Appendix B. Therapist Focus Groups

As previously described, informal therapist feedback inspired many improvements to the implementation of the study and the development and revision of clinical materials for therapists to utilize. The therapist focus groups were designed to offer therapists a dedicated and structured venue for providing additional feedback. A set of two focus group meetings was conducted on site during each interview occasion, one for therapists participating in the Integrated condition and a separate one for therapists participating in the Behavioral Only condition. One of the focus group sets took place midway through the study; five others were completed at the end of the study. A supervisor at one site was unable to attend her respective focus groups and sent written responses to the focus group questions.

All enrolled study therapists were invited to participate in the focus groups, which were voluntary; therapists were reimbursed for their participation. At each focus group, one member of the research team acted as a facilitator for the previously written discussion guide questions, and one or more additional research team members were present to support the facilitator and take notes. The focus groups were audio recorded for later transcription, coding, and analysis. Audio recording also enabled the facilitator to participate fully in the focus group discussion.

At each focus group, the facilitator asked predetermined questions from a script developed in advance (see below). The questions asked therapists to reflect on their experiences with the CASH-AA and MIP protocols and their experiences as research participants. The script also included follow-up prompts and probes for the facilitator to employ to gather more details from therapists.

A thematic analysis approach was used for analyzing the data collected during the focus groups. In this approach, two independent coders read each transcript statement-by-statement to identify ideas and themes in the participants' responses. After independent coding of all transcripts was completed, the group of coders met to develop the final list of codes and discuss the themes under which the codes belonged. The transcripts were then recoded using the finalized list of codes by a third coder, and the group met again after this process to finalize the organization of codes under themes and subthemes. In this way, the research team was able to determine the most salient ideas therapists discussed about using the two protocols, as well as their experience of being study therapists and their suggestions for improvement. The primary result of this process is a table (found below) containing the identified themes, subcategories under which each theme falls (when applicable), the codes developed during the initial stage of coding, and example statements. Some codes are included more than once to highlight the breadth of ideas included under each larger theme.

Focus Group Questions

- For those of you who have been using interventions that are part of the CASALEAP protocols, how have you been using them?
    - Which interventions most seamlessly fit into your therapy sessions? Which ones have felt more forced or disruptive to your therapeutic process?
    - To what degree do you believe these tools have become part of your treatment vocabulary (internalized vs. having to look it up)?
- How relevant do you find the CASALEAP interventions to be for your work in general?
    - Before your introduction to these protocols, what would your typical approach have been for adolescents with ADHD?
    - Which teens do you think benefit most from these kinds of interventions?
- If you have been using the interventions, what have been some of your greatest successes? Struggles?
    - Have you had cases for whom an intervention was particularly helpful?
    - Did success with that intervention encourage you to use more of the protocol with that client? Or with other clients?
- How successful would you say the interventions have been for the clients with whom you've used them?
    - How much do you think your teens and families buy into the CASALEAP interventions?
    - What do you think would improve their buy-in?
- What do you think would help you in using the CASALEAP interventions?
- If you were to teach a new therapist how to do the CASALEAP interventions, how would you do it?
    - How would you incorporate the manual(s) in this process? What about the training slides? What about audiotapes of treatment sessions?
- What was the most beneficial aspect of the monthly consultation meetings for you?

Analysis

The comments from therapists fit largely into two categories: (1) Opinions on the strengths and weaknesses of the protocol interventions in which they were trained, and (2) Statements about their general experiences as participants in the research study.

Strengths & Benefits of the Clinical Protocols

Therapists across study sites strongly agreed upon the usefulness of the psychoeducation content in the protocols. Therapists agreed that the protocols were relevant for their client populations—most therapists felt a vast majority of their clients exhibit problems with attention and/or hyperactivity. Many were excited at the prospect of new tools to help them recognize, describe, and address ADHD symptoms. They found the psychoeducation slides particularly helpful when it came to providing simplistic language for explaining ADHD to their clients and suggestions on how to reframe and relabel their clients' symptoms. They found that adolescents easily related to the celebrities also dealing with ADHD who are mentioned in the slides, helping to improve the clients' self-esteem and remove the stigma associated with their diagnosis. Therapists found the medication education components of the MIP protocol to be successful in reducing some of the hesitation and misgivings about starting ADHD medication. One therapist commented,

> "*I think it does a lot of good for the child and the family because you know naturally there is a little bit of a stigma, sometimes that is a big hurdle we have to get over as far as children not wanting to take medication, feeling it makes them different from other children. So I think the psychoeducation and just the medication education goes a long way and it's something I think that is kind of usable across the whole board."*

The psychoeducation components of both protocols seemed to be the most utilized by the study therapists.

