which both caregiver and therapist are confident is a prerequisite for starting a medication regimen. For substance-using adolescents, this is **absolutely crucial.** Medication monitoring needs to be especially stringent/vigilant with SU teens. That is, whereas a non-SU teen can legitimately be left to his/her own devices to take his/her own pills—if that's the most sensible monitoring arrangement (maybe the teen already takes his/her own vitamins etc.)—a caregiver NEEDS to be centrally and consistently involved in the monitoring plan for SU teens.

For substance-using teens, it is therefore also imperative to assess the caregiver's ability to act as a pharmacist:

- ✓ Does the caregiver have the capacity to properly monitor pill supplies and reliably oversee pill ingestion on a daily basis?
- ✓ Is the caregiver is in good position to provide reliable observations on medication effects and side effects?

A note about cannabis as self-medication

Keep in mind that cannabis use can have concrete salutatory effects on ADHD teens, such as decrease in racing thoughts, tics and extraneous verbalizations, and anxious feelings. That is, "self-medication" may be an important subjective benefit of cannabis use and thus needs to be addressed directly with the teen (and perhaps the family), along with education about the anticipated (identical/related) medication benefits of stimulants.

# Pros & Cons Worksheet for ADHD Medication

The top half of this worksheet lists 4 general PROS and 4 general CONS for initiating ADHD medication during the teenage years. The bottom half contains blank spaces for **families** to list both PROS and CONS that are specific to their unique circumstances.

Rate each PRO and each CON on a scale from 1-4 as follows:

| Not Important | Somewhat Important | Important | Very important |
|---|---|---|---|
| 1 | 2 | 3 | 4 |

| PROS | Ratings | | CONS | Ratings | |
|---|---|---|---|---|---|
| | A | C | | A | C |
| 1. Medication can help with inattention, impulsivity, and restlessness | | | 1. Medication does not help with organization, decision-making, or time management | | |
| 2. Medication can have immediate benefits | | | 2. Medication can have side effects | | |
| 3. Medication can be stopped immediately if it doesn't feel right | | | 3. It can take time to find the right dose | | |
| 4. Medication can help with academic performance | | | 4. Medication does not help with school motivation or approach to learning | | |
| 5. | | | 5. | | |
| 6. | | | 6. | | |
| 7. | | | 7. | | |
| 8. | | | 8. | | |

## MIP TASK 5: MEDICATION MANAGEMENT AND INTEGRATION PLANNING

NOTE: This module will be implemented **only for clients who have accepted and been prescribed an ADHD medication regimen**. Unlike the other four Tasks, Task 5 will not be implemented with every adolescent ADHD client. Although a decision about starting medication is routinely sought at the outset of treatment, the family may decide to begin medication at almost any point during treatment, after which Task 5 should commence as soon as possible.

## Task 5 Goals

- Family and therapist have discussed the current medication regimen and therapist is aware of any changes to the medication regimen that have already taken place (i.e., changes in dosing, timing and type of medication)
- Family is aware of what side effects to watch for with the current medication regimen
- Family and therapist have reviewed the ADHD Medication Log to be completed weekly for the first month and monthly thereafter

Task 5 consists of the following subtasks:

- Task 5a: Review of post-intake psychiatrist visits for medication management
- Task 5b: Consultation with psychiatrist about medication management & coordination
- Task 5c: Integration of the ADHD medication log and management issues into behavioral sessions

### Task 5a: Review of post-intake psychiatrist visits for medication management

In this task the psychiatrist develops a plan for medication initiation, titration and management.

**Guiding Therapeutic Principles:**

- Psychiatrist: Devise and implement a medication initiation and titration schedule for the client, including ongoing medication management visits as needed
- Review what has been discussed and decided at post-intake medication management visits

For Consideration by Prescribing Physicians (*Robin, 2006*)

- ✓ Be sure to start with an adequate dosage level that will have some immediate impact—creates credibility with the adolescent and caregiver
- ✓ Establish frequent contact with the client during the initial stages of prescription to establish a rapid titration schedule that is highly responsive to the teen's individual metabolism and circumstances
- ✓ Have a clear set of criteria for success—know how you'll know when it's working, and make this clear to the client as well
- ✓ Place a high priority on minimizing side effects and other negative aspects of taking meds

- ✓ Closely monitor medication coverage throughout (1) school days and (2) weekends, differentiate the prescription (school day versus weekends) as needed, and consider the use of short-acting meds to supplement long-acting ones on school days or difficult days

SPECIAL NOTES ABOUT OROS-MPH (Concerta)

The FDA recommended ceiling for osmotic-release oral system methylphenidate (OROS-MPH, aka Concerta) is 72 mg, but many practicing psychiatrists indicate that it is advisable to go up to 112 if tolerated and needed for impact. In general, 72 mg is considered to be a widely therapeutic dose for adolescents, and many physicians start dosing at that level and then titrate down based on reactions and side effects. Recent evidence suggests that extended-release stimulants such as Concerta produce peak effects at 6-7 hours and remain effective up to 12 hours after ingestion. Extended-release stimulants have proven safe and effective for ADHD in teens, to exert beneficial impacts on neuropsychological functioning, and to engender greater medication persistence and possession ratios in teens compared to rapid-acting systems. Importantly, a recently completed NIDA Clinical Trials Network study (Riggs et al., 2011) reported that OROS-MPH was well-tolerated, not prone to misuse, and promoted gains in ADHD symptoms when integrated with a manualized treatment for adolescent substance use.

**Task 5b: Consultation with psychiatrist about medication management & coordination**

In this task the psychiatrist and therapist develop a strategy for providing integrated medication monitoring and management, not only for ADHD, but also for any co-occurring conditions.

