ADHD MANAGEMENT

Behavioral Strategies Across Settings

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Learning Objectives

- Identify appropriate areas of functioning to address in the treatment of ADHD.
- Demonstrate evidence-based strategies across settings.
- List behavioral management strategies in school and clinic settings.
- Describe the importance of family involvement in behavioral management of ADHD.
- Identify self management strategies that clients can use to better control their environment

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Disclaimer

- This presentation discusses evidence based behavioral treatments for persons with an ADHD diagnosis. Some modalities may or may not be within your perspective scope of practice.
- Do not attempt any treatment modalities for which you have not been formally trained.
- Do not attempt any treatment modalities that are not within your professional governing body's area of expertise.
- Do not attempt any treatment modalities for which your current legal, license and/or certification does not approve as an effective approach under your profession.
- The modalities expressed in this presentation are for comprehension and knowledge purposes. By increasing understanding, a Minimal Viable Clinician™ (MVC™) can incorporate a more collaborative disciplinary approach, and in turn, obtain positive outcomes for the people whom you serve quicker.

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Presenter Bio

Dr. Ronald T Brown, PhD is a Professor and Dean in School of Allied Health Sciences at University of Nevada, Las Vegas, USA. He served as the Associate Vice-Chancellor for Academic (Health Affairs) at the University of North Texas System. Dr. Brown completed his Ph.D. from Georgia State University and has been the past President of the Society of Pediatric Psychology and the Association of Psychologists of Academic Health Centers. He is a board certified clinical health psychologist and has been an active clinician, teacher, advocate and investigator.

Dr. Brown has served as a member of the Behavioral Medicine study section of the NIH and chaired several special panels at NIH. Dr. Ronald Brown's area of specialization includes behavioral sciences, pediatric psychology, attention deficit disorders, neuropsychology, psychopharmacology, learning disabilities and psychosocial oncology. He is a current editor of Journal of Clinical Psychology in Medical Settings. He served as a previous editor of Professional Psychology: Research and Practice and Journal of Pediatric Psychology.

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Presenter Bio

Dr. Deborah Padgett Coehlo, PhD, C-PNP, PMHS, CFLE is a certified Pediatric Nurse Practitioner and Pediatric Mental Health Specialist with a Doctoral Degree in Family Sciences and Human Development.

A developmental and behavioral specialist, Dr. Coehlo is a Founder and Director of Juniper Pediatrics, a clinic modeled after John F. Kennedy's multidisciplinary system of care. Using a holistic, integrated care model, Juniper provides counseling, medication management and family therapy for children with ASD, ADHD and other childhood mental health disorders.

Dr. Coehlo completed her Masters in Nursing with a specialty in parent-child nursing. She spent 10 years working at the Child Development Center at the University of Washington in the Genetics Clinic and Multidisciplinary Clinic. In 1999, she completed her Doctorate degree in Human Development and Family Sciences.

She has continued to teach at the undergraduate and graduate level, and has pursued research in the area of social networking, transition to out of home care for families, and child development. Dr. Coehlo is a co-editor for the 4th and 5th edition of Family Health Nursing (F.A. Davis, 2010/2013) and has published several journal articles in the areas of families choosing residential care, families in transition, family health nursing, and care of children with special health care needs.

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Presenter Bio

Mike Marroquin PhD, BCBA-D, New York State Licensed Behavior Analyst
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Dr. Michael “Mike” Marroquin, is an Autism graduate & undergraduate professor at Queens College (CUNY). He also is a practicing consultant for families and school districts in New York. His is passionate about making behavior analysis accessible to students in public school settings. He specializes in parent and staff training on the use of ABA methodologies in both home and school settings to provide students with a consistent set of expectations in both environments.

Dr. Mike currently Supervises BCBA® applicants and state licensure applicants in public school settings. As a behavior analyst, he uses ABA to teach behavior analysis in higher education, school and home.

