



Strategic Investment in ADHD Support: Insights from Canadian Educational and Coaching Professionals

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Abstract

Attention-deficit/hyperactivity disorder (ADHD) is a commonly diagnosed mental health disorder, yet little is known about the priorities for funding, services, and research held by educators and ADHD coaches, particularly in Canada. This study, as part of a larger project surveying individuals with ADHD and those who support them in Canada, sought to develop a list of priorities held by educators and ADHD coaches (Total N=122) for ongoing attention using the Delphi method for gaining consensus across multiple survey iterations. Results from the three waves of data collection suggest that our educator and ADHD coach participants working with children, adolescents, and emerging adults have wide ranging concerns. The most critical issues are with access to care, reduction of stigma in professional settings (e.g., healthcare and schools), adequate funding to support the availability of services, and increasing knowledge and awareness about ADHD, as well as the need for dedicated research attention for socio-emotional functioning in the context of ADHD and ADHD in girls and women. From this study, it is clear that although progress has been made in ADHD services and research, there are substantial unmet needs identified by individuals with ADHD and those who support them.

Keywords ADHD · Delphi method · Funding priorities · Research priorities · Canada · Educators · ADHD coaches

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Attention-Deficit/Hyperactivity Disorder (ADHD): Core Characteristics and Cost

Attention-deficit/hyperactivity disorder (ADHD) significantly impacts individuals, families, and society. Current prevalence data suggests that approximately 1.8 million people in Canada have been diagnosed with ADHD (Espinete et al., 2022). The symptoms of ADHD typically impact an individual's ability to pay attention, control impulses, regulate their emotional states, and function optimally in multiple environments (American Psychiatric Association, 2022). These difficulties may result in challenges in nearly all contexts, including social relationships, educational and employment settings, comorbid mental health issues, and challenges to family functioning (American Psychiatric Association, 2022). Despite the ubiquity of the disorder and the impact across multiple contexts, there has been limited focus on priority setting for ADHD funding, particularly research funding, in Canada. The goal with this study was to collect information about the priorities for research and other funding held by people who have ADHD and those who support them at home, in educational settings, and through healthcare.

Although ADHD is commonly diagnosed in school-aged children, symptoms persist across the life span in many individuals (Sibley et al., 2021). The symptoms most likely to persist into adolescence and adulthood are those related to concentration difficulties and emotion dysregulation (Albesisi & Overton, 2023). Additionally, ADHD leads to increased healthcare costs due to the ongoing need for diagnostic services, medication, therapy, and accommodations (Libutzki et al., 2019). Furthermore, ADHD is often linked to higher rates of substance abuse, incarceration, and job instability, contributing to long-term societal costs (Schein et al., 2022). According to data from the Centre for Addiction and Mental Health, Canada's largest mental health teaching hospital and one of the world's leading mental health research centers, costs associated with ADHD total approximately \$7 billion annually in Canada (Mental Illness and Addiction: Facts and Statistics | CAMH, n.d.). Thus, the economic burden of ADHD in Canada, including educational, healthcare, and productivity losses, is substantial, highlighting the need for increased awareness, early diagnosis, effective intervention programs, and implementation of reasonable workplace/educational accommodations to mitigate its negative impact. Furthermore, the Canadian government has provided limited funding for human research on ADHD. For example, in 2025 the Canadian Institutes of Health Research awarded only two large scale grants on ADHD and both were bench science projects (CIHR, 2026). The same year, the Social Sciences and Humanities Research Council, another Canadian Tri-Council funding

agency, funded one project on ADHD narratives (SSHRC, 2026). The Kids Brain Health Network, another significant Canadian funder in neurodevelopmental disorders research funded only one project on ADHD in their last round of grant competitions with four additional projects focused on the needs of individuals with neurodevelopmental disorders more broadly. Thus, larger scale ADHD projects are not receiving the substantial funding support needed to meet the needs of people with this very common diagnosis in Canada.

ADHD in Learning Environments

The classroom and other educational environments are places that many people with ADHD struggle. As previously noted, these challenges begin early in educational experiences (i.e., kindergarten or before) and potentially continue through post-secondary experiences. The combination of a group setting with multiple distractions, peers with competing needs for accommodation, and perhaps content of limited interest to an individual is challenging when ADHD is also present. Demands on the executive functioning system, such as selective attention and working memory, are central to the diagnosis of ADHD and may be particularly taxed in the learning environment (Tamm et al., 2020). For example, difficulties in attentional control may make it hard for the individual to persist in focused work and task organization, leading to further difficulties while learning (Johnson et al., 2020). Furthermore, secondary difficulties associated with ADHD such as emotion dysregulation and social skills impairments often make relationships with peers and educational professionals more challenging. Indeed, the combination of emotional dysregulation and poor self-regulation are central to ADHD and predict ongoing social maladjustment, including in education environments (Barkley, 2015a, 2015b). ADHD has been associated with increased risk for multiple poor academic outcomes, including lower academic achievement, grade retention, and absenteeism (Barbarelli et al., 2007). Furthermore, students with ADHD are 3.7 times more likely to not complete high school when compared to students without ADHD (Ersine et al., 2016). Family members of students with ADHD are also more likely to be diagnosed with ADHD (Chen et al., 2017), exacerbating difficulties in interactions between parents and educators as they manage inconsistent expectations and communication differences (DuPaul & Stoner, 2014). Increasing stress and distress among educators as they seek to manage increasing demands associated with students who have a range of needs for accommodation, shrinking resources, and post-COVID changes to society all impact the learning environment (Pressley et al., 2024). It may also be that research results have not been disseminated to teacher training programs within universities or in

the in-service programming that teachers receive while they are working with students (Rubin, 2023). Thus, educators and ADHD coaches are “front line workers” for people with ADHD and are likely to have important ideas about where funding for ADHD services and research should focus.