**Guiding Therapeutic Principles**:

- Psychiatrist and Therapist: Create a working arrangement for regular communication and integrated case planning about medication compliance, effects, and family attitudes
- Develop a plan for coordinating treatment not only for ADHD, but also for any co-occurring conditions and/or substance use problems
- Develop and implement a plan for adolescents with substance use problems that includes additional medication monitoring and diversion considerations

Ongoing Medication Consultation in Behavior Therapy Sessions

Therapists have three basic options when faced with the task of providing ongoing, in-depth psychoeducation about medication issues during behavioral treatment sessions: (1) Refer the family directly to the prescribing pharmacologist (common practice), who will separately consult with the family in person or by phone; (2) Present all medication-related information in behavioral treatment sessions, and offer to conduct further research on all questions that cannot be immediately answered, and to consult with a prescriber as needed (autonomous practice); (3) Arrange to bring the pharmacologist into a future treatment session in person or by phone (integrated practice).

There are several potential downsides to the common practice option to be aware of:

- It can make knowledge about medication seem remote or complex in ways that potentially increase family wariness and weaken future self-sufficiency
- It de-centralizes the therapist as the coordinator of care and a knowledgeable counselor for central aspects of the combined treatment
- The caregiver and especially the adolescent are likely to have a lesser rapport with the pharmacologist and, if so, will not be able to pose questions and process information in as meaningful a manner
- It introduces the possibility of scheduling barriers that can delay case progress

Therapists should carefully consider the best approach for each family; all of the above methods are potentially useful depending on the client and circumstances, including a combination or a sequence of the three.

In addition to how medication consultation occurs, it is also beneficial for the therapist and prescriber to develop a strong working relationship so that both are aware of any developments or changes with regard to the teen's medication regimen. There are many strategies that could be employed to this end; for example, the prescriber could contact the therapist whenever there are changes to the dosing or timing of medication so that the therapist is aware of the current dose; in turn, the therapist could help by monitoring medication compliance and side effects (especially valuable given that the therapist sees the family more frequently than the prescriber does).

## Medication Assessment and Treatment Priorities for Teens with Co-Occurring Disorders

The adage that for teenagers with ADHD, comorbidity is the rule rather than the exception, has been widely supported in the literature. Mood, anxiety, substance use, disruptive behavior, and learning disorders all commonly co-exist with ADHD. Untreated, each class of co-occurring disorder may adversely affect several aspects of ADHD treatment, from client engagement to medication compliance and outcomes. Thus, it is vital that prescribers and behavior therapists alike pay careful attention to additional behavioral health conditions affecting teens with ADHD.

Co-occurring behavioral disorders often share symptoms with ADHD that interact in ways that complicate differential assessment. Therefore, all teenagers with ADHD should undergo a comprehensive mental health evaluation that focuses on areas of symptomatic overlap: anxiety (excessive worry, repetitive behaviors, trauma history); mood (lability, excessive irritability, dysphoria, grandiosity, impulsivity); learning problems (academic performance, standardized test scores for basic literacy, history of academic supports and special education); drug and alcohol involvement (substances used, frequency, setting, consequences); and disruptive behavior (symptoms of oppositional defiant and conduct disorders).

It is clear that addressing co-occurring conditions with medication and/or behavioral treatments is crucial for treatment success (see Sibley, Kuriyan, Evans, Waxmonsky & Smith, 2014). However, as with assessment, treatment of ADHD and its comorbid symptoms can be complicated by the overall clinical picture. For example, stimulant medications can adversely affect mood in bipolar individuals, worsen anxiety and repetitive behavior among anxious youth, and be diverted or misused by teens with substance use and disruptive behavior disorders.

A number of strategies for treating ADHD in clients with comorbid disorders advocate for using non-stimulant medications in these circumstances. One strategy, the Texas Children's Medication Algorithm for Pharmacotherapy of ADHD, proposes distinct treatment approaches for ADHD with comorbid anxiety, depression, aggression, tics, and substance use disorders (Pliszka et al., 2006). All strategies stress the concomitant treatment of both conditions while critically evaluating the efficacy of medications in addressing target symptoms, to avoid problems associated with polypharmacy.

## Providing ADHD Medication Interventions to Adolescents Who Use Substances

Behavior therapists who routinely treat adolescent substance use (ASU) need to adopt reliable strategies for assessing and treating ADHD. As indicated above, ADHD is highly prevalent among adolescents with substance use problems, with comorbidity estimates ranging from 25% to 60% of ASU clients. Moreover, co-occurring ADHD presents a major barrier to successful ASU treatment. Compared to drug-using teens without ADHD, those with ADHD tend to transition more quickly from substance use to dependence, drop out of treatment earlier, demonstrate a worse symptom course and worse treatment outcomes, have worse mental health prognoses, and return to using substances in greater numbers and more rapidly after ASU treatment (see Hogue, Bobek, Tau, & Levin, 2014). These facts underscore the importance of integrating evidence-based interventions for ADHD into substance use treatment for teenagers with comorbid diagnoses.

Are ADHD medications a viable option for adolescents with substance use problems? One common concern among clinicians and families alike is that prescribed ADHD medications will exacerbate substance problems and/or create risk for misuse or diversion by substance-involved teens. However, the best available evidence strongly suggests that ADHD medication does not present additional risk for substance misuse. Several literature reviews have concluded that ADHD medication during childhood does not exacerbate risk for ASU (see Fischer & Barkley, 2003). A recent meta-analysis of longitudinal studies (Humphreys, Eng, & Lee, 2013) found that initiating stimulant medication in children with ADHD neither protects them from developing a substance use disorder nor creates greater risk for one. Similarly, in the most complete study to date, Molina and colleagues (2013) reported that lifetime ADHD medication had a neutral impact on ASU, neither increasing nor decreasing ASU risk. To date this is the only study to measure the effects of medication use across the developmental span—not just initial medication acceptance in childhood—on ASU outcomes.