Therapists found many of the behavioral interventions in the CASH-AA protocol to be helpful as well. Backpack organization, behavior contracts, and homework management plans were all cited as useful academic support tools. Several therapists found these interventions useful enough to incorporate into their non-study participants' treatment. As one stated:

> "*I think the organizational one is a very important thing. The individuals that I have worked with that aren't a part of the study will at times come in and it*

seems like their classwork is kind of all over the place, so coming up with a kind of clear and concise plan as far as where we put homework, where we put class assignments, things like that, I think that makes sense, I think that's something that can be used."

Though therapists may have been utilizing organizational strategies before, they appreciated the new structured tools presented by the protocols.

Therapists appreciated the flexibility of the protocols. They felt it was a strength of the interventions to be able to choose modules which fit most organically into a session rather than having to follow a regimented treatment plan. Therapists mentioned multiple times how the piecemeal implementation option differed from methods in which they had been trained previously—whereas before they often felt locked into strict session-by-session plans, these protocols allowed more freedom to employ their own clinical judgement.

Weaknesses and Barriers to Protocol Delivery

The most common complaints about the protocols included the length of the manual and the general lack of time and resulting stress experienced by most therapists on a daily basis. Whereas many commented that the manual was too long to read thoroughly, this was often followed with an appreciation for the more succinct psychoeducation slides. Even though the trainings were meant to kick-start their understanding of the interventions, it was still expected that the therapists would be able to review the manuals more thoroughly on their own time—that largely was not the case. The addition of the bulletins and one-pagers further into the study were both reported to be helpful training tools. Therapists also frequently mentioned significant time constraints, which led to feeling as if they did not have time to adequately prepare to include the protocol in their sessions. Paperwork and the number of patients each day were reported as the biggest factors contributing to lack of time.

Though many therapists found the CASH-AA or MIP protocols useful and relevant to their work, significant barriers to successful delivery arose. These barriers can be separated into therapist factors (e.g., time constraints, low confidence) and external factors (e.g., poor treatment attendance, low family involvement). The most common challenge was that other treatment concerns took precedence over ADHD—therapists felt unable to implement interventions to address attention and behavior problems if a client was experiencing trauma, anxiety, depression, problematic substance use, or other serious co-occurring issues. Therapists commented that in an ideal setting, these protocols could be used easily with a young client who presented only with ADHD and ADHD-related problems; even so, that type of

client was rare in real-world therapy settings. Even if a therapist had intentions to use protocols going into a session, more time-sensitive topics often came up that would necessitate a change in plans for the session. One therapist described it succinctly:

> *"I think here in general I would say 60-70% of our kids have a ADHD diagnosis, so it's pretty pertinent for us, but again, the one big challenge is that there's so much other stuff happening and there's crises all the time happening that we're having to constantly deal with, it kind of gets thrown underneath everything else that's happening."*

Therapists who were excited about and planned to use the ADHD protocols were often faced with other serious issues, which took priority over ADHD interventions.

However, an interesting counterpoint to this idea of other treatment concerns taking precedence emerged. Therapists who had difficulties engaging a teen with multiple comorbid diagnoses expressed how they used the protocols as an initial step to prove that therapy works. Noticing progress in his or her ADHD symptoms can be strong impetus for a client to build enough trust with the therapist and in the treatment process to open up about other serious issues. As one study therapist described it:

> *"However, it can be helpful with the engagement, sometimes anxiety or depressed mood gets in the way of some of the organizational strategies, but if they're having trouble engaging with their emotions or avoiding getting to a trauma right away, it might be helpful to show that this is one concrete thing that can change very quickly and we can work on it. Can help with initial rapport with someone who is initially avoidant or resistant to the idea of processing emotions right away."*

For those with clients who were initially hesitant to talk about some of these issues, addressing ADHD symptoms turned out to be a vital first step in proving the value of therapy.