The Roles of Educators in Supporting People with ADHD

Regardless of who provides services, the responsibility for meeting the needs of students with ADHD at school falls on those in direct contact with the student, particularly teachers and other educational professionals. Unfortunately, educators often report they have had inadequate training or exposure to information about ADHD (Bernhardt, 2017; DuPaul & Stoner, 2014). This problem has been noted to be particularly problematic at the post-secondary level, where faculty members and other instructors may have limited understanding of ADHD (Lasky et al., 2016). In addition, teachers report high levels of stress and distress around their work with students who have ADHD (DuPaul & Stoner, 2014). Educator attitudes also make a substantial difference in the outcomes experienced by people with ADHD. For example, more positive attitudes about ADHD by educators have been linked with increased collaboration with professional peers and increased patience with their students identified with ADHD (Blotnick-Gallant et al., 2014; Mulholland et al., 2015; Sherman et al., 2008). The inverse is also true—educators with less positive attitudes about their work with children with ADHD are more likely to blame parents and avoid seeking new knowledge (Blotnick-Gallant et al., 2014; Sherman et al., 2008). Unfortunately, educators who do not understand ADHD may also be more likely to describe learners with ADHD as irritating and hold beliefs that are unlikely to be empirically supported; for example, they may assume students with ADHD need to “try harder” to behave like their neurotypical peers (Adamis et al., 2024). The combination of inconsistent systemic support for educators working with people with ADHD (Dong et al., 2020) and limited educator knowledge about ADHD in the context of a setting with multiple competing demands may create a toxic educational environment and elevated teacher distress (Miller & Brooker, 2017). Thus, the educational environment is a setting where ongoing funding support is critical.

The Role of ADHD Coaches

ADHD coaching is a relatively new development in ADHD treatment models. It is typically used as a complementary psychosocial intervention designed to support individuals with ADHD develop new skills, strategies, and behaviours across settings (Prevatt, 2016; Sleeper-Triplett, 2008). For

example, coaches may help individuals with ADHD develop new routines to ensure medication compliance, support the development of self-advocacy skills, teach organizational strategies, and provide feedback on ineffective strategies. In terms of how coaches work, many of their interactions with their clients who have ADHD may involve tutoring or one-on-one instruction models in addition to larger group presentations and workshops. When coaches first started advertising their services two decades ago, it was not clear how they were trained or what skillset they should have. In some cases, they may have been former educators and in other cases, ADHD coaches were often people who had ADHD and had been through their own coaching experience. More recently, models for the professionalization of coaches have developed and now there are organizations such as the Professional Association of ADHD. Although ADHD coaching is not generally endorsed as an empirically supported treatment and there are concerns that coaching may be ineffective or even harmful, it remains a highly sought after resource among people with ADHD (Jaeschke & Sułkowska, 2025; Sibley et al., 2026).

ADHD in the Canadian Context

The Canadian context for ADHD-related spending involves federal, provincial, nongovernmental, non-profit, and commercial funding. It is unique in comparison to other countries as it combines single payer healthcare that provides physician services but not pharmaceutical support, highly limited publicly funded mental health care services, and a population that includes highly urbanized cities, smaller cities and suburban areas, and very rural/remotes areas without easy access to care. Systematic reviews of the literature suggest there are substantial unmet needs related to ADHD in Canada, including poor access to care, poor ADHD health literacy, and limited opportunities for consumer needs, to be considered in research (Bisset et al., 2023). Often, spending, particularly research spending, is not designed to directly address the interests of individuals with ADHD and those who support them. Those with focused interests in ADHD, including people with ADHD, educators and ADHD coaches, parents and caregivers, healthcare providers, and community members, may also have ongoing concerns that have been inadequately addressed in older research or have questions that are challenging to answer.

Priorities for ADHD Research Funding: What is Known

Although there are existing international sources to consult, there are a limited number addressing priorities for ADHD and very few answer the specific question of priorities held

by individuals with ADHD and those who support them in Canada. For example, in an American position paper, a group of scientists developed a list of eight key research needs for ADHD (Gaynes et al., 2014). This list of needs included determining the most effective diagnostic and outcome assessment tools and multiple concerns about children under the age of six years. The list also included how to identify people with ADHD in epidemiological samples and administrative databases and a concern for what predicts a positive treatment response. In another study, data from a sample of 14 Swedish participants focused on treatment priorities in ADHD-related research (Jacobson et al., 2016). Their responses highlighted concerns about the risk of stimulant treatment for future substance problems, the effects of teacher support, the results of multimodal treatment, the consequences of computer-aided working memory training, and the impact of psychoeducation. Unfortunately, there are limited examples of empirically sound investigations of priorities for ADHD funding in Canada from individuals with ADHD and those who support them. Notably, the concerns of educators in the cited papers are either absent or received very minimal attention.

Notably, a Canadian study used focus groups to gather data from parents, educators, and healthcare providers about the experiences of children with ADHD from diagnosis through treatment (Corkum et al., 2024). Of the 136 participants in that study, 76 were self-identified educators. Educator participants indicated that there are substantial socio-economic barriers to the diagnosis and treatment of ADHD. They also noted significant concerns about treatment adherence in educational settings, especially as those issues interact with stigma. The educators in this study were also concerned that it is difficult for females to receive a diagnosis of ADHD and treatment adherence in adolescents with ADHD is often poor.