Moreover, there is emerging evidence that ADHD medication can have additive benefits when combined with behavioral treatment for adolescents with comorbid ADHD and ASU. The largest study to date, a multisite trial of stimulant medication versus placebo combined with cognitive-behavioral therapy for adolescents with comorbid ADHD and ASU (Riggs et al., 2011), found that ADHD medications were well-tolerated by ASU clients, rarely misused or diverted, and produced benefits in multiple areas (e.g., caregiver reports of ADHD symptoms, urine assays for substance use). Altogether, it seems prudent to include ADHD medication in routine treatment planning for most teenagers with co-occurring ASU, with additional monitoring for medication compliance and diversion.

Psychiatrists and therapists should be sure to discuss how they will address issues related to medication and adolescent substance use. While seamless communication between prescribers

and therapists is always beneficial, it becomes even more important with substance-using teens, since there are concerns about misuse or diversion of medication. To this end, the psychiatrist and therapist could develop strategies for increased monitoring of medication adherence. For example, while for most teens it may not be necessary to track adherence and side effects at every session, especially once a stable dosage has been reached, for substance-using teens it may be useful since the therapist sees the family more often than the psychiatrist and could therefore catch potential misuse or diversion earlier. Additionally, if the therapist knows when the teen's prescription is due for refill, and also knows when any pills have been missed or skipped, the therapist can provide valuable insight to the psychiatrist if a family requests a refill before they should need one.

Additionally, see the special section in Task 4c "Special Arrangement for Substance-Using Teens: Caregiver as Pharmacist" for information about how caregivers can assist in ensuring that teens are using medications appropriately.

### Task 5c: Integration of the ADHD Medication Log and Management Issues into Behavioral Sessions

In this task the therapist/psychiatrist introduces the ADHD Medication Log so the family can track medication-related information. Medication monitoring is, of course, and ongoing process that continues throughout treatment.

**Guiding Therapeutic Principles**:

- Establish routine assessment of medication issues during treatment sessions: titration, compliance, effects & side effects, and management visits with the psychiatrist
- Initiate weekly completion of the ADHD Medication Log to track medication compliance, effects, and tolerance/side effects

| Monitoring and Minimizing Risk |
|---|

Integrated care that includes ongoing case planning and consultation that is coordinated among therapist, caregiver, adolescent, and prescribing physician is the best mechanism for monitoring medication effects, side effects, and potential diversion or other misuse of prescribed ADHD medication. The Task 5 strategies described above for medication management and integration planning are the key to success in this area. Comprehensive case planning and monitoring around medication safety issues should include regular completion and collaborative review of the ADHD medication log (proctored by either the behavior therapist or prescribing physician) described below.

## Completing the ADHD Medication Log

The ADHD Medication Log is completed in session by therapist and family; it charts data on current medication prescription, daily compliance with ingestion, notable positive impacts, and the severity of common side effects. Tracking this information is invaluable for logging treatment-relevant data for ongoing review by the therapist, initiating in-session dialogue and interventions with the family regarding ADHD-related issues, and providing a feedback loop for effective case planning and medication management for the therapist and psychiatrist together.

It is recommended that the ADHD Medication Log be completed every session for the first 4-8 weeks, until a stable dosing level is achieved to 1) monitor any side effects as they occur and 2) bolster medication compliance. Once an effective dose is reached, and the adolescent is reliably taking the medication, completion of the log can be reduced to a monthly basis instead.

## Potential Risks for Client Participants: ADHD Stimulant Medication

Despite the potential benefits of ADHD stimulant medication, there are still risks.

| **People should NOT use stimulants if they:** | |
|---|---|
| o have marked anxiety or agitation<br>o have glaucoma | o have tics<br>o are already being treated with monoamine oxidase inhibitors |

The medical community has not yet determined the long-term effects of having stimulants (methylphenidate) in the bloodstream for prolonged hours every day for numbers of years.

**The first few days of ingestion should be carefully monitored by a qualified physician to detect common side effects and titrate or desist the medication as indicated.**

| **Common side effects:** | |
|---|---|
| o abdominal pain<br>o aggravation<br>o nervousness<br>o hostility<br>o sadness<br>o dizziness and/or shortness of breath<br>o headache<br>o tics<br>o insomnia and prolonged sleepiness | o loss of appetite<br>o depressive symptoms, or depression<br>o increased coughing, sinusitis, or upper respiratory tract infection<br>o vomiting<br>o allergic reaction<br>o increased blood pressure and/or tachycardia<br>o psychosis (abnormal thinking or hallucinations)—in rare cases |

Black Box Warning

As of April 2015, the Food and Drug Administration (FDA) mandated that a "black box" warning label be affixed to bottles of stimulant medication that contains the following consumer safety information: (1) chronic abusive use can lead to marked tolerance and psychological dependence with varying degrees of abnormal behavior; (2) frank psychotic episodes can occur, especially with abusive use; (3) should be given cautiously to patients with a personal or family history of drug dependence or alcoholism; (4) careful supervision given during drug withdrawal from abusive use since severe depression may occur: (5) withdrawal during chronic therapeutic use may unmask symptoms of the underlying disorder that may require follow-up.

