Academic Paper

ADHD Coaching and Interprofessional Communication: A Focus Group Study

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Abstract

Multimodal care, including Attention deficit/hyperactivity disorder (ADHD) coaching, is considered optimal in ADHD treatment. Still, little research has explored the topic of interprofessional communication and collaboration for this population. Following COREQ guidelines, this report of focus group research identifies attitudes and experiences of ADHD coaches regarding communication and collaboration with other professionals in support of their clients. Key themes in the data suggest a perception that collaboration is important but that there are barriers to overcome. Interprofessional learning opportunities, training in collaborative approaches, and research on varied professionals' perspectives related to collaboration might all enhance optimal support for individuals with ADHD.

Introduction

Attention deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition, characterized by symptoms related to inattention, hyperactivity, and/or impulsivity (American Psychiatric Association, 2013), and increasingly understood to impact the executive functions (EF) (Brown, 2013). Between 5% and 10% of young people are diagnosed with ADHD worldwide (Antshel, 2015), and as many as 80% of these individuals continue to experience symptoms into adulthood (Barbaresi et al., 2013; Fredriksen et al., 2014). ADHD has a high rate of comorbidities (e.g., depression, anxiety disorders, substance use disorders) and is associated with impairments in both basic and instrumental functioning (Kessler et al., 2006).

While medications are often considered first-line treatment for ADHD, they do not yield improvement always in behavioral symptoms or in the skills and strategies required for success, such as self-regulation, organization, planning, and time management (e.g., Kolar et al., 2008). Depending on an individual's age, interventions including behavior therapy, psycho-education, strategy instruction, cognitive behavioral therapy, and ADHD coaching (see below) have all demonstrated benefit in addressing behavioral and functional concerns (Ahmann, Saviet & Tuttle, 2017; Ahmann et al., 2018; Kooij, et al., 2010; Prevatt & Young, 2014; Sprich et al., 2016; Weiss et al., 2008; Wolraich et al., 2019).

The first description of "ADHD coaching" in the literature was in Hallowell and Ratey's *Driven to Distraction* in 1994; the first study of ADHD coaching was reported in 2001 (Zwart & Kallemeyn, 2001); and a descriptive literature review of ADHD coaching (Ahmann, Saviet & Tuttle, 2017; Ahmann et al., 2018) found that research demonstrates benefit across the age span. While there is no one definition of "ADHD coaching", the following descriptions provide a broad overview of this field:

- ADHD Coaching is a collaborative, supportive, goal-oriented process in which the coach and the client work together to identify the client's goals and then develop the self-awareness, systems, skills, and strategies necessary for the client to achieve those goals and full potential (ADHD Coaches Organization; https://www.adhdcoaches.org/)
- ADHD coaching is a specialty skill set that empowers clients to manage their attention, hyperactivity, and impulsivity (Professional Association for ADHD Coaches; https://paaccoaches.org/learn-about-adhd/).

Multimodal Care and Interprofessional Collaboration

Multimodal, or multidisciplinary, care is increasingly recognized as important to client care in health and behavioral health fields (e.g., World Health Organization, 2010). In fact, multimodal treatment is widely considered optimal for ADHD (Antshel, 2015; Hinshaw & Arnold, 2015; Kooij et al., 2010; Philipsen et al., 2015), and ADHD coaching can be a useful part of this approach. As Murphy (2005) stated, multimodal care may include:

> … psychoeducation, medication, psychotherapy, compensatory behavioral/self-management skills, technological tools and devices, coaching, advocacy, and reasonable school or workplace accommodations (p. 607).

Ideally multidisciplinary care is built on collaboration and communication between the multiple involved professionals caring for an individual client - a practice termed "interprofessional communication and collaboration" (IPC). IPC may lead to care that is "more accessible, comprehensive, and cost efficient" (Shaw & Brown, 2011, p. 84). Key organizations such as the American Academy of Pediatrics (Katkin et al., 2017), the American Academy of Child and Adolescent Psychiatry (AACAP, 2010), and the American Psychological Association (APA, 2020) have encouraged IPC as well as training in relevant skills.

Despite how common it is for numerous professionals to work with any given individual seeking support for managing ADHD, little research has explored the topic of interprofessional communication and collaboration for this population. While several studies have demonstrated that there are benefits of care models promoting collaboration among professionals working with children having behavioral health needs, including ADHD (Guevara et al., 2009; Power et al., 2010; Power et al., 2013; Shahidullah et al., 2018), some studies have found low rates of interprofessional communication and collaboration in practice (e.g., Bradley-Klug et al., 2013; Newacheck et al., 2004; Schwab & Gelfman, 2005), and scant research has focused on these topics in the care of adults with ADHD.