Another recent paper used the Delphi approach to query research priorities among international participants who work in professional ADHD organizations (Stephens et al., 2024).

In the final wave of data collection, this study included 73 participants. Among the participants, there were no self-identified educators, few ADHD coaches, and only a small subsample of Canadians ($n=20$). Results from this study suggested there is substantial need for more research attention on enhancing assessment strategies for adults and individuals of high intelligence/coping, long-term outcomes and side effects associated with ADHD medications,

intervention development for a range of specific concerns about ADHD comorbidities, and ADHD in women and girls.

Priorities for ADHD Research Funding in Canada: Perspectives of Educators and ADHD

Coaches (Study Aim)

In line with concerns raised in other studies of individuals with ADHD and those who support them, outcomes from a panel discussion at the 2021 Canadian ADHD Resource Alliance Research Day suggested that ADHD continues to be misunderstood, accessing mental healthcare in schools is challenging, definitions of impairment vary, and there is an ongoing need for nonpharmacological ADHD treatment (Bedard et al., 2021). From that discussion, we looked to the empirical literature for work that has highlighted specific spending priorities in Canada and other countries and found very limited information.

In order to address the lack of documentation about these priorities, we set out to gather information from individuals with ADHD and those who support them in Canada, including people with lived experience, healthcare professionals, parents, educators, and researchers in a large-scale, federally funded project (Social Sciences and Humanities Research Council of Canada Partnership Engagement Grant #892–2022-1023, entitled “*Identifying stakeholder priorities to guide the advancement of ADHD research and services across Canada using a Delphi approach*”). As described below, we used a Delphi approach across multiple iterations to gather these data. The present study describes the priorities of self-identified educators and ADHD coaches in that project.

Methods

Participants

The participants for this study were part of a national information-gathering effort to identify research priorities and services for people with ADHD and those around them. As explained in greater detail below, participants could endorse multiple roles (i.e., person with lived experience, educator/coach, healthcare professional, researcher) and rate priorities within each role if they wished. For this paper, 122 participants who initially endorsed a role as an educator ($n=86$) and/or an ADHD coach ($n=36$) were included in

the analyses (results for other partner groups to be published elsewhere). Coaches and teachers were combined into a larger group of educators because all are typically involved in skill development, instruction, and the provision of feedback. Notably, 114 of the participants for this paper also endorsed being a person with lived experience with ADHD (i.e., they were diagnosed with ADHD or someone close to them has been diagnosed with ADHD such as their child). The number of participants rating priorities items ranged from 86–97 individuals. Sample size for individual items is reported in the summary tables.

The Delphi Method

The present study was part of a larger research project that used the Delphi method to integrate perspectives of individuals with ADHD and those who support them on topics and themes that should be prioritized in ADHD research and services in Canada. The Delphi method is a repetitive and structured communication technique that first aims to gather a broad range of opinions and views from expert individuals, which are summarized to provide the basis for further discussion and controlled feedback in subsequent surveys (Stonefish & Busby, 2005). The goal of the Delphi method is to gather consensus. For the broader project, we gathered information from a group of expert individuals by experience (i.e., those living with, or supporting someone with ADHD), as well as partners by training (i.e., ADHD researchers, clinicians, and educators/ADHD coaches—the focus of this paper). A detailed description of the methodology for the broader project can be found here: <https://osf.io/gu4w8/>.

In this study, we used a three-round modified Delphi method (Khodyakov et al., 2020) to collect the opinions of Canadian experts on ADHD via online surveys. An initial list of 21 priority areas was generated through iterative discussion among a convenience sample of 73 individuals with ADHD and those who support them in Canada at a national meeting (Bedard et al., 2021; Hsu & Sandford, 2007). In the three subsequent Delphi rounds, additional participants were surveyed about their opinions on these 21 items and asked to generate new items. These surveys took place one after the other over a period of 15 months with several e-mail reminders sent out to encourage participation during each round of data collection. Surveys for each round were developed and disseminated using Qualtrics (Provo, UT). Data were collected via an anonymous survey link sent by

e-mail to facilitate honest and unbiased responses. Participants were given the option to take the surveys in English or in French and were offered the chance to win one of 10 \$50 gift cards during each of the three rounds of data collection.

During the first round in December 2022, a survey invitation was sent out through the membership email lists of the Centre for ADHD Awareness, Canada (CADDAC: <https://caddac.ca/>; $n \sim 25,000$) and the Canadian ADHD Resource Alliance (CADDRA: <https://www.caddra.ca/>; $n \sim 750$), as well as through personal connections and research networks of the study team. Given that we were looking at Canadian priorities, only Canadians or those living in Canada were targeted for this project. This first round survey consisted of demographic questions, the initial 21 items, as well as a free text response box for any additional ideas or information. Participants were asked to rate each of the 21 items on a 5-point Likert scale (i.e., 1=Not a priority, 2=Low priority, 3=Undecided, 4=High priority, 5=Critical priority). Data collection for round 1 lasted for just under three months. The free-text responses, submitted by participants in round 1 were thematically organized and examined by two raters and a research assistant to determine the creation of new items for subsequent rounds. This process resulted in a list of 62 new items that were suggested in free text responses. This list of items was further reduced to a final list of 34 new items when suggestions were similar. Only those new items that had been suggested by at least 10 participants in round 1 were retained. In total, 34 new items were created, excluding suggestions that were not unique or that overlapped with the 21 original items.