In addition, the FDA recommends caution in treating patients whose underlying medical conditions might be compromised by increases in blood pressure or heart rate, e.g., those with preexisting hypertension, heart failure, recent myocardial infarction, or hyperthyroidism, or those already using vasopressor agents.

Atomoxetine (Strattera)

The non-stimulant medication atomoxetine also has specific safety warnings related to possible liver damage and increase in suicidal thoughts. The most common side effects are headache, upset stomach, and decreased appetite. Other noted side effects include gastric irritation, tiredness, dizziness, and dry mouth.

Long-acting Medications

There are additional cautions related to taking long-acting, osmotic-release medication rather than short-acting doses:

1) If not taken early in the morning, doctors often recommend skipping the dose for that day since the stimulants will affect normal sleep patterns.
2) Some people find that, even with early morning dosing, OROS-MPH (aka Concerta) significantly disrupts normal sleep patterns.
3) Because of the tablet's non-deformable shell, the Concerta pill cannot be cut to decrease the dosage. This aspect causes trouble for users who are working to find the best dosage levels or for those who wish to give their child a lower dose for half-days at school. Increasing or decreasing the dosage by any amount requires a new prescription.

Working with Adolescents Alone

When caregivers are absent or virtually absent from behavioral treatment sessions, therapists can collaborate with the prescriber to provide direct support and monitoring of the teen's medication uptake and impacts, using the strategies (or slight variations) described in Task 5.

# ADHD Medication Log

Client ID: _____ Therapist: _____ Date: _____

Current Primary Regimen: Type _____ Dose _____

Current Booster Regimen: Type _____ Dose _____

| | |
|---|---|
| # Days since completing previous Log | |
| # Days primary medication taken | |
| # Days medication forgotten/refused | |
| # Days medication vacation | |
| # Days medication halted b/c of side effects | |

Time the morning pill usually taken _____ Time the morning pill usually wears off _____

When, if any, are difficult time period(s) during the day? _____

Please describe the use of any evening booster medications:

Please describe the use of any nighttime sleep aids:

| **Medication has helped you:** | Not at all | A little | A lot |
|---|---|---|---|
| At home | | | |
| At school | | | |
| With friends | | | |

| **Experienced this side effect?** | Not at all | A little | A lot |
|---|---|---|---|
| Reduced Appetite | | | |
| Weight Loss/Gain | | | |
| Sleeping Problems | | | |
| Headache/Stomachache | | | |
| Irritability/Mood Swings | | | |
| Other _____ | | | |

# Monthly ADHD Medication Calendar

Client ID: _____ Therapist: _____ Date: _____

Current Primary Regimen: Type _____ Dose _____

Current Booster Regimen: Type _____ Dose _____

| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

X=medication forgotten or refused; O=medication vacation day; !=medication halted due to side effects

## MIP Treatment Planning and Tracking Forms

For most families of adolescents who enter treatment, ADHD is not the main referral problem; moreover, it is not presented as a major problem or even as a possible underlying cause for referral. However, this perspective is expected to change dramatically once MIP Tasks 1-4 are completed. In the process of completing the ADHD Psychoeducational Modules during Task 2, the therapist and family will have together completed the ***ADHD Style Index***, ***School Problem Scorecard***, ***Family Problem Scorecard***, and ***Peer Problem Scorecard***. Completing the Scorecards is essential to adolescent ADHD assessment and treatment planning, as they are the means by which generic psychoeducational information is personalized for a given client.

After the Scorecards are completed, the therapist and family will be well positioned in Task 3 to complete the ***Our Goals for Treatment*** worksheet specifying problem areas and treatment goals in key domains of functioning (Family, School, Peers), making ADHD symptoms and related problems an area to be targeted directly for intervention. In this way, the ***Our Goals for Treatment*** worksheet helps to transform the client's profile of ADHD-related problems into a set of ADHD-related treatment goals that are meaningful for the adolescent and the family.

The ***Our Goals for Treatment*** worksheet also serves to highlight the most important ADHD-related challenges faced by the family, which are also the challenges most likely to be impacted by medication. This sets the stage for Task 4, in which the therapist and family together complete the ***Pros & Cons Worksheet for ADHD Medication*** in order to reach a family consensus about medication.

In Task 5, which is only for those clients who start medication, the therapist and family fill out the ***ADHD Medication Log***, which charts data on current medication prescription, daily compliance with ingestion, notable positive impacts, and the severity of common side effects. This in-session tracking tool is invaluable for logging treatment-relevant data for ongoing review by the therapist, initiating in-session dialogue and interventions with the family regarding ADHD-related issues, and providing a feedback loop for effective case planning and medication management for the therapist and psychiatrist together.

The ***MIP Fidelity Monitoring Checklist*** is a therapist-report tool designed to help the therapist track case progress in completing each Task/Subtask prescribed by MIP. A single Checklist sheet can serve to track MIP implementation over the entire length of a case. Because MIP is a modular protocol (see Introduction), the Checklist does not prescribe a fixed sequence or timing window for completing various Tasks. Also, not every Task/Subtask will be appropriate for every family, such that the protocol may be effectively "accomplished" for a given family without having completed every Checklist item. The "Dates of Task Activity" spaces allow therapists to document whenever Subtasks are addressed, including those requiring multiple sessions to complete. As needed, therapists may revisit one or more completed Tasks/Subtasks to reinforce key clinical issues or underscore clinical gains over the course of treatment.