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Review of Facts

ADHD is one of the most common neuro-developmental disorders diagnosed in childhood

- Prevalence rates estimate that between 3-7% of children in the United States are diagnosed with ADHD.
- Geographic studies show higher prevalence rates in southern states, and in urban communities.
    - ➢ Access to health care?
- Symptoms broadly include impairments in the areas of attention, focus, concentration, hyperactivity, impulsivity, and poor executive function skills.
- Symptoms are considered chronic and persist into adulthood.
- Symptoms are pervasive and occur across settings, and across time.

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Treatment Guidelines: Medication Management

- The American Academy of Pediatrics recommends the following elements to treatment of ADHD (2011)
  - Medication management
    - ➢85-91% of children diagnosed with ADHD in the United States are treated with stimulant medication.
      - ○ Stimulant medication has good efficacy (and limited negative side effects) for reducing target symptoms of ADHD.
      - ○ The most common forms of stimulant medication include Methylphenidate immediate and extended release (i.e., Ritalin™, Concerta™) and Amphetamine salts (i.e., Adderall™, Vyvanse™).
    - ➢Other alternative medications:
      - ○ Guanfacine (Intuniv™)
      - ○ Atomoxetine (Strattera™)
      - ○ Bupropion (Wellbutrin™)

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Classes of Medication

Table 4
FDA-Approved Medications for the Management of ADHD Symptoms

Class	Brand name	Form		Common side effects
		Short-acting	Long-acting	
Stimulant medications				
Amphetamine/dextroamphetamine	Adderall	✓		Loss of appetite, weight loss, sleep difficulties, irritability, tics.
	Adderall XR		✓	
	Dexedrine	✓		
	Dexedrine Spansule		✓	
	Dextrostat	✓		
	Vyvanse		✓	
Methylphenidate	Concerta		✓	Loss of appetite, weight loss, sleep difficulties, irritability, tics.
	Daytrana patch		✓	
	Focalin	✓		
	Focalin XR		✓	
	Metadate CD	Intermediate		
	Metadate ER	Intermediate		
	Methylin	✓		
	Methylin ER	Intermediate		
	Ritalin	✓		
	Ritalin LA	Intermediate		
	Ritalin SR	Intermediate		
	Quillivant XR		✓	
Nonstimulant medications				
Atomoxetine	Strattera		✓	Sleep difficulties, anxiety, fatigue, upset stomach, dizziness, dry mouth.
Guanfacine XR	Intuniv		✓	Sleepiness, headache, fatigue, abdominal pain.

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Treatment Guidelines: Behavioral Interventions

Behavioral Therapy

- The focus of today's discussion
  - Two major approaches to behavioral therapy:
    - Cognitive Behavioral Therapy
    - Applied Behavior Analysis (ABA)