Bradley-Klug et al. (2013) report that there is a "sizeable gap between the need for collaborative care and the existence of models for (such) partnerships" (p. 10). While ADHD coaching is increasingly a part of multimodal care for individuals with ADHD, only one study to date has explored ADHD coaching and IPC: a case report that directly explored the experience of an ADHD coach collaborating with a psychiatrist in the care of a graduate student with ADHD (Ahmann et al., 2020). This coaching experience illustrated the benefit of collaboration for one particular client and stimulated curiosity about the experience of other ADHD coaches with IPC.

This qualitative (focus group) study identifies and assesses the attitudes and experiences of ADHD coaches regarding communication and collaboration with other professionals, with respect to their clients.

Methods

Approval for this study was obtained from the Institutional Review Board at Maryland University of Integrative Health.

Recruitment

This study utilized a purposive convenience sample, with additional snowball sampling. Recruitment occurred through social media platforms of the ADHD Coaches Organization (ACO); using flyers and in-person contact at the 2019 International Conference on ADHD; and via email invitations to individual coaches. Interested coaches completed an informed consent and brief survey online responding to questions about inclusion criteria and indicating availability for focus group dates/times.

Study inclusion criteria were: 18 years of age or over; self-identification as an ADHD coach; a minimum of 30 hours of coach training; training in working with individuals having ADHD; and living in the United States (due to restrictions of the videoconferencing package used). Potential participants were invited to a focus group matching their availability and were sent several automated text reminders.

Focus Group Procedure

A focus group design was selected for this study since the group interaction often supports participant identification and clarification of perspectives, uncovers deeper insights and varied perspectives than might be achieved in either surveys or even interviews, and adds to a comprehensive exploration (Coenen et al., 2012; Kitzinger, 1995; Tausch & Menold, 2016). Four 90-minute focus groups were held via Zoom video conferencing and were recorded; only audio-recordings were retained. Two researchers (TR and RF), both ADHD coaches, conducted the focus groups. Facilitator 1 (TR), was the moderator and had experience conducting focus groups while Facilitator 2 (RF) took notes during each focus group, offered a summary of key points at the end of each session, and sought confirmation from the group. Both facilitators were board members of the ADHD Coaches Organization and known to at least some of the study participants.

The following four questions, broadly reflective of issues identified in the literature on IPC, were used to guide discussion (sub-prompts for each question were also available to Facilitator 1 to use as needed):

1. In general, what are your experiences communicating and/or collaborating with other professionals working with any of your clients?
2. What are your thoughts and experiences about the benefits and challenges of communicating with other professionals?

3. What are your thoughts and experiences about roles and boundaries as you communicate with other professionals?
4. What else is important to talk about when you are thinking of communication and collaboration with associated professionals?

One focus group was not directly asked the second question (above) because the topic was addressed by group members when discussing the first question.