The survey for round 2 was sent out in September 2023 to those who completed the round 1 survey and agreed to be contacted for subsequent waves. These surveys were targeted to the roles people identified in round 1. For example, participants who self-identified as ‘educators’ or ‘ADHD coaches’ in round 1 were asked to reconsider their ratings on the 21 initial items in light of the average ratings of all participants who also identified as ‘educators’ or ‘ADHD coaches’ (presented graphically), and to garner their opinions on 34 new priority areas generated from round 1 suggestions shared in the free-text response boxes. Again, participants were asked to rank each item on the same 5-point Likert scale used in round 1. Round 2 data collection took place for two months.

Finally, the survey for round 3 was sent out in July 2024 to those who had completed either/both round 1 and 2 surveys and agreed to be contacted for subsequent waves. This

Table 1 Summary of participant demographics

	%
Sex	
Female	81.8
Male	16.5
Other	1.7
Ethnicity	
White	74.2
Black/African	2.2
Middle Eastern	2.2
South Asian	1.1
Asian	2.2
Filipino/Pacific Islander	1.1
Indigenous Canadian	1.1
Mixed	14.6
Other	1.1
Education completed	
Some post-secondary	2.2
Trade/technical training	2.2
Professional certificate/diploma	15.5
Bachelor's	24.2
Master's	40.7
Doctorate	14.3
Household income	
<\$25,000	4.5
\$25,000–50,000	5.6
\$50,001–75,000	11.2
\$75,000–100,000	13.5
\$100,000–150,000	25.8
\$150,000–200,000	16.9
\$200,000+	22.5

survey was again targeted to participants' self-identified roles (i.e., those who self-identified as an educator or ADHD coach received the round 3 Educator survey). In this wave, participants were only asked to reconsider their ratings on the 34 priority items from the round 2 survey considering the average ratings of all participants who shared their role (summarized graphically); no new items were added to the round 3 survey. Again, participants were asked to rank each item on the same 5-point Likert scale used in the earlier rounds. Participants' responses on all 55 priority items were considered final at this point. Additional demographic questions were also included in the round 3 questionnaire to gather information such as racial and ethnic background, reported family income, years of professional training in education, current role in education settings, and employment status. Round 3 of data collection remained open for six weeks.

Identification of 'Educators. During round 1, participants were asked 'What is your primary role with regard to ADHD?' This question was a forced-choice response (i.e., only one response allowed), with a free-text box where participants could specify an 'other' role not listed among the choices provided. In this box, many participants expressed frustration that they could not self-identify with many roles (e.g., educator and individual with lived experience with ADHD). Therefore, in subsequent surveys, participants were provided the opportunity to endorse any role(s) they felt was(were) applicable to them. In data analyses, those who had selected 'I am an educator working with individuals with ADHD' or 'I am a student/trainee with plans to continue as an educator' at any point during data collection were grouped together as 'Educators', whether they indicated this role as their only role or not. In addition, those who identified themselves as ADHD coaches in the 'Other' roles free-text box in round 1 were also considered part of the 'Educators' group as these individuals typically have a role in teaching, instruction, or training of coping/educational/workplace strategies for success for people with ADHD. Table 1.

Statistical Analyses

All analyses were completed using SPSS 30. Missing data were not imputed in line with standard Delphi methodology (Grime & Wright, 2016). Descriptive statistics were calculated for participants' sociodemographic characteristics. Consensus statistics reported below were calculated by dividing the number of participants who rated an individual item either a 4 (high priority) or a 5 (critical priority) by the total number of participants who responded to that item. As detailed in Table 2 below, the results include both percent agreement, and the mean rating and standard deviation for each high-priority item, in addition to 95% confidence intervals, minimum/maximum values, and the number of participants responding to each item. The mean score was intended to indicate the level of the priority while the standard deviation indicated the amount of diffusion among the participants with that opinion. From the list of high/critical priority items, the 10 highest priority items (based on mean ratings and standard deviations) were identified and are listed in Table 3. Specifically, when mean ratings were identical, the item with a lower standard deviation (i.e., score dispersion) was rated higher priority than the item with a higher standard deviation.

Table 2 Summary of results from Delphi method data collection (* items were Top 10 priorities)