Another external factor that hindered protocol implementation was poor treatment attendance. As is the case with many therapeutic interventions, getting clients and families to show up for appointments consistently is difficult enough; having a client consistently complete assignments and practice interventions to be ready for subsequent sessions is especially difficult. Several study participants were discharged due to poor treatment attendance. Furthermore, therapists often had difficulty involving parents in their child's treatment, a cornerstone of success for these interventions.

Therapists reported a myriad of difficulties with onboarding families: parents resistant to an ADHD diagnosis, medication-resistant families, and parents' reluctance to reward youth progress or mitigate their own expectations. All of these proved to be significant barriers to successful protocol delivery and progress for their adolescent clients.

Suggestions for Improvement

Therapists suggested multiple improvements to the current protocols. Therapists felt that several of the organizational interventions were outdated for current school needs. Many students use laptops and tablets instead of folders and planners, necessitating an update to interventions such as the backpack organizing activities. As one therapist described it,

> *"…that is good consideration for moving forward or for different iterations of this kind of thing because it's not just high school it's all grades. I'm working with kids who are not even in high school yet and it's all Chromebook this and Chromebook that. So the idea, that old-school idea of, 'Let's organize your bag and let's change and identify your notepads and all, it might not fit any more. It might have to be different sort of thing."*

Similarly, therapists felt that the protocols were most appropriate for younger adolescents. This likely had to do with the fact that younger children were more likely to have ADHD as their primary presenting problem, and therefore therapists felt they would benefit more from ADHD-related interventions. Therapists suggested the inclusion of psychoeducation materials specifically targeting the academic demands and medication concerns of older teens, including information about managing ADHD in college and the workforce.

When it came to the structure of training therapists in the protocols, they also had suggestions. They discussed a need to find a way to train therapists that enables them to feel confident in the interventions but also does not take up too much of their time. Some suggestions for improvement included: short videos demonstrating the interventions that were discussed, as well as having a 'test case'–a relatively straightforward ADHD case where you could try out the interventions in the exact order they appear in the manual to become more comfortable with them. After that, therapists could use clinical judgment to apply the pieces as intended with future clients.

Finally, therapists would have preferred more easily accessible materials to use in session and handouts to give to clients and families to take home. Once again bringing up therapists' lack of time to prepare between sessions, one clinician said,

"I think along the same vein, if there was a separate PDF that just had the handouts that would be really helpful. Sometimes I just want to see the actual thing that I'm going to use versus trying to flip through and make a copy."

Making these materials more user-friendly for therapists would help to reduce their workload and increase the likelihood that a therapist will utilize them in sessions. This should be made a priority for future iterations of the protocols.

Systems Approach to ADHD

The CASH-AA and MIP protocols stress the importance of taking a systems approach to addressing ADHD. Comments from therapists supported this framework—they remarked that their clients with involved families, schoolteachers, and guidance counselors seemed the most successful in treatment. For this reason, therapists appreciated the collaboration modules, emphasizing the therapist-school-family partnership. Therapists who were previously hesitant to involve school stakeholders in their clients' treatment appreciated the module outlining how to do this effectively. Though therapists oftentimes had difficulty getting parents and other family members involved in study client's treatment, they found the engagement and reframing techniques helpful, as well as the language for explaining to families how ADHD is a systemic, not an individual, problem. When the treatment techniques were reinforced at home and school, therapists reported better outcomes for their clients.

Comments on the Research Participation Process

Overall, therapists responded positively when asked about their thoughts on being research partners. One of the most consistent complaints during the focus group was about the amount of time that therapists had to dedicate to the study. They all cited heavy caseloads and busy schedules as barriers to attending consultation meetings and submitting data. They felt that the consultation and facilitation process, especially listening to other therapists' audio recorded sessions and offering feedback, was helpful for their professional development. Study therapists said they liked getting to hear how their colleagues implemented the interventions, that it gave them new ideas for how to implement them in their own practice, and gave them a better understanding of the interventions themselves. They reported that it was a valuable experience to convene as a group and devote supervision time to their specific ADHD cases, something they may not have done before this study. It is interesting to note that although a vast majority of therapists agreed that listening to audio-recorded sessions was the most useful feedback tool, several therapists mentioned feeling uneasy about audio-recording their own sessions.