Figure 1: Coding Tree
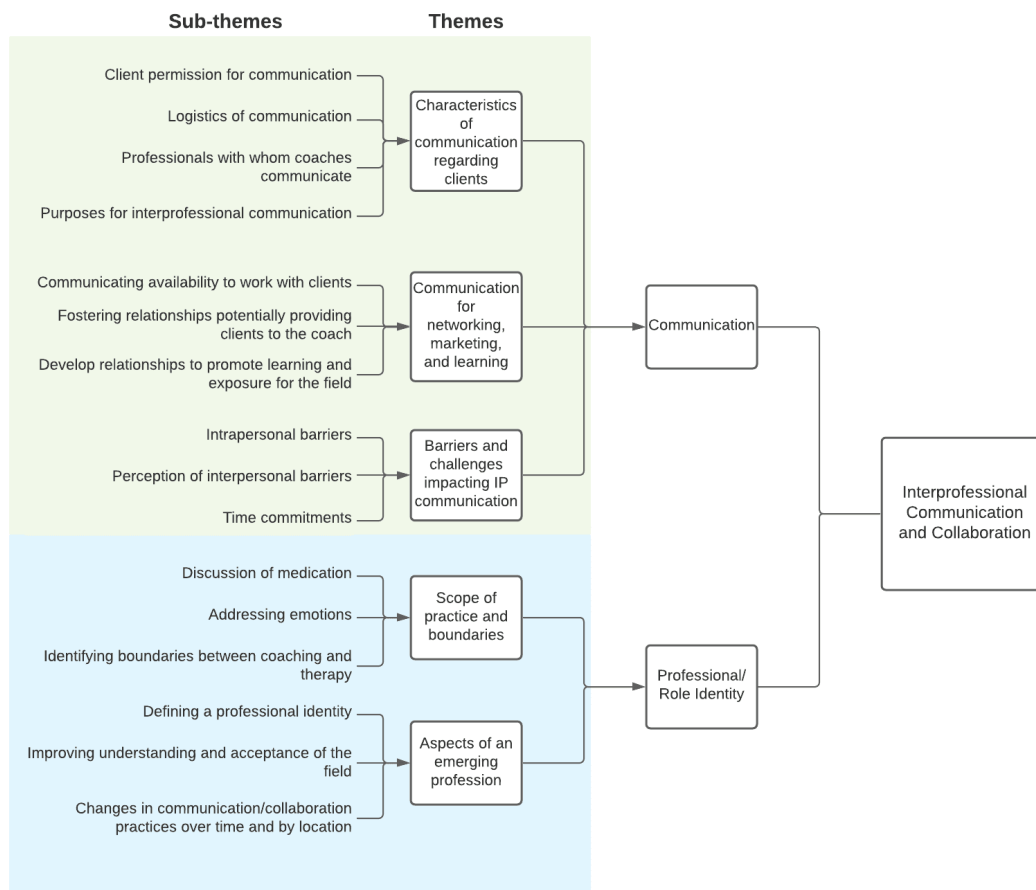
In the last 10 minutes of each focus group, participants were provided a link in the Zoom chat box to complete a brief online survey, using SurveyMonkey, to gather relevant demographic data. No personal identifying information was requested. Participants had the option to link to a separate site where they could leave a contact email to participate in a random drawing for one of three $20 Amazon gift cards.

The focus group recordings were transcribed using embedded Zoom artificial transcription services, and transcripts were verified/corrected by two of the researchers (EA, MM). All data and transcripts were kept in password protected online storage accessible only to the research team. Transcripts were not returned to focus group participants for comment.

Data Analysis

The transcripts, and one follow-up email comment from a participant, were analyzed using thematic analysis (Braun & Clarke, 2006). This iterative inductive method for identifying, analyzing, and reporting themes and patterns within data, without the use of any pre-existing framework, is an approach particularly useful for under-researched topics (Braun & Clarke, 2006).
Based on a review of the transcripts, and Facilitator 2's fieldnotes, three researchers (RF, MS, EA) identified initial categories for coding.

Two of these researchers (MS, EA) developed the codebook, and two (RF, EA) coded the data, with the third (MS) engaged as needed to resolve discrepancies. Coding was done by hand in several rounds, leading to inductive identification of key themes (see Fig. 1). All conversations about the data included challenging each other about potential assumptions and biases. Participants were not asked for feedback on identified themes. The COREQ (consolidated criteria for reporting qualitative research) guidelines were used in reporting this study (Tong et al., 2007).

Results

Participant Demographics

Twenty-six coaches met study inclusion criteria, but only 18 were available at the four times focus groups were held. Sixteen of the 18 participants completed the online demographic questionnaire.
While coaching is not a licensed profession, a number of organizations offer formal credentialing, several at more than one level. Fifteen of 16 coaches completing the demographic questionnaire held one or more credential from established coach credentialing bodies including: Center for Credentialing and Education, International Coaching Federation, International Association of Coaching, Professional Association for ADHD Coaches and National Board for Health and Wellness Coaching. Over 50% of the participants reported that they did not recall content on communication with other professionals or interprofessional collaboration in their coaching training. Of the 16 coaches, one participant was a medical doctor and seven others held higher education degrees (PhD or Masters), including four with masters in counseling or education fields. One participant had no degree.

Half of the 16 coaches reported coaching full-time, and half part-time, with 14 indicating that they practiced coaching as solopreneurs (i.e., working for themselves). The number of years coaching clients having ADHD ranged from 2-6 years (n=6 coaches), to 7-10 years (n=6), to over 10 years (n=4). The average reported number of individual clients each coach was currently working with was 9 (SD=3.5; range=4-15).