# Medication Integration Protocol (MIP)
# Fidelity Monitoring Checklist

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

Date of initial meds prescription: _____ (☐ N/A) Type/Dose: _____

**Dates of Task Activity**
**(x when Task completed)**

## MIP Task 1: ADHD & EF Intake Assessment and Medication Consult

1a. Consultation with intake assessor and/or psychiatrist on results of ADHD assessment ☐ _____
*Diagnosis:* ☐ Inattentive ☐ Hyperactive/Impulsive ☐ Combined

1b. Consultation with psychiatrist on family interview about ADHD medication prescription ☐ _____ ☐ N/A
*Status:* ☐ Accepted ☐ Declined ☐ Deferred ☐ Not Discussed ☐ Not Eligible

1c. Preparation of EF assessment feedback for delivery to the family during Task 2 ☐ _____ ☐ N/A

## MIP Task 2: ADHD Psychoeducation and Client Acceptance

2a. Review of ADHD intake data and Presentation of Basic Facts Module ☐ _____
2b. Review of EF intake data and Presentation of Executive Skills Module ☐ _____
2c. Completion of ADHD Style Index ☐ _____
2d. Completion of Family Problem Scorecard ☐ _____
2e. Completion of School Problem Scorecard ☐ _____
2f. Completion of Peer Problem Scorecard ☐ _____

## MIP Task 3: ADHD Symptoms and Treatment Planning

3a. Presentation of relational reframe of ADHD-related behaviors ☐ _____
3b. Presentation of ADHD relabeling interventions and Linking ADHD to referral problems ☐ _____
3c. Completion of the Our Goals for Treatment worksheet ☐ _____

## MIP Task 4: ADHD Medication and Family Decision-Making

4a. Review of psychiatric intake assessment related to ADHD medication ☐ _____
4b. Completion of Medication Module: ☐ Psychiatrist ☐ Therapist ☐ _____
4c. Completion of Pros & Cons Worksheet for ADHD Medication ☐ _____

## MIP Task 5: Medication Management and Integration Planning

5a. Review of post-intake psychiatrist visits for medication management ☐ _____ ☐ N/A
5b. Consultation with psychiatrist about medication management & coordination ☐ _____ ☐ N/A
5c. Integration of medication log and management issues into behavioral sessions ☐ _____ ☐ N/A

# Your thoughts on MIP

Please indicate Task number and date of note; feel free to add more pages if needed

Task number: Date:
NOTES:

Task number: Date:
NOTES:

Task number: Date:
NOTES:

## Evidence Base Supporting the Integration of Medication Interventions into Behavioral Services for Adolescent ADHD

In order to reduce the quality-of-care gap for adolescents with ADHD, it is essential to conduct valid, multimodal, multidomain assessments of ADHD symptomatology and related areas of functioning (Wolraich et al., 2005) and develop innovative clinical procedures designed to support the integration of ADHD medication into behavioral care (see Bukstein & Cornelius, 2006; Robin, 2006). Such procedures would enhance therapist confidence in addressing ADHD problems within their caseloads as well as supply basic clinical tools for effective intervention. Specifically, new procedures are needed to (1) increase opportunities for adolescents and caregivers to make informed decisions about ADHD medication acceptance and (2) support family participation and compliance in medication regimens. Below we briefly describe three evidence-based strategies that can advance ADHD medication integration efforts in this manner; these strategies constitute the empirical foundation of MIP.

**Family Psychoeducation in Adolescent ADHD**. ADHD psychoeducation refers to a set of well-developed interventions that provide structured information about signature symptoms, course of the disorder, impacts on multiple domains of functioning (family, school, peers), individual differences associated with ADHD, and best treatment practices that include the combination of medication, behavior therapy, and school-based interventions (Montoya, Colom, & Ferrin, 2011). This information is packaged in an easy-to-digest format and sets the stage for developing a unique profile of ADHD-related symptoms and problems for each client (e.g., Lopez, Toprac, Crimson, Boemer & Baumgartner, 2005). Psychoeducation in mental health disorders has been shown to enhance medication and behavioral treatment effects (e.g., Fristad, 2006) and to improve treatment adherence (Vieta, 2005) and medication compliance (Cummings & Fristad, 2007) for clients with a variety of behavioral problems. Moreover, family psychoeducation targeted to caregivers and youth conjointly is especially helpful for youth receiving psychiatric medication (Fristad, 2006). Several research-based protocols exist for childhood disorders in addition to ADHD, including depression (Sanford et al., 2006), bipolar disorder (Fristad, 2006), and eating disorders (Geist, Heinmaa, Stephens, Davis & Katzman, 2000).

**Family-based Medication Decision-Making.** Family-based medication decision-making interventions, in which family history and attitudes about psychiatric medication are systematically processed in the context of current options and benefit-cost decisions about adolescent ADHD medication, appear to be prerequisite for safe and consistent medication use in teenagers with ADHD. There are two compelling reasons to favor family-based interventions for facilitating decisions about medication. First, family factors play a lead role in predicting medication acceptance and compliance among teenagers (Smith, Waschbusch, Willoughby & Evans, 2000) as well as affecting safety, tolerance, polypharmacy, and liability issues associated with prescribing stimulants to at-risk youth (Kollins, 2007). Second, evidence-based family therapy models for adolescent behavior problems (Henggeler & Sheidow, 2012; Hogue & Liddle, 2009) feature interventions that specifically boost adolescent investment in therapy activities by (a) developing a personally meaningful treatment agenda in which the teen can be a motivated participant and (b) (re)moralizing the teen by generating hope that self-defined problems can and will improve (Diamond, Liddle, Hogue, & Dakof, 1999; Liddle, 1995; Robbins et al., 2006). Family-based motivation and change interventions can also be used to link