Priority items	N	% Agreement	Mean rating (SD)	95% CI	Min–Max
Access to services					
Access to healthcare providers who understand ADHD*	97	100	4.74 (0.44)	4.61–4.79	4–5
Access to ADHD-related services (i.e., coaching, etc.)*	97	100	4.70 (0.46)	4.57–4.83	4–5
Access to funded services for ADHD*	90	100	4.70 (0.66)	4.60–4.79	4–5
Access to support for families	97	92.8	4.28 (0.66)	4.10–4.47	2–5
Making services available in rural and smaller communities	90	92.3	4.47 (0.74)	4.30–4.61	2–5
Identifying barriers to timely assessment and treatment	90	92.2	4.49 (0.68)	4.35–4.64	2–5
Access to holistic treatments/multidisciplinary teams	86	84.9	4.16 (0.84)	3.98–4.33	1–5
Awareness/knowledge					
Increasing knowledge about ADHD among educators*	97	97.9	4.72 (0.69)	4.53–4.91	1–5
Educate schools about best practices for people with ADHD*	90	97.8	4.76 (0.48)	4.66–4.87	3–5
Increase knowledge about stigma in ADHD in health-care/mental health care*	90	96.6	4.76 (0.54)	4.65–4.88	2–5
Increase awareness about ADHD in women and girls*	89	94.4	4.55 (0.63)	4.41–4.70	2–5
Increase awareness of ADHD as a condition warranting recognition by government and education systems*	86	94.2	4.69 (0.65)	4.55–4.82	2–5
Increase knowledge about ADHD among parents	97	94.0	4.47 (0.61)	4.29–4.66	3–5
Increase knowledge about effective treatment for ADHD in people with ADHD and their families	96	90.7	4.19 (0.85)	4.01–4.37	1–5
Increase awareness about ADHD among employers/workplaces	97	89.7	4.24 (0.69)	3.96–4.38	2–5
Increase knowledge about ADHD in people who may interact with youth (i.e., police, dentists, etc.)	90	87.7	4.28 (0.77)	4.11–4.43	2–5
Increase awareness about the different ways ADHD may present	89	86.5	4.12 (0.85)	3.94–4.30	2–5
Increase awareness about ADHD in the general public	97	84.5	3.96 (0.77)	3.72–4.20	2–5
Increase knowledge about ADHD in marginalized and underserved groups	89	84.2	4.22 (0.82)	4.05–4.40	2–5
Increase knowledge about the implications for untreated vs. treated ADHD	89	80.9	4.06 (0.90)	3.87–4.25	2–5
Increase knowledge/awareness of the impact of intergenerational ADHD	88	79.5	3.98 (0.85)	3.80–4.16	2–5
Redefining ADHD in a more positive/normative way as a facet of neurodiversity to destigmatize and de-medicalize it	89	62.9	3.80 (1.25)	3.53–4.06	1–5
Supports/tools					
Making information about health-care system easier to access	89	98.9	4.54 (0.53)	4.43–4.65	3–5
Providing tools/information/strategies for self-advocacy	89	95.6	4.39 (0.65)	4.26–4.53	2–5
Optimizing diagnostic tools/processes to improve accuracy	90	90.0	4.40 (0.72)	4.25–4.56	2–5
Increasing social support networks for ADHD	90	88.9	4.17 (0.68)	4.03–4.31	2–5
Increase availability of supports within schools (e.g., report cards specifically for children with ADHD)	90	86.6	4.30 (0.86)	4.12–4.48	2–5
Increase workplace opportunities/accommodations for ADHD	90	81.2	4.10 (0.88)	3.92–4.29	1–5
Providing housing programs for people with ADHD	95	27.3	3.00 (1.02)	2.72–3.28	1–5
Research questions/ approaches					
Socio-emotional functioning in ADHD*	88	97.8	4.61 (0.58)	4.49–4.73	2–5
How to manage comorbidities in the diagnosis of ADHD	97	95.9	4.47 (0.75)	4.27–4.68	1–5
ADHD and co-occurring health conditions (e.g., obesity)	88	95.4	4.45 (0.62)	4.32–4.58	2–5
Diagnosing women and girls with ADHD*	97	94.8	4.55 (0.57)	4.37–4.71	3–5
Increase involvement of people with lived experience in ADHD research	86	91.9	4.51 (0.68)	4.36–4.65	2–5
Long-term consequences of untreated ADHD	95	91.6	4.32 (0.76)	4.11–4.53	2–5
Ensuring adequate funding for ADHD research	95	89.5	4.28 (0.88)	4.04–4.53	2–5
Creating tools to measure social relationships and emotion regulation	89	88.8	4.36 (0.85)	4.12–4.59	1–5
What “impairment” means in ADHD	88	88.5	4.28 (0.77)	4.07–4.50	1–5
How to treat addiction in the context of ADHD	86	88.4	4.31 (0.79)	4.15–4.48	2–5
Prevalence of ADHD with other mental health challenges	89	86.6	4.18 (0.76)	4.02–4.34	2–5
Develop and evaluate person-centered approaches to treatment	86	86.0	4.37 (0.73)	4.22–4.52	3–5
Impact of hormones on ADHD and medication treatments	89	84.3	4.30 (0.85)	4.13–4.48	2–5
What should be part of ADHD assessments	97	84.2	3.96 (0.90)	3.71–4.21	1–5

Impact of ADHD on families	89	82.7	4.06 (0.79)	3.84– 4.28	2– 5
Stigma in ADHD	86	81.3	4.04 (0.95)	3.83– 4.23	2– 5
Diagnosing ADHD in mid-life	89	79.7	4.06 (0.83)	3.88– 4.28	2– 5
Impact of ADHD medication treatment on hormonal fluctuations	89	76.4	4.09 (0.88)	3.91– 4.27	2– 5
Causes of ADHD	86	73.3	3.86 (1.03)	3.64– 4.07	1– 5
New non-drug treatments	89	71.4	3.83 (1.09)	3.49– 4.17	1– 5
How well treatment works and how safe it is for older adults (50+)	89	72.2	3.89 (0.84)	3.66– 4.11	2– 5
Optimizing existing non-drug treatments	86	72.0	3.83 (1.01)	3.62– 4.05	1– 5
Understand the unique strengths of those with ADHD	86	70.9	3.80 (1.04)	3.58– 4.02	1– 5
Benefits of treatments relative to their costs (costs-benefits analysis)	95	69.5	3.71 (1.13)	3.40– 4.03	1– 5
How to improve treatment compliance	97	64.2	3.62 (1.02)	3.34– 3.9	1– 5
Diagnosing ADHD in older adults (50+)	97	63.7	3.68 (0.83)	3.45– 3.91	2– 5