All of the coaches responding to the survey reported working with adults. Some also reported working with clients in elementary (n=5 coaches); high school (n=12 coaches); young adults not in school (n=13 coaches); undergraduate (n=15 coaches) and graduate students (n=12 coaches). Thirteen coaches worked with adults 65 years and older.

Of the 16 respondents, 15 reported having clients working simultaneously with other professionals. These included, in descending order of frequency; psychiatrists (n=15 coaches); other doctors (n=10); tutors (n=8); school personnel (n=7); and occupational therapists (n=1). Other responses included speech pathologists, chiropractors, neurofeedback practitioners, Veterans Affairs, and "organizing professionals, other coaches with different specialties". The most commonly reported professions with which coaches initiated communication on behalf of their clients included: therapists (n=12); psychiatrists (n=10); school personnel (n=10); other doctors (n=7); and tutors (n=5).

Qualitative Findings

Five key themes in two broad categories emerged from the focus group data (see Fig. 1). In the category of communication, three themes were identified: characteristics of client-related communication; and communication for networking, marketing, and learning. In the category of professional/role identity two themes emerged: barriers and challenges impacting interprofessional communication; scope of practice and boundaries; and aspects of an emerging profession. These themes are expounded upon and illustrated by exemplar quotations below. (Note: Participants are identified by number of focus group, 1-4, and individually by letters: e.g., 1a)

Theme I: Characteristics of communication regarding clients

Characteristics of communication regarding clients is a theme that included: client permission for communication with other professionals, logistics of communication, professionals with whom coaches communicated, and the purposes for interprofessional communication.

Coaches emphasized that any interprofessional communication hinged on the client's agreement, and logistics of communication began with obtaining a release of information from the client (or the parent if working with a younger client). Coaches reached out to other professionals by phone, email, and formal letter (e.g., to disability services in college). Logistical barriers identified included the fact that some professionals' offices require a fax and that doctors "don't seem to like texting and email very much" (1a).

Coaches mentioned a wide range of professionals with whom they communicate (see Box 1). In general, coaches described initiating the communication with other professionals, although one participant mentioned a psychiatrist who reached out to check on a client's progress.

Box 1: Professionals with whom ADHD Coaches Mentioned Client-related Communications (in alphabetical order)

> • College/university disability department(s)
> • Counselors
> • Department of Aging and Rehabilitative Services
> • Doctor
> • Educators
> • General practitioners
> • Guidance counselors
> • Interprofessional team
> • Nurse practitioner
> • Pediatrician
> • Psychiatrists
> • Psychologists
> • Physician (medicating)
> • Physician's assistant
> • Primary [care provider] (if prescribing ADHD medication)
> • Social workers
> • Specialists
> • Staff at outpatient drug rehabilitation agency
> • Therapists

One coach explained the purpose of communicating with other treating professionals as primarily "let[ting] them know there is somebody else working with their patient" (2a). Additional reasons identified for communicating with other professionals included: 1) explaining what coaching is and what it does; 2) explaining what the client is working on; 3) sharing observations or concerns; 4) asking "if there is anything that would help [the coach] work better with the client" (1b); 5)

explaining what the coach notices about the impact of ADHD on the client's life; and 6) advocating on behalf of the client (e.g. for accommodations for a college student). As examples, coaches stated:

- I'll call them [and] say "I'm working with your client, your patient…. And, "Is there anything that would be helpful for me to know?" (1b)
- [I send] a letter to the doctor saying, "We're doing coaching, and I'll let you know if there's anything…" (2a)
- I've collaborated with several psychologists about what's been occurring during the coaching session, what we're working on, and what the plans are in the future (1c).

Some coaches in the focus groups agreed that there is "really no corresponding back and forth" (2a) as might be expected in interprofessional collaboration. For several coaches, though, active collaboration with other professionals seemed to occur in the following circumstances: when a client had dual diagnoses; to define roles for therapist and coach both working with a client; and to share perspectives on an issue (e.g. missed appointments). As an example, one coach shared the following:

I let the therapist know that I'm working with [the client] on emotions and he said "Great, because I'm working with [the client] on PTSD". So, that was a great collaboration there. He did his thing as a therapist, and I did mine as a coach (3a).

Theme II: Communication for networking, marketing, and learning

While the purpose of the study was to explore coaches' use of interprofessional communication and collaboration to support the care of their clients, a great deal of participant discussion addressed communication for networking, marketing, and collaborative learning. This addressed fostering relationships that would potentially provide clients for the coach or, conversely, provide professional services to which a coach could refer clients as needed, and also to provide both professional learning and growth as well as exposure for the field.