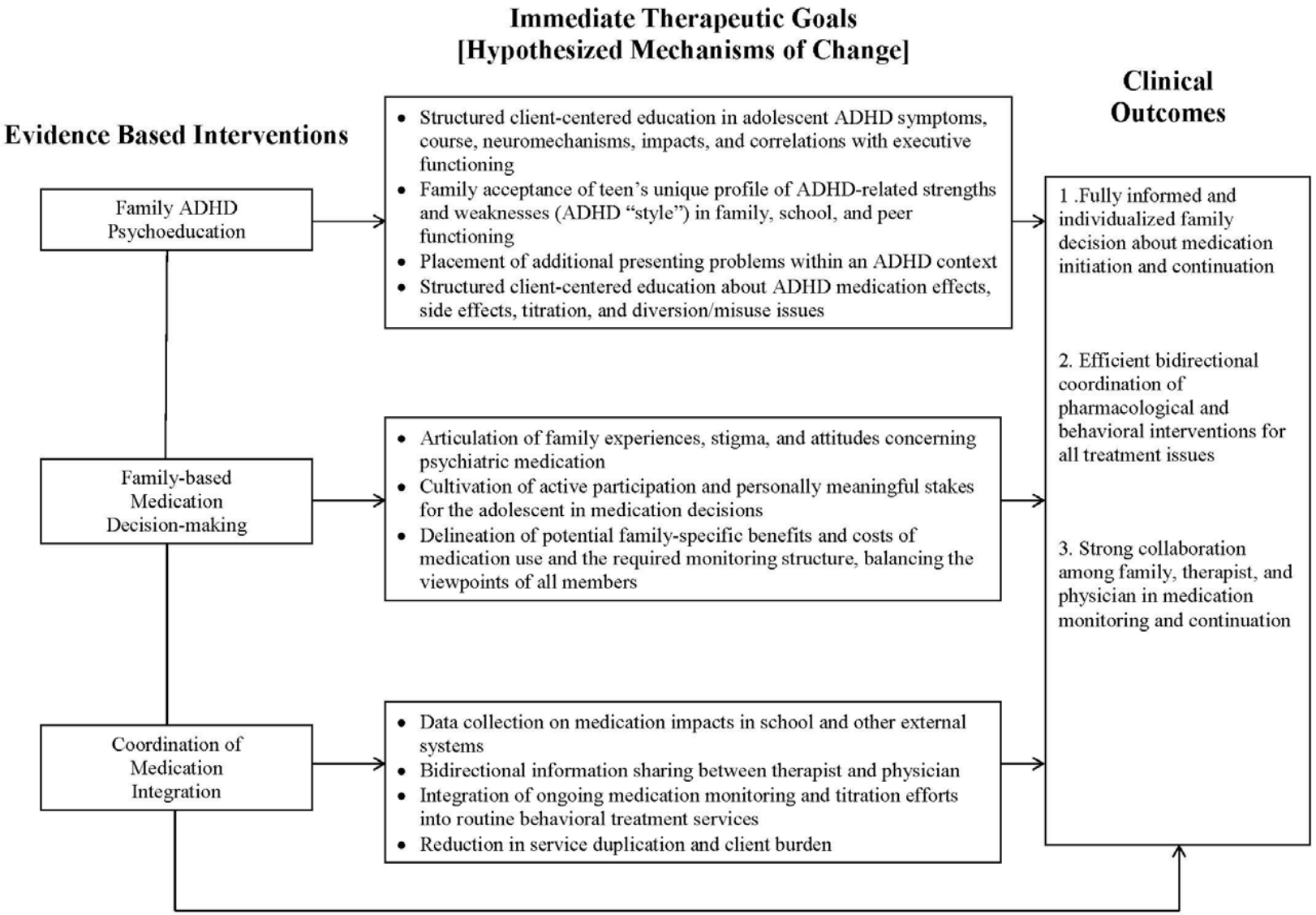
adolescent ADHD problems to family processes and create positive expectations for change. Specifically, relabeling and reframing techniques (Alexander, Waldron, Barton, & Mas, 1989; Robbins, Alexander, Newell, & Turner, 1996; Robbins, Alexander, & Turner, 2000) can help launch an ongoing therapy dialogue on connections among ADHD symptoms, ADHD-related family accommodations at home, and family decisions about medication and treatment planning. Thus, because family-focused interventions are well suited to address caregiver monitoring and family relational processes that influence ADHD medication usage, and also to meaningfully engage teens as well as caregivers in the decision-making process, they are ideal candidates for promoting effective medication decision-making among adolescents with ADHD (see Robin, 2006).

**Behavior Therapist Leadership in Coordinating Medication Integration.** Most practicing behavior therapists are non-medical professionals—social workers, psychologists, and counselors of other kinds—who are not certified to prescribe and monitor psychiatric medications. Nevertheless, in order to integrate ADHD medication interventions more fully into behavioral services for adolescents, behavior therapists need to play a lead role in coordinating the pharmacological and behavioral aspects of treatment for each client. For behavior therapists who are not certified prescribers, this means expanding their traditional clinical duties in two ways. First, they should acquire reasonable fluency in the types, dosing algorithms, anticipated effects, and potential side effects of ADHD medications for teenagers. This will afford them information about ADHD medication that is required to consult effectively with prescribing providers and work effectively with families in making medication decisions and assessing medication impacts across multiple domains of functioning. Numerous educational resources on adolescent ADHD medication are targeted directly at non-medical counselors to facilitate self-education in this area (e.g., Dendy, 2000, 2006). Therapists can also access a wealth of continuing education materials, including on-line distance learning courses (e.g., www.dcplearner.com/chadd_ceu), that provide structured education in this area along with assessment and certification of knowledge gained.