The decision to use % agreement was based on a systematic review showing that this is the most widely used measure of consensus in Delphi studies. Further, there was intuitive appeal for % agreement being easier to interpret, making these results potentially more impactful for policy advocacy. e therefore thought using % agreement would be most intuitive to readers, and potentially more impactful for policy advocacy (e.g., it is easier to understand "93% of teachers agreed on X", vs. "X items fell within the top quartile"). 'Consensus' was defined as at least 90% of participants agreeing that a given item was a 'critical' or 'high' priority. In some Delphi studies a less conservative 75% consensus rate is used. Because there was a very high rate of agreement across items in our study, we set a more rigorous consensus rate was used. This decision is supported by a paper providing a systematic review of Delphi methodology which demonstrated that consensus criteria across studies ranged from 50 to 97% (Diamond et al., 2014).

Acknowledging small cell sizes, exploratory post hoc analyses were conducted to investigate the differences between educators and ADHD coaches across the items.

Results

The first analyses were conducted to more fully describe participants in the educators and ADHD coaches group overall. Although 125 participants indicated they identified as educators or ADHD coaches in the initial sections of the

Table 3 Top 10 ADHD Priorities for Educators and ADHD Coach Participants

1. Educate schools about best practices for people with ADHD
2. Increase knowledge about stigma in ADHD in healthcare and mental healthcare
3. Access to healthcare providers who understand ADHD
4. Increase knowledge about ADHD among educators
5. Access to ADHD-related services (i.e., coaching, etc.)
6. Access to funded services for ADHD
7. Increase awareness of ADHD as a condition warranting recognition by government and education systems
8. Research on socio-emotional functioning and ADHD
9. Research about diagnosing ADHD in women and girls
10. Increase awareness about ADHD in women and girls

survey, three participants in that group denied having any role in education or in providing any kind of instruction in their qualitative responses. These three participants were eliminated from the analyses. Some participants provided only demographic information but did not provide priority ratings. The final sample size for the priority ratings ranged from 86 to 97 participants. These two subgroups were combined as many of the activities in coaching overlap heavily with educational/teaching activities. The groups could not be separated in the planned analyses due to a limited sample size.

Most participants were between the ages of 26 and 59 years (83%; mean age 47.8 years; range: 26–88 years) and identified as women (82%). Although most participants' self-identified race/ethnicity was White/Caucasian (74%), a range of ethnicities was endorsed and 15% of the sample consisted of people of mixed ancestry. As expected in a sample of educators and ADHD coaches, most completed at least one degree in a higher education setting (78%) with the rest completing either technical training or a professional certificate. Reported family annual income ranged from less than \$25,000 to more than \$200,000 with 66% endorsing family income of greater than \$100,000. Participants had a range of employment statuses with 51% employed full-time, 12% employed part-time, and 23% self-employed. Of those reporting their residential area, 39% lived in a large metropolitan area, 12% lived in a medium sized city, 23% lived in a small city, and the remainder lived in towns, villages, or rural areas. The demographics for the sample as summarized in Table 1.

In terms of educational settings, participants reported working with a range of learners, including preschoolers (1%), elementary school students (25%), secondary students (11%), postsecondary students (25%), and either multiple ages of students or as a consultant/specialist teacher (38%). Participants endorsed a range of current roles as educators, including classroom teacher (24%), special educator (9%), consultant/specialist teacher (14%), allied

professionals (16%; e.g., school psychologist), administrators (4%), and “other” (33%; i.e., coaches). Their teaching and coaching locations included dense urban or urban settings (56%), suburban settings (14%), rural settings (16%), or “other” (14%; i.e., online or in multiple types of settings). Participants were generally highly experienced, with 37% endorsing 20 or more years’ experience, 25% endorsing 10–19 years, 20% endorsing 5–9 years, and 18% in their first four years as an educator.

Educators and ADHD coaches endorsed items as critical or high priority (i.e., these terms were linked to ratings of 5 or 4 on a 1–5 scale) in multiple areas, which included issues related to access/services, raising awareness and knowledge promotion, increasing supports and tools, and specific research questions to be addressed. Consensus items fell into four broad categories: *Access to services*, *need for increased awareness of and knowledge about ADHD*, *need for supports and tools*, and *specific research questions*. Across all priority items, the most highly rated items were in the broad category of *access to services*. Specifically, all participants (i.e., 100% of participants) agreed that access to healthcare providers who understand ADHD, access to ADHD-related services, and access to funded ADHD services are critically or highly important. Additionally, 90% or more of participants indicated that there is need for access to supports for families, making ADHD services available in smaller/rural communities, and identifying barriers to timely ADHD care.

Another priority area identified by participants was the need for efforts to *increase awareness of and knowledge about ADHD*. As one might expect with educators and ADHD coaches, school personnel learning more about ADHD and what constitutes best practices for ADHD in school contexts were the priority items with highest consensus in this category (~98%). Additionally, the participants noted a need to raise awareness and knowledge in the context of families, such as an increase in information about ADHD available to parents (94.0% agreement) and information about how to most effectively treat ADHD (90.7%). Participants also agreed on the importance of addressing the stigma experienced by people with ADHD in healthcare settings (96.6%) and that ADHD is a condition warranting recognition by the government and in education systems (94.2%). Notably, increasing awareness about ADHD in women and girls was also highlighted as particularly important (94.4%).