Many participants did not enjoy the marketing aspect of communication, with some wishing their training had enabled them to do this more effectively. As one coach put it, "If I didn't have to market and I could just coach. I'd be really happy but, it's part of the deal" (1b). One coach remarked that it would be nice to have a marketing spiel of sorts to use in contacting other professionals: "… talking points, like five slides: 'I'm calling you because…. And five things I'd like to talk with you [about]' …. And then what coaching is, the benefits, and how it can enhance whatever they're doing with their patient" (1c).

Coaches seemed to take networking seriously to find resources for clients. One participant explained that she would ask other providers if "...they take insurance, what their availability is, are they seeing new clients, ... do [they] treat a lot of people with ADHD?" (4c)

Coaches generally seemed enthusiastic about opportunities to learn together with other professionals, feeling it supported professional growth as well as contributed to other professionals having a better understanding of ADHD coaching. Examples of collaborative learning that were shared included case study roundtables, presenting joint workshops, inviting other professionals to trainings a coach offers, and participating with wellness groups.

Theme III: Barriers and challenges impacting interprofessional communication

Coaches identified several barriers and challenges impacting interprofessional communication, including intrapersonal barriers, perceptions of interpersonal barriers, and time commitments.

Personal challenges reaching out to other professionals were identified by several participants. One coach stated, "I'm a little shy sometimes…. It's outside my comfort zone to make those calls… but I'll do it" (1b). Several participants mentioned aspects of their own ADHD, such as procrastination, being a barrier. One participant mentioned being particularly intimidated by psychiatrists; another shared, "I'm intimidated a little bit; ... it's partly my own ADD and my hypersensitivity…" (1a).

The perception that other professionals did not understand or respect coaching was a barrier to communication that surfaced repeatedly in the focus group conversations, as the following examples illustrate:

- A lot of psychiatrists and therapists are not that familiar with coaching (1b).
- The barriers I've found locally are the therapists that feel threatened, and they don't know anything about coaching (2g).
- I have some sense that they don't especially respect coaching… (1a).
- I read somewhere that there's a feeling that coaching is 'therapy light' (1c).

One participant articulated a shared perception that therapists see coaches as competition "rather than [a] kind of parallel or collaborative, interacting approach" (4c) that focus group participants generally would have preferred.

Coaches noted that the lack of regulation in the profession may contribute to others not understanding what some well-trained ADHD coaches can offer. One participant commented, "I think [other professionals] don't understand the depth of the knowledge [we have]" (3c). Another participant spoke about factors contributing to lack of understanding:

So, it stares me in the face, the difference between, ... just a life coach and an ADHD coach that is trained first in life coaching and then adds the specialty on top of that….
I agree totally with everyone who said there is a problem with people just hanging out a shingle … "Coach" is such a buzz word. And so when anybody calls me and asks about coaching, I make sure that they understand that I am a certified coach and what that means… (4b).

Another barrier to interprofessional communication some participants identified was the time commitment it requires. One coach stated, "When my practice is really busy, I don't do a lot of it" (1b). Another stated:

There's the [barrier] of time. For a long-term established client, [for me] to spend a half an hour chatting with a therapist, that's not a big deal. But, if it's going to turn into a regular time commitment… that's not something I would necessarily volunteer to do without a boundary around money (2f).

Theme IV: Scope of practice and boundaries

Scope of practice arose a number of times in the focus group discussions. One coach shared, "As an ADHD coach there is a grey area with other professionals" (2e). In this regard, discussion of medication, addressing emotions, and the boundary between coaching and therapy were particular areas of discussion.

Coaches seemed to have uncertainty about discussing medication with clients. One participant asked the focus group:

I'm curious what people think about [talking about medication with clients]. I'm thinking 'Is this a boundary I'm crossing that I shouldn't be?' ...But I feel like I know more than most of the people around, and I make a point of learning about it (3b).

The same coach shared:

> I get a lot of questions about medication because most of the physicians [in my area] do not have [that] expertise. So, I question my own boundaries, and, you know, I am very careful about not recommending but just giving my knowledge and experience. So, it's about personal boundaries for me (3b).

However not all participants shared that perspective. In fact, one coach remarked: "I don't do any medication [discussions. That's] out of my swim lane" (2b).