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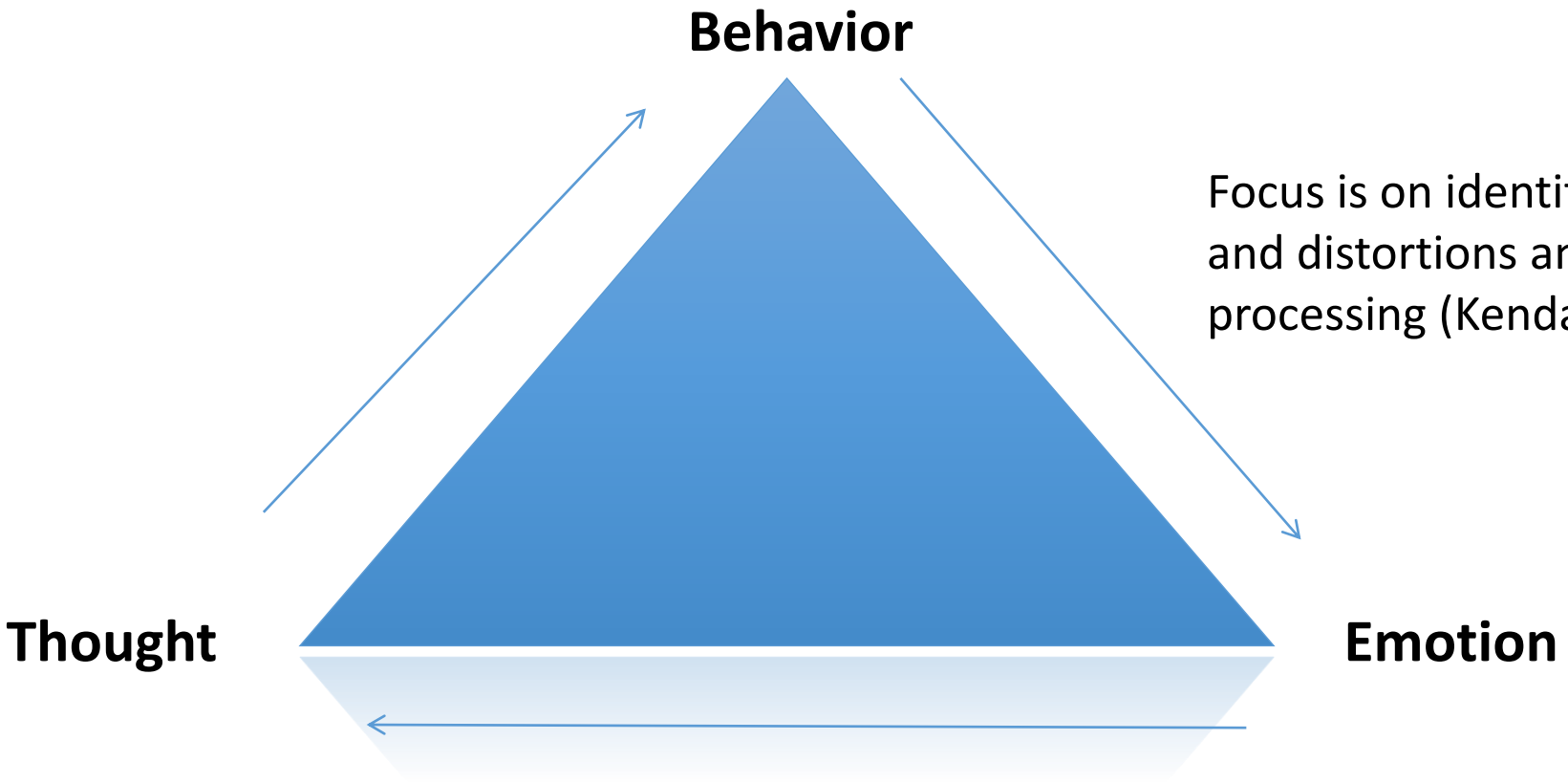
Cognitive Behavioral Therapy (CBT)

Focuses on helping the patient think about behavior differently



Focus is on identifying cognitive errors and distortions and errors in information processing (Kendall & Braswell, 1993)

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Behavioral Interventions (CBT)

- Most effective when compared to all other counseling models (Levine & Anshel, 2011)
- Behavioral interventions are effective in addressing symptoms of inattention, poor impulse control, and motor restlessness, which occur as part of pre-verbal processes.

  - These preverbal skills are not always appropriate targets for CBT

    - CBT may be useful for children over 8 years of age, who is capable of self reflection

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Behavioral Interventions (ABA)

Effective ABA Strategies and Techniques

- Antecedent Strategies
- Shaping
- Task analysis
- Preference assessment
- Reinforcement
  - Frequency (high magnitude)
  - Dense schedule (fixed ratio or fixed interval)
- Visual and/or auditory prompts (plus plan to fade-out prompts)
- Token economies and Points Systems with carry-over across settings
- Response cost (Start with functional, non-aversive procedures)
- Functionally equivalent replacement behaviors
- Structured environment (routine)
- Transition

Self-monitoring (teach student)

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Medication Management: To do or not to do?

Side effects of medications are often cited by parents as barriers to seeking medical help.

What are the "side effects" of *not* medicating a child with ADHD.

Can behavioral interventions compensate for the effects of non-medication?