Thematic Analysis Table

Themes	Subcategories	Code with example statements
Benefits & Strengths	For client	• **Protocol strength: Client Psychoeducation** "That piece, the psychoeducation piece, I think is the most important to really getting the parents to understand what it is and, you know, what their kids are going through and what it might feel like to be inside the brain of a kid with ADHD, that always goes really well. That's very natural." • **Protocol strength: Reframing** "This is their safe place away from all the negative stuff that's all around ADHD. I know, for me, the most natural thing is the reframing and the strengths-based with ADHD. It's all about, 'Oh, I'm lazy,' 'Oh, no, you know, you're not lazy, you're this.' You know, you're always giving them a more positive." • **Protocol strength: Flexibility** "I think, one of the strengths, this is what you were talking about, is, I like the flexibility of the program in general. So, and again maybe this was because I didn't have an assigned client, but it really was sort of a, alright, this is today, so let's talk about this, or this is what you're coming in with today. It's not, 'Oh we were doing organization last week but now you're down and you're negative and 'You know, the diagnosis has got to top this and now we've got to do some reframing and we've got to do some empowering stuff'….So I did like that, whatever walks in the door, there's something in the packets to be able to use regardless of how they're showing up that day." • **Protocol strength: Relevance for population** "I think overall the interventions are useful and successful because every different type of teen, not like this is the only thing, not just painting with a broad brush, like everyone has to use this technique for all of them. So it kind of individualized it which I think helps with the kids so they don't feel like they're just—they feel like they're an individual." • **Protocol strength: Reframing** "The normalization piece of it, with the celebrities, talks about what it is as a neurochemical balance and you just think differently…those pieces of it. Personally as a clinician, I think I should be doing more of that and having it down on paper helps."

	For therapist	• **Study participation benefits: Increased therapist knowledge** - "My approach was more general in nature and I would not have necessarily recognized some of the symptoms/feelings/behaviors as a result of ADHD. I feel my ability to address this with adolescents greatly improved as a result of being part of the study." - "I get a lot of anti-meds families, kids, and so it helps with just explaining how they are another tool to put in your toolbox to help, and that you can sort of try different things. So same thing, it was like an added tool in my toolbox for working with the clients and patients." - "I think it encouraged me, especially with the medication management, just providing information because it allowed them to kind of see it from their point of view. What the potential benefits are, rather than kind of saying, you know, your parents want you to be on medication or this is something that, me telling them, a lot of times for kids, especially adolescents, when an adult's telling them to do something they're not going to do it simply because it's an adult telling them, versus them fostering their own independence and making decisions for themselves to choose to go the medication route. I think just being able to provide the information helped shift how I may have been approaching it." • **Study participation benefits: Consultation tape review** "Yeah, because it helped--it actually showed how they were being implemented rather than just kind of reading about it. You could see different ways they're being implemented, you know, how they respond, did they respond not well—the kids, did they respond well, not well, and can help you form your own style and how you could then implement them, so hearing the recordings definitely helped how to implement the techniques." • **Study participation benefits: Consultation feedback** "Also, like, having a caseload of fifty patients in supervision once a week, I focus on the, like, priority cases, and a lot of the cases who are enrolled in the project are not high priority. They're stable, but they still have like their, a lot of things to work on. So, being able to focus on those specific [ADHD] patients in this monthly meeting, helps me really, like, reflect on how far they've come and reflect on, like, other things that I think we need to work on. So that's been really helpful."