Coaches also had differing views of scope of practice in relation to client emotions. One coach shared her strict boundaries:

> Everybody cries from time to time. They'll cry. And I just hand them a tissue and I say, I see, "I see you're upset." And that's as far as I'll go. That's a boundary with me. I'm not going there. You know, I'll hold a space for you while you're upset. Yeah, I'll be very sympathetic. But then we have to get back to work (1b).

However, one coach shared that because ADHD impacts self-regulation, and "ADHD people are emotional", it is hard not to address the impact of emotions in coaching (1a).

The boundary between coaching and therapy, and when to make a referral to a therapist, were issues discussed by many participants. One coach was very clear about professional boundaries and roles:

> I totally believe in the multimodal approach. I think it's great when a client has a therapist, a psychiatrist for their medication, and a coach. They can explore more about themselves and what's going on with the therapist; and with us [coaches], it's about moving forward to get the results they want (4b).

Another described explaining the distinction between coaching and therapy to clients: "[W]e are simply [working on] skills, and there's just a fine line that crosses over into psychology, but I always assure them that as a coach, I know where that line is that I have to refer them out" (3a). One coach noted, "I just think of the boundaries of my coaching - where I know I have reached a point where this is now a therapeutic issue and I need to refer someone out" (3b). Another coach spoke of the "fine line" between coaching and therapy: "…[T]he difference [between] who should be seeing a counselor and who should not can be a pretty fine line I would say" (1a). Yes the same coach spoke about being careful in relation to that boundary: "…[T]he boundary of you need a counselor vs. a coach … that's the big thing. I mean, that's the one we have to be most careful [of] right there" (1a).

Additionally, although it only came up once in the various focus groups, one coach described explicitly defining roles and responsibilities in collaboration with mental health professionals as follows:

> I have a couple of clients with dual diagnoses of either mood disorders or other disorders that can complicate things…. We have an agreement and a plan with their health care provider, mental health provider, on what I can do to intervene, and who I communicate with, and how (3c).

Several coaches spoke very generally about scope of practice, including the importance of being aware of "scope creep" (3c); the need to be clear on what the coaching focuses on, especially when a client has co-occurring conditions; and the need to assure that the most pressing issues for a client, such as anxiety, are addressed before coaching begins.

Theme V: Aspects of an emerging profession

The fifth theme identified in the data relates to aspects of an emerging profession. Elements of this theme include the need to define a professional identity as well as wanting to improve understanding and acceptance of the field. Changes in communication/collaboration practices over time and in varied locations also emphasized the emerging nature of the field.

One aspect of professional/role identity several coaches mentioned was the fact that trained ADHD coaches really understand the nitty-gritty of ADHD. Additionally, because coaches meet with clients frequently and often have between-session contact, coaches are often the "boots on the ground" (2b), as one participant put it, and provide a type of support other professionals typically cannot. Participants agreed that this frequent contact gives coaches a certain type of expertise and the ability to share valuable information with other involved professionals.

Expertise was another aspect of professional/role identity directly discussed in the focus groups. One coach shared, "I still don't tell people that I'm an expert...I'll say, you know, this is an area of my expertise...I'll just talk about my expertise...But if somebody else wants to say I'm an ADHD expert, I don't poo-poo that" (4d). Another coach said "I don't hesitate to say that I'm [an] expert in ADHD" (4c). Another participant shared: "...I feel if there was some sort of a credential ... if there was such a thing as a masters in ADHD, I'd have it" (3b). Some coaches talked about possibly carving out specific areas of expertise as well, such as case coordination (which can actually be a separate field); "advocacy", particularly for college students (3d); and being a resource or "connector" regarding ADHD services for clients and others (3c).

One participant emphasized the greater understanding and acceptance of the field she has seen in recent years (3a). Several participants talked about ADHD coaching being better understood in larger urban areas (e.g., 4b). A few suggested that credentialing approaches that might enable billing insurance for client care would contribute to improved acceptance of this emerging profession (e.g., 4c). In terms of the field, itself, however, many participants felt that they needed to explain coaching to many other professionals. One coach asked, "Might part of the role in our collaboration be to see what it is we can do for our profession, ... sort of as an outreach feature of our work, or an educational aspect?" (4d)

Participants in the focus groups identified educating other professionals about the unique services ADHD coaches offer as of paramount importance, as follows:

- I realized that I had something to offer and educate them on. And that it was actually part of my mission…(3c).
- I feel like "ADHD coach" is a kind of nebulous term for a lot of people. [S]o when I'm asked what I do, who I am, I say "coach and consultant - ADHD/executive function coach and consultant (3b).