Second, non-prescribing behavior therapists should assume leadership for coordinating the case activities shared among the family, therapist, and prescriber (who may be a physician, nurse, or psychologist). This may include gaining family consent to consult directly with the prescriber about family issues that arise week-to-week in therapy sessions and bear upon medication titration, compliance, and liability; working with the prescriber to establish a coordinated service plan to support medication maintenance; helping to monitor ongoing effectiveness and side effects, especially when medication management sessions with the prescriber become less frequent; minimizing client burden related to regular appointments with multiple providers; and including the prescriber as indicated in behavioral treatment sessions. For guidance in this heightened liaison role, behavior therapists can rely on evidence-based protocols for therapist-family-school collaboration for ADHD youth (Power et al., 2012), or other case coordination models for multidisciplinary clinical teams (e.g., Mitchell, Tieman, & Shelby-James, 2008), adapting relevant principles for the purpose of managing therapist-family-prescriber activities related to ADHD medication.

The MIP conceptual model is depicted below. The figure links the three practice innovations—family ADHD psychoeducation, family-based medication decision-making, and behavioral

therapist leadership in coordinating integration efforts—to hypothesized mechanisms of change (i.e., immediate outcomes) targeted in the adolescent and family during protocol implementation, and ultimately to the desired case outcomes. As described above, MIP is a modular protocol composed of five Tasks. The MIP Tasks and their constituent subtasks are listed in the MIP Fidelity Monitoring Checklist (see above), which functions as a clinical log that can be appended to standard case notes and used by the therapist to support MIP case planning and Task implementation throughout treatment.


Immediate Therapeutic Goals
[Hypothesized Mechanisms of Change]
Evidence Based Interventions
Clinical Outcomes
Family ADHD Psychoeducation
Family-based Medication Decision-making
Coordination of Medication Integration
• Structured client-centered education in adolescent ADHD symptoms, course, neuromechanisms, impacts, and correlations with executive functioning
• Family acceptance of teen's unique profile of ADHD-related strengths and weaknesses (ADHD "style") in family, school, and peer functioning
• Placement of additional presenting problems within an ADHD context
• Structured client-centered education about ADHD medication effects, side effects, titration, and diversion/misuse issues
• Articulation of family experiences, stigma, and attitudes concerning psychiatric medication
• Cultivation of active participation and personally meaningful stakes for the adolescent in medication decisions
• Delineation of potential family-specific benefits and costs of medication use and the required monitoring structure, balancing the viewpoints of all members
• Data collection on medication impacts in school and other external systems
• Bidirectional information sharing between therapist and physician
• Integration of ongoing medication monitoring and titration efforts into routine behavioral treatment services
• Reduction in service duplication and client burden
1 .Fully informed and individualized family decision about medication initiation and continuation
2. Efficient bidirectional coordination of pharmacological and behavioral interventions for all treatment issues
3. Strong collaboration among family, therapist, and physician in medication monitoring and continuation

## RECOMMENDED RESOURCES

**The following resources are referenced above and were instrumental in developing the ideas, clinical approach, and treatment recommendations described in this *Manual*:**


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

Dendy, C. A. Z. (2006). *Teenagers with ADD and ADHD: A Guide for Parents and Professionals (2nd edition).* Bethesda. MD: Woodbine House.

Dendy, C. A. Z. (2011). *Teaching Teens with ADD, ADHD & Executive Function Deficits: A Quick Reference Guide for Teachers and Parents (2nd edition).* Bethesda. MD: Woodbine House.

Dendy, C. A. Z., & Zeigler, A. (2007). *A Bird's Eye View of Life with ADD and ADHD: Advice from Young Survivors (2nd edition).* Cedar Bluff, AL: Cherish the Children. (www.chrisdendy.com)

Dendy, C. A. Z., & Zeigler, A. (2011). *Real Life ADHD: A DVD Survival Guide for Children & Teens*. Chris A. Ziegler Dendy, LLC. (www.chrisdendy.com)

Hogue, A., Bobek, M., Tau, G. Z., & Levin, F. R. (2014). Clinical strategies for integrating medication interventions into behavioral treatment for adolescent ADHD: The Medication Integration Protocol. *Child & Family Behavior Therapy, 36*, 280-304.

Kellison, I., Bussing, R., Bell, L., & Garvan, C. (2010). Assessment of stigma associated with attention-deficit hyperactivity disorder: Psychometric evaluation of the ADHD Stigma Questionnaire. *Psychiatry Research, 178*, 363-369.

Robin, A. L. (2006). Training families with adolescents with ADHD. In R. Barkley (Ed.), *Attention-Deficit Hyperactivity Disorder—Third Edition (pp. 499-546).* New York: Guilford.

## References Cited


Alexander, J. F., Waldron, H. B., Barton, C., & Mas, C. H. (1989). The minimizing of blaming attributions and behaviors in delinquent families. *Journal of Consulting and Clinical Psychology, 57,* 19-24.

Bukstein, O. G., & Cornelius, J. (2006). Psychopharmacology of adolescents with substance use disorders: Using diagnostic-specific treatments. In H. A. Liddle & C. L. Rowe (Eds.), *Adolescent substance abuse: Research and clinical advances* (pp. 241-263): Cambridge University Press.

Cummings, C. M., & Fristad, M. A. (2007). Medications prescribed for children with mood disorders: Effects of a family-based psychoeducation program. *Experimental and Clinical Psychopharmacology, 15*, 555-562.

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.

Dendy, C. A. Z. (2011). *Teaching Teens with ADD, ADHD & Executive Function Deficits: A Quick Reference Guide for Teachers and Parents (2nd edition)*. Bethesda. MD: Woodbine House.