Barriers	Therapist factors	• **Implementation problems: Therapist/Client relationship** "Sometimes even with the adolescents, it's finding that fine line between being just another authority figure like a school or a parent and then being a therapist where it's a safe place. So I was always trying to just walk that line and trying to always be that safe person but also having these tools and techniques and knowledge to share." • **Therapist participation problems: Time constraints** "The greatest challenge in using the interventions was something I struggled with a lot—having the time to prep to use them effectively with the client." • **Therapist participation problems: Low therapist confidence** "I mean there are definitely certain things that I am more comfortable with than others. Me being newer and only having one case, that like I said we haven't really been able to fully implement a lot of the things. So I think after doing it for a little while and doing similar things over and over I think it would become more routine and I would feel more confident but I think there are definitely areas where I am more comfortable and areas where I am not." • **Therapist participation problems: Lack of therapist buy-in** "For me, I actually felt like it was very opposite from how I would typically work with clients, so I never felt comfortable bringing any materials into session. That's why I kind of opted out of using them. As I said earlier, you kind of end up utilizing some of it anyway naturally in the way that you work with the clients, especially when the topic of the diagnosis comes up."
	Non-therapist factors	• **Implementation problems: Family involvement** - "A lot of the families don't realize that they play an important role, and this is what I mentioned earlier that I had had the family sign their homework so the kid could see: 'Well, my parent's going to look to see what I'm doing'. Because like you said, if you don't have the family reinforcing then everything you do is not going to really work because there is no accountability." - "I had a kid I remember specifically and he was in treatment for months and I couldn't even get a hold of the father, I kept calling, he wouldn't return calls, I know he was dropping him off, he didn't come inside even when I would tell him, leave voicemails. So stuff like that, when the family is just not willing to be involved in treatment, it's hard to get them to then buy in to CASALEAP because they're not buying into treatment in general. That's sometimes a struggle." • **Implementation problems: Other treatment priorities** - "You know a person coming in there may be a hundred and one other things you have to touch on before even getting to that, so I think that's a big issue. I mean I think a lot of times unfortunately the ADHD does take a little bit of a back seat. Again I can only speak from my experience with this one particular family but that seems to be a very consistent thing, each week they come it's kind of taking a back seat because of whatever crisis has happened that week, a lot of issues with family dynamics, things like that." - "I think it's easy to get wrapped up in all those behaviors and the failing in school and kind of, drug use and everything else they have going on when this is underlying and this, you know, is highly associated with those behaviors at the same time. I think it gives us more of a framework for sure. It's very easy to fall into that trap of the behaviors and all that. And it's kind of, doing this whole thing, kind of put it more in the forefront for us, a little bit."

	Non-therapist factors (cont.)	• **Implementation problems: Treatment attendance, Follow-through** "I think that one of the biggest struggles for me is them actually implementing it. It's one thing to go over it and talk about it and say okay, this is what your homework is, but then to actually go home and do the work... And then also just attendance, or adherence to their treatment schedule. So if you're scheduling individuals and they're just not coming it makes it difficult to—or even group and stuff. So those are the two biggest pieces for me I think. Struggles-wise." • **Implementation problems: Teen buy-in** "To me I feel there are some kids with ADHD who are cognizant of the fact that they're not doing as well as they could and want to do better. That's the kind of kid who benefits more from this rather than the 'I don't care, people have been telling me I'm a screw-up my whole childhood and adolescence and I don't care about treatment' kids. It's harder to motivate that kid even though these things are true for them too—it's just harder to get buy-in from someone who is more demoralized or oppositional."
Suggestions for Improvement	Additions	• **Suggestions for protocol improvements: Additional psychoeducational information** - "For those older kids, more on the executive functioning piece as they move into adulthood, because I think that is going to be really helpful for a 17-18 even 19 year old kid sometimes that we get here. Learning about that and—because I think kids have this focus, like ADHD is all a school-related type of thing, and I can't focus in school and I can't do this, and kind of changing that to be like well, if this continues, this is what it's going to look like into adulthood, type of thing would be helpful. And maybe some strategies that as you grow into adulthood you could utilize to help you with managing those executive functions." - "But for the older kids, my suggestion is we talk a lot about the executive functioning piece and how ADHD gets kind of harder to deal with as you get older because there's so much more on your plate with that executive functioning type of stuff, so for those older kids that he's talking about, we'd be kind of going into the executive functioning piece, if there's more stuff for those kids who are moving towards college and kind of talking about, okay this is what's going to happen for you with ADHD as you move forward in your life, would be probably pretty helpful, too." • **Suggestions for protocol improvements: User-friendly materials** "I think along the same vein, if there was a separate PDF that just had the handouts that would be really helpful. Sometimes I just want to see the actual thing that I'm going to use versus trying to flip through and make a copy." • **Suggestions for protocol improvements: Additional resources** "And I think that's a system issue that the study can look into—like if having case management, other community services that can help reinforce like the study and the problems that the kids are having."