The third area in which participants’ views converged to consensus was the *need for supports and tools* that are not specifically about access to services but are highly related. For example, nearly all participants (98.9%) would like information about ADHD to be easier to access in the

Canadian healthcare system. Additionally, the participants placed emphasis on the need for learning more about self-advocacy (95.6%) and optimizing tools to improve the accuracy of ADHD diagnosis (90.0%).

Among items focused on *specific research questions*, the items with highest consensus included a need for research on socio-emotional functioning in ADHD (97.8%), managing comorbidities in the diagnosis of ADHD (95.9%), ADHD and co-occurring health conditions (e.g., obesity; 95.4%), diagnosing ADHD in women and girls (94.8%), long-term consequences of untreated ADHD (91.6%) and increasing involvement of people with lived experience with ADHD in research activities (91.9%).

Post-hoc exploratory analyses were conducted to examine differential trends in the priority ratings provided by educators and coaches. Independent samples T tests on each groups’ (i.e., ADHD coaches versus educators) mean ratings were calculated. Results indicated that research on the diagnosis of ADHD in women and girls was the *only* item where ADHD coaches indicated significantly higher priority ratings ($M=4.83$, $SD=.63$) than educators ($M=4.43$, $SD=.39$; $t=3.21$, $p<.001$, $d=.71$).

Although the educator group (coaches and educators combined) prioritized many items, there were several items of note that were of very low priority (i.e., fewer than 70% of participants said an item was of ‘high’ or ‘critical’ priority, and the average rating was less than 4.00). For example, this group did not prioritize efforts to normalize ADHD, provide housing for people with ADHD, research on diagnosing or treating ADHD in older adults, costs-benefits analyses of ADHD treatment, and research on treatment compliance.

From the ratings, a list of the 10 highest priority items endorsed by educators and ADHD coaches was constructed and is summarized in Table 3. Most of these top 10 items focus on either increasing knowledge or reducing stigma in healthcare settings, schools, and within government entities. There are two items that center on accessing services: funded services for.

ADHD and access to ADHD-related services, such as coaching or tutoring. Lastly, there are three items anchored on increasing research emphasis, specifically with socio-emotional functioning in ADHD, ADHD as it presents in women and girls, and increasing awareness about ADHD in women and girls.

Discussion

This study describes ADHD priorities as rated by Canadian educators and ADHD coaches. Data were collected online across three iterations of a Delphi study as part of a larger

sample of priorities of individuals with ADHD and those who support them in Canada across multiple roles, including many with lived experience. Among educators and ADHD coaches, priorities emerged in four areas: access and services, awareness and knowledge, supports and tools, and research questions.

Educators and ADHD coaches indicated many significant areas of priority. Of the 55 issues initially generated, at least 90% of educators and ADHD coaches in our sample agreed that 22 of these items were of the highest priority of need. This highest priority list spans multiple areas and likely reflects the breadth of functional impairments and difficulties experienced by people with ADHD in learning environments. Because comparable studies have not focused exclusively on educators and ADHD coaches, it is difficult to know if the high number of concerns reflects something specific to a Canadian sample or if this might be similar in other demographically similar locations (e.g., Western countries). Although there is no definitive answer whether this number of priorities should be seen as disproportionately large, it should be noted that our participants had concerns across multiple areas, which were not necessarily issues pertinent in educational settings only.

Results within the Educational Context

In a sample of people working in educational roles, including ADHD coaches, it is not surprising that our participants prioritized items directly related to their professional roles. Yet these findings likely also reflect the substantial difficulties that learners with ADHD experience. Teachers who do not understand ADHD, administrators who do not have adequate resources to support teachers while they work with students who have special needs, and higher education curricula that may not offer adequate learning opportunities about ADHD all impact the classroom experiences of people with ADHD (DuPaul & Stoner, 2014). Because children, adolescents, and some young adults with ADHD spend a sizable part of their waking hours in learning environments which may include traditional schools as well as coaching sessions, tutoring, and alternative learning settings, people working in these capacities who are not well prepared or under-resourced may have significant deleterious effects on these students' learning outcomes. As front-line educational professionals, our participants are well placed to understand the value of government funding to support teacher preparation, ongoing professional development, adequate professional staffing, and access to resources.

Access to Services

Concerns about access to services received substantial emphasis in our sampling with all participants endorsing either critical or high priority for access to healthcare providers that understand ADHD and access to ADHD-related services, as well as access to funded services. This may be the result of several factors, such as provincial healthcare systems that do not provide funded mental healthcare services, services that are difficult to access, limited availability of appropriate services or providers in smaller cities and rural areas, and long wait times for services taking months or even years. This focus on access is particularly pressing because without a diagnosis, treatments and accommodations cannot be implemented in most cases. Further, individuals with ADHD are also not eligible for specialized school services until they have a diagnosis. In some cases, those diagnoses happen only after expensive and time intensive full psychological assessments which are paid for out-of-pocket. This delay comes at a real cost that is not isolated within the individual with ADHD—numerous studies have shown that untreated and undertreated ADHD has lasting and significant consequences for individuals, those around them, communities, and Canada overall (Barkley, 2008, 2020; Centre for Addiction and Mental Health, n.d.; da Silva et al., 2023).