Participants also emphasized the need to clarify that what coaches bring to the table is different from what other treating providers offer. One coach put it this way:

We're educating [other professionals] about what ADHD coaching is, or what we do. But I think it's also … that we're also educating them on how we would collaborate. Where are our overlapping areas of expertise or non-overlapping areas of expertise, and how we can be of support to their clients? (4d)

Another coach described the following process of educating other providers about coaching:

A lot of psychiatrists and therapists are not that familiar with coaching. So, I like to take the opportunity to tell them how I work as a coach. And what I'm working on is usually different from what they're working on. And I tell them I'm not really working on...the past or emotional

components, but just very pragmatic, like what can you do to make things better. And teaching [clients] about their executive functions and how their brain works... and how [coaching is] very goal based and future based (1b).

Several coaches spoke about the value of interprofessional collaboration, one sharing:

I can think of only pros and benefits of communicating and opening up conversations and collaborating on how clients move forward .... [G]aining new information, new ideas, and new strategies that other people are using … is helpful and informative (1c).

Another spoke aspirationally, saying, "So it would be amazing to have something ... where [coaching and other professions] are flowing in and out with each other and filling in all of the gaps [for a client]" (4c).

Discussion

Focus group discussions with ADHD coaches revealed five key themes regarding interprofessional collaboration that fell into broad categories of communication and professional/role identity: characteristics of communication; communication for networking, marketing and learning; barriers to collaboration; scope of practice and boundaries; and aspects of an emerging profession. The following sections analyze and contextualize these themes within the existing literature.

Communication

Theme I: Characteristics of communication

Client confidentiality is respected in coaching, and coaches commented on the need to obtain client agreement and a written release in order to communicate with other involved professionals.

Communication and collaboration that occurs across disciplines can range from "cursory, disorganized, and ad hoc in nature" to "coordinated, responsive, and well managed,"—an approach that may require an investment of time and attention, but likely results in "more accessible, comprehensive, and cost efficient" care (Shaw & Brown, 2011, p. 84; Wodrich, 2004). Forms of collaboration can include: sharing information on a specific case; interdisciplinary and transdisciplinary assessment or behavioral consultation; joint planning; and joint decision-making (Weinstein, 2006). In general, coaches in this study spoke more about communication, or sharing information, than interdisciplinary or transdisciplinary collaboration. The communication described by participants was largely ad hoc in nature. Only two coaches talked about clearly defining roles with other professionals in relation to clients with multiple diagnoses. Also, only a few participants, one of whom happened to be part of an ADHD practice including other professions, talked about actual interdisciplinary collaboration around care.

Heuer and Williams (2016) suggest email, short phone conversations, and teleconferences as some concrete approaches to interprofessional communication. All of these approaches were described by coaches in the current study. Lynch et al. (2014) propose the possibility of health communication exchanges (e.g., shared databases on the internet or some form of shared health record), although potentially costly, as one approach that might improve both shared access to information as well as communication among professionals with shared clients. This would likely only occur in group practices or larger health care settings; only two participants in this study were part of group practices. Power et al. (2013) suggest both that care coordinators or case managers may be part of the solution to improved cross-discipline communication. In this study, one coach talked about potentially taking on a care coordination role, but otherwise no discussion of this role occurred. Power et al. (2013) also suggest that specific training in cross-disciplinary collaboration is

important. The majority of study participants (56%) reported that their coach training did not include the topics of interprofessional communication or collaboration; several (6-13%) were uncertain. Explicit training in inter-professional communication and collaboration might be a useful offering in training programs and coach continuing education.

Rice et al. (2020) define interprofessional collaboration as a "two-way exchange of information between professionals that is conducive to developing collaborative working relationships" (p.351). Focus group participants described a lack of two-way exchange of information encountered in practice. This highlighted a desire on the part of ADHD coaches to establish more collaborative relationships with other professionals supporting their clients but suggests limited application in practice.

Theme II: Communication for networking, marketing, and learning

Networking and marketing were described by study participants as elements of interprofessional communication utilized to both obtain clients and identify professionals to whom they could refer clients. Brooks and Wright (2007), in a survey of executive coaches in New Zealand, found that the preferred method of marketing was word-of-mouth, and the most effective method was referral from clients or other professionals. Other approaches coaches reported were offering free introductory sessions, a common practice in the field, public/media talks, advertising and other, such as book publication(s) and networking.