	Edits	• **Suggestions for protocol improvements: More diversity in examples** - "On that though, just a note, I think I might have mentioned once before, but really, really need, like working with diverse—we're not even that diverse here, but it's everybody there is just, you know, John Kennedy and we need maybe people they'll relate to more. Hip hop people and certain females, transgender individuals would be great, whatever it might be. But otherwise the point still gets there so, so that part was really good." - "If I may, sometimes the disorganization actually is beneficial. And not always is disorganization not helpful. Sometimes kids like that work better when everything is all over the place because they know where it is and that's their system." • **Suggestions for protocol improvements: Technology** "So like the idea, or that, that old-school idea of, 'Let's organize your bag and let's change and identify your notepads' and all kind of, it might not fit any more. It might have to be different sort of thing. and I don't know and I'm not in the school settings so I don't know exactly what is a kid carrying around day to day, what are they taking from class to class, what do they even keep in their lockers as far as that goes. You know? So like it might be something to take into consideration as far as just the specific wording of, 'We're not going to talk about organizing your backpack any more, we're going to talk about, you know, cleaning up your computer desktop'."
Systems Approach to ADHD	Family involvement	• **Importance of family involvement** - "And then again just going back to the whole inconsistency thing—quite honestly I think there should be parent educating type things going on. I think unfortunately a lot of the time it takes a bit of a backseat again because the main focus is the child. It's their session, but think a lot of these parents need the support and the educating, kind of understanding how to implement." - "The kids that I have, the clients that I have, with the parents that are always on board with everything and try and, you know, try to implement what we talked about at home, the kids are doing amazing. I see a great deal of success and it's really fun to watch too." - "I also think that having family sessions to start out and talk about what are the specific treatment goals we're working on and what are the variables that affect it. That's how I've been using the homework management and other pieces to increase engagement. I'll be like, 'So the problem is that we're having issues getting the homework home. What do we do to treat that? So the issue is we're having difficulties getting the homework back to school. How do we manage that?' Really being specific and involving the parents in the process to show there are actually things we can do to show, 'Oh, he's willfully not bringing the homework back.' I feel like that has worked to increase engagement a little bit."

	School involvement	• **School involvement: Positive** - "However, this family I have to say they are very supportive, very involved and I feel like a lot of times when you kind of start the discussion with you know how it will improve academics and things like that, I feel the family generally will buy on pretty quickly because I feel that is a pretty big struggle. For the child in middle school, high school age, they want to make sure they are on the right track for graduation and things like that, so usually when it's around ways to improve academic performance they usually do buy on fairly quickly, I think." - "Yeah, I think a big thing is also getting the school to buy in. You know, as long as there is consistency around the board you know what we are doing here is being carried out in school as well, and then obviously when they go home too, so everything becomes almost a norm, not just okay I have to do this one day a week because I went to see my therapist. It's carried out throughout the whole entire week. So I think getting school involvement is a very integral part of it as well." - "One of the things that I also found with the patients in school that were part of the study, I would really try to get the school on the phone and it helped in two of my cases where the parents were like, 'Oh, I didn't know my child was doing that well'. Having that feedback from the school, okay here's the report card, here's the transcripts, and these were parents who really didn't call the school unless there was a problem. Having all this good news for them was helpful." - "For Module 3, there were several times when I communicated with a client's guidance counselor via telephone and provided information about their ADHD diagnosis/symptoms and advocated for specific types of support on 504 plans or IEPs. In some cases, I provided letters summarizing appointments with the doctor and treatment findings for advocacy purposes." • **School involvement: Negative** "And um, just the frustrations of working with the kids with school and what happens at school and trying to work with teachers is I think the biggest frustration and probably a great point for your next study, because we do everything we can to work with teachers and school social workers and parents on making it a little easier for kids. And you say 'Alright, give them something to fidget with,' or 'Let them doodle,' or 'Let them have something to push their legs on in the class,' and the teachers say 'Well, that's too distracting,' and 'You can't have a toy in class.' Or they get labeled the Problem Kid, or 'Why can't you just focus?' or 'Why can't you just pay attention?' And it's kind of like, 'Well, why can't you just get rid of cancer if you have cancer.' You can't, you know."