Affects quality of life:

- Poor academic performance
- Low self-esteem
- Poor social skills and few friends if any
- Physical aggression towards peers or self harm

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Parent and Staff Training

Parents and teachers often have difficulty understanding what a student can and cannot control.

Staff and Parent trainings on behavioral strategies and techniques should include:

- Setting achievable goals
- Fading prompts (instructions/commands) over time
- Selecting appropriate reinforcers
- Allowing the child to make choices
- Being flexible when attempting to achieve desired outcomes
  - Demands should be within the child's ability to achieve
  - Add flexibility – "Sit in your seat" vs "stay in your area"
- Setting limits effectively

Being consistent in the home and classroom

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Student Involvement

Students can be taught to participate in managing their ADHD symptoms is by using behavioral strategies

Self management

- Identify behaviors they want to work on
- Incorporating choice
- Create token charts together
- Select reinforcers
  - Public or private
- Use technology for reminders
  - Breaks
  - Deadlines (due dates)
- **Self advocacy (e.g. Participate in IEP Meetings)**

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5-Minute Break

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Stay in Your Lane…

… But look out for the best interest of the client

Behavior Analysts should encourage that parents discuss both medication and behavioral options with medical professionals.

BACB Ethics Code 2.03 Consultation

(a) Behavior analysts arrange for appropriate consultations and referrals based principally on the best interests of their clients, with appropriate consent, and subject to other relevant considerations, including applicable law and contractual obligations.

(b) When indicated and professionally appropriate, behavior analysts cooperate with other professionals, in a manner that is consistent with the philosophical assumptions and principles of behavior analysis, in order to effectively and appropriately serve their clients.

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Stay in Your Lane… *(Continued)*

BACB Ethics Code 2.09 Treatment / Intervention Efficacy

(a) Clients have a right to effective treatment… Behavior analysts always have the obligation to advocate for and educate the client about scientifically supported, most effective treatment procedures.

(b) Behavior analysts have the responsibility to advocate for the appropriate amount and level of service provision and oversight required to meet the defined behavior-change goals.

(c) In those instances where more than one scientifically supported treatment has been established, additional factors may be considered in selecting interventions, including, but not limited to efficiency and cost-effectiveness, risks and side-effects of the interventions, client preference, and practitioner experience and training.

(4) Behavior analysts review and appraise the effects of any treatment about which they are aware that might impact the goals of the behavior-change program, and their possible impact on the behavior-change program, to the extent possible.

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Stay in Your Lane… *(Continued)*

BACB Ethics Code 3.02 Medical Consultation

Behavior analysts recommend seeking a medical consultation if there is any reasonable possibility that a referred behavior is influenced by medical or biological variables.

BACB Ethics Code 4.06 Describing Conditions for Behavior-Change Program Success

Behavior analysts describe to the client the environmental conditions that are necessary for the behavior-change program to be effective.

BACB Ethics Code 4.07 Environmental Conditions that Interfere with Implementation

(a) If environmental conditions prevent implementation of a behavior-change program, behavior analysts recommend that other professional assistance (e.g., assessment, consultation or therapeutic intervention by other professionals) be sought.

(b) If environmental conditions hinder implementation of the behavior-change program, behavior analysts seek to eliminate the environmental constraints, or identify in writing the obstacles to doing so.

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Stay in Your Lane… (Importance of Sharing Data)

… but collaborate by sharing **data** to make better informed decisions

BACB Ethics Code 3.01 Behavior Analytic Assessment

(a) Behavior analysts conduct current assessments prior to making recommendations or developing behavior-change programs. The type of assessment used is determined by client's needs and consent, environmental parameters, and other contextual variables. When behavior analysts are developing a behavior-reduction program, they must first conduct a **functional assessment**.

(b) Behavior analysts have an obligation to collect and graphically display data, using behavior-analytic conventions, in a manner that allows for decisions and recommendations for behavior-change program development.

BACB Ethics Code 3.04 Explaining Assessment Results

Behavior analysts explain assessment results using language and graphic displays of data that are reasonable understandable to clients.