Increasing Awareness of and Knowledge About ADHD

Highly related to access to services is the concern that individuals with ADHD and those around them experience stigmatizing interactions as they seek healthcare and mental healthcare. ADHD is a highly stigmatized disorder as many individuals with symptoms of overactivity, impulsivity, and poor attention are ostracized by peers and may be poorly integrated into society (DuPaul & Stoner, 2014; Weir, 2024). This scenario is more problematic when the person with ADHD or their family members feel judged by the providers they have vulnerably sought out for care. Reducing barriers to care, including stigma, is a critical element to people with ADHD continuing to seek care as they optimize their educational, social, and employment outcomes. The experience of stigma in healthcare settings may also reflect the high rate of misinformation about ADHD, particularly in older adolescents and adults, assumed to be true by healthcare providers. If there is misinformation, people with ADHD are less likely to receive care that is empirically supported, compassionate, and accessible.

Experiences of Women and Girls with ADHD

Our participants' responses reflected the increasing focus on the experiences of women and girls with ADHD. Until recently, there was little consideration of what information was missing in the research literature about females with ADHD. Because ADHD was traditionally thought to be a disorder primarily impacting boys, few resources were devoted to challenging that assumption. Indeed, across all the large-scale longitudinal datasets focused on individuals with ADHD, only one has focused on females (Hinshaw et al., 2022). In our sample, the results indicate the need for increased awareness about ADHD in women and girls and diagnosing ADHD in women and girls were among the top 10 most important priorities. This is important because females with ADHD often present with a preponderance of attention difficulties and are less likely to be described as hyperactive or behaviourally impulsive (Attoe & Climie, 2023; Hinshaw et al., 2022), which may reduce the likelihood of a girl or woman being diagnosed or receiving interventions/accommodations. Furthermore, while not in the top 10 priorities, more than 80% of our participants rated research on the impact of hormones on ADHD and medication treatments as a significant priority. There is a small but growing research literature on these issues (Camara et al., 2022; da Silva et al., 2023; de Jong et al., 2023), but limited work has been done in Canada thus far. Research on ADHD in women and girls suggests that there is a consistent pattern of underdiagnosis (Young et al., 2020), increased stigma (Fairbank, 2023), and insufficient treatment programming (Quinn, 2005).

Specific Research Questions

Among the items asking about specific research questions and approaches, there were multiple that would benefit from more attention. Making a diagnosis of ADHD using “gold standard” practices is not necessarily difficult, but the presentation of comorbidities and difficulties in multiple life domains, such as socioemotional functioning and co-occurring health conditions makes the process more challenging, especially for family doctors and general practitioners who are the backbone of provincially-funded healthcare in Canada. Furthermore, because there are limited accessible tools to assess domains like emotion regulation in the primary care setting, these issues may be ignored, misunderstood, or even stigmatized. This lack of assessment tools also creates conditions that are ripe for the undertreatment of ADHD, another significant research concern highlighted by many of our participants. Our participants also

emphasized the importance of including people with lived experiences with ADHD in the research questions that are developed. Research advisory boards, partner focus groups, and projects like the current study all create opportunities to hear the perspectives on what research priorities are important to individuals with ADHD and those who support them. Clearly, there is substantial work to yet be done in ADHD research and there are numerous topics that might be included in lists of future research directions.

Items Less Highly Rated

Some of those items that were not rated as highly may also merit discussion. If one reads what is posted on social media, there are communities of self-described neurodiverse people, many of whom say they have ADHD, who want to change how ADHD is seen. Perhaps in line with the emphasis on stigma reduction seen in the Top 10 priorities, these communities seek to influence the conversation about ADHD. In some cases, the efforts are focused on “demedicalizing” ADHD and recasting it as a facet of neurodiversity. Among educators and coaches, only 63% agreed that this is a high or critical priority issue with a high degree of score dispersion. This lower level of emphasis is consistent with the 71% of participants who endorsed the importance of understanding the unique strengths of people with ADHD. As has been noted by Barkley and others (e.g., Barkley, 2022; Franke, 2023), these perspectives may be counterproductive to advocacy efforts for enhanced services, increased spending, and greater access to care for people with ADHD. Furthermore, our data demonstrate what a controversial area this is: these items were at the low end of consensus with relatively high mean ratings and large standard deviations, all showing the level of disagreement about the issue of normalization/de-medicalization even among ADHD partners working in education.

Limitations

The Delphi method, while valuable for gathering consensus on priorities among individuals with ADHD and those who support them, has several limitations. One key issue is the potential for bias due to the subjective nature of public opinion. These opinions may not fully reflect the diversity of perspectives within the broader clinical or research community. The iterative nature of the Delphi method may also lead to conformity or “groupthink”, where participants adjust their views toward the majority rather than maintaining independent judgments. It should also be noted that the choice of top 10 items (versus 12 or 15) was also arbitrary. In

some cases, notably the items with the 11th and 12th highest priority were only minimally lower in the rankings than the 10th item. Thus, those using these data for decision making may wish to consider more than the top 10 priorities. Lastly, as Delphi studies typically rely on questionnaires and structured feedback rather than empirical data, they cannot substitute for direct clinical research in establishing causal relationships or treatment efficacy. Yet, without projects like this one, researchers, policy makers, and government officials making funding, research, and policy decisions may not be able to address the most pertinent needs of individuals with ADHD and those who support them.

Summary

This study underscores the ongoing need for progress in supporting individuals with ADHD and those who work closely with them, such as educators and ADHD coaches. Despite ADHD being recognized in medical literature as far back as the 1700s (Barkley, 2015b)—and the substantial research and policy developments that have followed—critical gaps remain. The findings from this project highlight specific areas for future action as perceived by educators and coaches, offering clear direction for researchers, legislators, and clinicians committed to advancing care, understanding, and outcomes for those affected by ADHD.

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Declarations

Conflict of interest None of the authors have conflicts of interest to report.

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