Diamond, G. M., Liddle, H. A., Hogue, A., & Dakof, G. A. (1999). Alliance-building interventions with adolescents in family therapy: A process study. *Psychotherapy: Theory, Research, Practice, & Training, 36*, 355-368.

Fischer, M., & Barkley, R. A. (2003). Childhood stimulant treatment and risk for later substance abuse. *Journal of Clinical Psychiatry, 64*(Suppl. 11), 19-23.

Fristad, M. A. (2006). Psychoeducational treatment for school-aged children with bipolar disorder. *Development and Psychopathology, 18*, 1289-1306.

Geist, R., Heinmaa, M., Stephens, D., Davis, R., & Katzman, D. K. (2000). Comparison of family therapy and family group psychoeducation in adolescents with anorexia nervosa. *Canadian Journal of Psychiatry, 45*, 173-178.

Henggeler, S. W., & Sheidow, A. J. (2012). Empirically supported family-based treatments for conduct disorder and delinquency in adolescents. *Journal of Marital and Family Therapy, 38*, 30-58.

Hogue, A., Bobek, M., Tau, G. Z., & Levin, F. R. (2014). Clinical strategies for integrating medication interventions into behavioral treatment for adolescent ADHD: The Medication Integration Protocol. *Child & Family Behavior Therapy, 36*, 280-304

Hogue, A., & Liddle, H. A. (2009). Family-based treatment for adolescent substance abuse: Controlled trials and new horizons in services research. *Journal of Family Therapy, 31*, 126-154.

Humphreys, K. L., Eng, T., & Lee, S. S. (2013). Stimulant medication and substance use outcomes: A meta-analysis. *JAMA Psychiatry, 70*, 740-749.

Kollins, S. H. (2007). Abuse liability of medications used to treat Attention-Deficit/ Hyperactivity Disorder (ADHD). *The American Journal on Addictions, 16*, 35-44.

Liddle, H. A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family-based adolescent treatment. *Psychotherapy: Theory, Research, Practice, & Training, 32*, 39-58.

Lopez, M., Toprac, M., Crimson, M., Boemer, B., & Baumgartner, J. (2005). A psychoeducational program for children with ADHD or depression and their families: Results from the CMAP feasibility study. *Community Mental Health Journal, 41*, 51-66.

Mitchell, G. K., Tieman, J. J., & Shelby-James, T. M. (2008). Multidisciplinary care planning and teamwork in primary care. *Medical Journal of Australia, 188,* S61-S64.

Molina, B. S., Hinshaw, S. P., Arnold, L. E., Swanson, J. M., Pelham, W. E., Hechtman, L., …& Marcus, S. (2013). Adolescent substance use in the Multimodal Treatment Study of Attention-Deficit/Hyperactivity Disorder (ADHD)(MTA) as a function of childhood ADHD, random assignment to childhood treatments, and subsequent medication. *Journal of the American Academy of Child and Adolescent Psychiatry, 52,* 250-263.

Montoya, A., Colom, F., & Ferrin, M. (2011). Is psychoeducation for parents and teachers of children and adolescents with ADHD efficacious? A systematic literature review. *European Psychiatry, 26,* 166-175.

Pliszka, S. R., Crismon, M., Hughes, C. W., Corners, C. K., Emslie, G. J., Jensen, P. S., ... & Lopez, M. (2006). The Texas Children's Medication Algorithm Project: revision of the algorithm for pharmacotherapy of attention-deficit/hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 642-657.

Power, T. J., Mautone, J. A., Soffer, S. L., Clarke, A. T., Marshall, S. A., Sharman, J., … & Jawad, A. F. (2012). A family–school intervention for children with ADHD: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 80,* 611-623.

Robbins, M. S., Alexander, J. F., Newell, R. M, & Turner, C, W. (1996). The immediate effect of reframing on client attitude in family therapy. *Journal of Family Psychology, 10,* 28-34.

Robbins, M. S., Alexander, J. F., & Turner, C. W. (2000). Disrupting defensive family interactions in family therapy with delinquent adolescents. *Journal of Family Psychology, 14,* 688-701.

Robbins, M. S., Liddle, H. A., Turner, C. W., Dakof, G. A., Alexander, J. F., & Kogan, S. M. (2006). Adolescent and parent therapeutic alliances as predictors of dropout in multidimensional family therapy. *Journal of Family Psychology, 20,* 108-116.

Robin, A. (2006). Training families with adolescents with ADHD. In R. Barkley (Ed.), *Attention Deficit Hyperactivity Disorder: A handbook for diagnosis and treatment* (3rd ed., pp. 499-546). New York: Guilford.

Sanford, M., Boyle, M., McCleary, L., Miller, J., Steele, M., Duku, E., & Offord, D. (2006). A pilot study of adjunctive family psychoeducation in adolescent major depression: Feasibility and treatment effect. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*, 386-395.

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.

Smith, B. H., Waschbusch, D. A., Willoughby, M. T., & Evans, S. (2000). The efficacy, safety, and practicality of treatments for adolescents with Attention-Deficit/Hyperactivity Disorder (ADHD). *Clinical Child and Family Psychology Review, 3*, 243-267.

Vieta, E. (2005). Improving treatment adherence in bipolar disorder through psychoeducation. *Journal of Clinical Psychiatry, 66*(Suppl. 1), 24-29.

Wolraich, M. L., Wibbelsman, C. J., Brown, T. E., Evans, S. W., Gotlieb, E. M., Knight, J. R., …& Wilens, T. (2005). Attention-Deficit/Hyperactivity Disorder among adolescents: A review of the diagnosis, treatment, and clinical implications. *Pediatrics, 115,* 1734-1746.