BACB Ethics Code 4.03 Individualized Behavior-Change Programs

(a) Behavior analysts must tailor behavior-change programs to the unique behaviors, environmental variables, assessment results, and goals of each client.

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Stay in Your Lane… (Scope of Competence)

Do not work outside of your prevue! Partner with people who have the skills that you don't.

BACB Ethics Code 1.01 Reliance of Scientific Knowledge

Behavior analysts rely on professionally derived knowledge based on science and behavior analysis when making scientific or professional judgements in human service provision, or when engaging in scholarly or professional endeavors.

BACB Ethics Code 1.02 Boundaries of Competency

(a) All behavior analysts provide services, teach, and conduct research only within the boundaries of their competence, defined as being commensurate with their education, training, and supervised experience.

(b) Behavior analysts provide services, teach, or conduct research in new areas (e.g., populations, techniques, behaviors) only after first undertaking appropriate study, training, supervision, and/or consultation from personas who are competent in those areas.

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Case Study: Evaluation Process

Background:

Alex is a 10 year old male diagnosed with ADHD at age 5 years, with concurrent learning disability in reading and writing. He has reported difficulties in academic, social, and home functioning, requiring extensive school support and weekly individual and family counseling. His current medications include Dexmethylphenidate ER 15 mg per day, with added Dexmethylphenidate IR 5 mg in the morning and the early afternoon.

Parent Interview:

Parents note that Alex was adopted at 3 days of age. They described Alex as an active toddler, progressing to an “out of control” five year old. They described spending hours during times of transition (i.e., getting ready for school, or going to bed). They noted they control his behavior with use of an I-Pad, noting Alex spends 3-4 hours on his I-Pad each day. Father stated he is the primary parent now as Alex’s mother is “burned out and checked out”, spending more and more time at work. They noted Alex has been on several medications, and his current medications “work the best”. He has also had extensive neuropsych testing, showing an overall IQ of 88, with difficulty with visual processing, fluency, and executive functioning. Using the Conner’s Comprehensive Behavioral Checklist-Parent Report, Alex scored 9 out of 9 symptoms of inattention and 9 out of 9 symptoms of hyperactivity/impulsivity.

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Case Study: Evaluation Process *(Continued)*

Teacher Interview:
Alex's teacher noted that Alex was easily distracted throughout the day, and did much better if taught in a quiet room with direct 1:1 instruction. She also noted that Alex receives weekly speech therapy, and after school tutoring for reading and writing. Writing samples were shared, which showed writing skills closer to the first grade level with simple sentences and numerous errors. Alex's teacher noted he rarely completes assignments, and if he hands in a completed assignment, it is messy and full of errors and omissions. Using the Conner's Comprehensive Behavioral Checklist-Teacher Report, Alex scored 9 out of 9 symptoms of inattention and 9 out of 9 symptoms of hyperactivity/impulsivity.

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Case Study: Evaluation Process *(Continued)*

Child Observations:
Alex was observed on the playground, in the classroom, and during a home visit. During the hours of peak medication effectiveness, Alex was cooperative, but remained distractible. His overall behavior was closer to a younger child of 6-7 years of age. He had a difficult time interacting with peers, especially during unstructured time. He tended to make loud, inappropriate noises, and rarely interacted with organized games (i.e., kick ball). At home, Alex spent over 50% of the time playing on his I-Pad. He refused to do more than 80% of what his parents asked him to do. When directly talked to, Alex was friendly and cooperative, asking appropriate questions and answering questions with thought. He was open about being lonely at school and home, and stated he thought “I am just a weirdo”. He constantly fidgeted with his shirt, and could only remain seated for less than 10 minutes.
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Case Study: Treatment Plan

*= ABA Approach

Course of Treatment

- *Initial feedback: Feedback given to the school personnel, the parents, and Alex.
- Multi-model approach to treatment
  - *School accommodations
  - *Behaviorally Based Parent and Teacher Training
    - *Behavior modification using positive and negative consequences for steps towards success.
      - *Token system to increase motivation on a dense schedule
        - *Consistency between home and school, with clear, Alex-directed goals
    - Antecedent focused interventions
      - *Looking at the environment (Pfiffner et al., 2006) using a Functional Assessment
      - *Example: Alex was rewarded for disruptive behavior by being sent to the student teacher for 1:1 attention. This was changed to providing attention in the classroom when he was engaged.

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Case Study: Treatment Plan *(Continued)*

*= ABA Approach

- Improved attention by using frequent and targeted prompting (eye contact, calling his name, calm repetition).
  - *Breaking a task into manageable parts. *(task analysis)*
  - *Decreasing distractions by moving Alex to the front of the classroom by the teacher *(environmental modifications)*
  - *Decreasing number of tasks to be completed; measuring competence rather than amount *(avoiding ratio strain)*
  - *Color coding assignments *(visual supports)*
  - Organizing learning space and supplies
    - *Improved positive attention with monitoring *(VI Schedule of NCR)*
    - *Active ignoring of minor "hiccups" *(planned ignoring)*
    - *Active play with parents a minimum of 15 minutes per day *(pairing)*

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Case Study: Treatment Plan *(Continued)*

- Parent and Teacher Focused Cognitive-Behavioral Interventions
  - Understanding the connection between attributions about a behavior and child's emotional and behavioral response (Levine & Anshel, 2011)
  - Example: Cognitive distortion of "telling the future" (predicting a negative outcome): "I have tried all this before- it won't work"; or magnification: "I don't have time for this".

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Case Study: Treatment Plan CBT Model

Date	Event	Automatic Thoughts	Emotions	Alternative Thoughts
6/1	Alex forgot to turn-in homework	I am tired of having to monitor homework	Discouraged	Alex & I can work on a better system to help him use tools to remember to turn in his homework
		He is old enough to be responsible- what is wrong with him?	Anger	Alex had ADHD. He will need help organizing his life
		He is just lazy.	Frustrated	Alex is not lazy. He just struggles with organization skills
		He will never be independent	Anxious/afraid	If we all work together, Alex will be independent. Many adults with ADHD are independent

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Case Study: Treatment Plan ABA Model (FBA)

Date	Behavior	Antecedent	Consequence	Possible Antecedent Behavioral Programs
6/1	Alex did not turn-in homework	Left completed homework at home	Received “0” on homework assignment	Self-monitoring and checklists; point system that carry-overs across school & home
		Shoved homework in bottom backpack	Received “0” on homework assignment	Visual prompts, auditory prompts (i.e. cell phone calendar reminders)
		Teacher requested class to bring homework to her	Received “0” on homework assignment	Visual prompts; least-to-most prompting to complete task of “turning in homework”
		Classmates enter classroom and place homework on tray	Received “0” on homework assignment	Self-monitoring; routine/schedule; visual/auditory prompts

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Case Study: Treatment Plan - Individual Counseling Goals

- Psycho-education about ADHD
  - What is ADHD and who else has this label (Einstein)
  - How does medication work and why is it important to take it *(may address this behavioral if medication refusal is behavior being monitored)*
  - Why are the other parts of treatment important and what is Alex's part
  - *What to expect over time *(setting expectations and goals of ABA programming)*

*= ABA Approach

- Identify negative cognitions about self
- Change negative cognitions to positive cognitions
- *Participate in developing, monitoring, and evaluating teacher and parent interventions
- *Develop positive coping strategies to cope with challenges *(i.e. Coping skills replacement behavior)*
- *Social skills development *(i.e. accepting delay and/or denial in reinforcement)*

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Case Study: Treatment Plan - Psychopharmacological Tx

*= ABA Approach

- Continued Psychopharmacological treatment
  - Increased dose of Dexmethylphenidate ER to 20 mg per day, with continued 5 mg IR at 7:00 am and 3:00 pm
  - *Continued monitoring of growth, neurological status, cardiac function, side effects, efficacy (Vanderbuilt or Conner's Questionnaires), and academic progress. *(Monitor behaviors with phase change lines as medication is titrated)*

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Case Study: Assessment of Progress

*= ABA Approach

Classroom observations

- *Alex was able to participate in the classroom full time, with a drop in out of class time from 80 minutes per day to 0 minutes per day after one month. *(Increased duration of attending class)*

Parent and teacher ADHD Rating Scales

- Alex dropped from a t-score of 99 in inattention, hyperactivity, and impulsivity to a t-score of 62 after one month on the designed treatment plan.
- *Daily report cards shared between the teacher and parents reported improved behavior across settings. *(Behavioral Monitoring- possible point system)*
- *Alex has 3 close friends after 6 months. *(Social significance of behavior change program- ultimate/terminal outcomes)*
- *The only change needed is updating his rewards for tokens earned *(Thinning schedule of reinforcement to replicate the least intrusive and most natural environment)*

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Case Study: Summary

*= ABA Approach

ADHD treatment is dependent on a careful evaluation, individualized multi-model approach to treatment, ongoing assessment of progress, and fine-tuning the plan based on the assessment of progress.

- *In-put is needed from the school, parents, and the child. *(Buy-in from stakeholders)*
- *Active participation is needed from the school, parents, and the child. *(All stakeholders implement programming across settings)*
- While CBT is not effective alone, it can help the child understand ADHD, build a positive self esteem, and build social skills, and can help teachers and parent reframe their thinking from failure to success.
- All the Alex's in the world count on us to change a "faulty brain" into a "quick brain".

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Case Studies

Jose is a first grader who is always on the move. He jumps over children sitting at the carpet and climbs the bookshelves at library. He is smart, and empathetic. He doesn't understand why kids are afraid of him. He has hurt himself three times and hurt other students more frequently In the first month of school. The teacher shows the BCBA a stack of letters from other parents requesting that Jose not sit near their child. When he is spoken to about his behavior he will sob uncontrollably, and attempt to hurt himself. Mom reports that his grades are fine and he is just boy. She is not interested in speaking to her doctor. She is more focused on the fact that 25 classmates were invited to his birthday party and no one showed up. She wants to know what the school is doing about all of the bullying happening to her son.

- What does this parent need to know to help her son?
- How would a medical professional approach this situation?

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Case Studies

Jason, a kindergartener, is frequently out of his seat, he wanders in the classroom, is having difficulty making or maintaining friendships, and is not making progress on all academic assessments. His teacher mentions that he cries daily and asks to use the bathroom at least every thirty minutes. His parents were contacted and his mother's response is that she knows he has ADHD but is not interested in medication and will wait for him to outgrow it. She suggests retention as another year in kindergarten may help.

- How does a BCBA address this Mother's belief that her son will simply outgrow it?
- How would a medical professional approach this situation?

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Case Studies

Tiffany is a third grade student who will often draw pictures when she is supposed to be working and has large holes in her academic abilities. She is missing some basic math facts and first grade sight words. All academic tasks are a challenge. She was referred because of her poor academic performance and her inability to make friendships. At recess she sits by herself on a bench and watches the other kids play. Her father feels medication is appropriate but her mother is against medicating her daughter for any reason. Mom is treating her daughter with lavender oil to help calm her. At parent teacher night mom told the teacher “since when does just being a kid mean something is wrong with her?” The parents are divorced and have joint custody. Dad cannot medicate without mom’s consent.

- How does a BCBA navigate this delicate situation?
- How would a medical professional approach this situation?

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Case Studies

Tim is a first grade student whose teacher reports that he is often “spacing out” in class and very angry at his peers. He has been in three fights so far in three months of school. The BCBA meets with his parents at their home and learns that he already has a diagnosis of ADHD that was not shared with the school. The family reports that medication was recommended by the neurologist but Dad is against it because of his own experiences with taking medication for ADHD as a child. He wants his child to toughen up and feels he just needs to learn to listen. The child reports being the stupidest kid in school because he forgets everything and always has to be told to sit down.

- What does a BCBA say to this father?
- How would a medical professional approach this situation?

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