In the current study, a lack of training in marketing, and feeling uncomfortable "marketing" oneself, were concerns mentioned by a number of coaches. Reaching out to find resources or services for clients seemed less of a concern, so framing "marketing" in this way might be useful. Promoting an understanding of coaching among other professions might also make networking and marketing easier for individual coaches; in this regard, see the discussions below in relation to both "Barriers" and an "Emerging Profession".

The issue of interprofessional learning caught the interest of many coaches in this study and might be an area of opportunity that could build interprofessional understanding and foster collaboration. Individual coaches or coaching organizations could create such opportunities whether locally, online, and/or at conferences, for example the International Conference on ADHD or the Annual Meeting of the American Professional Society for ADHD and Related Disorders.

Theme III: Barriers and challenges impacting interprofessional communication

Numerous studies of IPC in the care of varied populations suggest a myriad of barriers that may contribute to low rates of collaboration. Identified barriers fall into three main areas: 1) logistics (undefined mechanisms for communication or collaboration; privacy laws; failing to get client/parent signatures on release of information forms; time constraints and schedule issues; funding constraints and billing concerns; lack of a "point person"; and logistical concerns regarding communication); 2) roles and perspectives (e.g., role definition/identity; lack of understanding of each other's training and expertise; differing perspectives; use of differing discipline-specific language and reporting styles; territory and/or power issues); and 3) lack of training in IPC (Arora et al., 2016; Atkinson & Shute, 1999; Bradley-Klug et al., 2013; Briggs-Gowan et al., 2000; Heuer & Williams, 2016; Leslie, et al., 2004; Leslie & Wolraich, 2007; Power, et al., 2013; Rose, 2011).

Barriers to interprofessional communication and collaboration identified in this study were consistent with those identified in extant literature on IPC. Logistics, in particular, were discussed at some length.

Role issues were identified as a key barrier to interprofessional communication in this study, with coaches feeling that their roles, training, and expertise were poorly understood. Additionally, participants felt that therapists, in particular, might see coaching both as 'therapy light' and as

competition, possibly hindering collaborative care for clients. Being seen as competition when there is some similarity or overlap in services offered is not an uncommon concern for an emerging profession (Minnesota Department of Health, 2017).

Finally, also consistent with barriers identified in the literature, a lack of training about how to communicate with other professionals was identified as a concern by several coaches in this study, and more than half had not been trained in IPC. Training programs, continuing education opportunities, and/or professional organizations, might fruitfully offer coaches curriculum content in this area. As an example, Graham and Carroccia (2020, November 5) held a workshop titled "Applying the collaborative care model to create a better partnership among ADHD coaches and clinicians" at the 2020 ADHD Professionals Institute conference.

Professional/Role Identity

Theme IV: Scope of practice and boundaries

A qualitative study comprised of interviews with seven International Coaching Federation Master Certified Coaches (the highest coaching credential within the ICF), exploring roles and boundaries, found that boundaries were largely self-defined by a coach's feelings of competence as well as whether a client was moving forward using the coaching process (Sime & Jacob, 2018). This seems consistent with the findings of the present study in which participants seemed to have somewhat differing "boundaries" around certain practices, in particular in relation to discussing medications, addressing emotions, and the "fine line" boundary with therapy.

Coaches are bound to the codes of ethics of any body by which they are credentialed, but not all such credentialing bodies (e.g., International Coaching Federation) have a defined scope of practice. While most participants in this study were not credentialed by the Professional Association for ADHD Coaches (PAAC), this organization does have a scope of practice, delineating certain practice parameters, as part of its Code of Ethics (see: https://paaccoaches.org/paac-ethics/). One parameter is specific to the topic of medications, an issue raised by participants in this study:

> 2.5. PAAC Certified Coaches do not recommend medications or give medical advice. In the event that a PAAC Certified Coach feels that a client might benefit from medication, the coach will communicate that impression to the client and refer the client out to an appropriate health professional. (https://paaccoaches.org/paac-ethics/)

This scope of practice guideline leaves open to interpretation whether it is appropriate for a coach to share information, as distinct from advice, about medications. Another PAAC scope of practice guideline relates to the boundary between coaching and therapy:

> 2.6. PAAC Certified Coaches do not provide psychotherapy or treat mental disorders. If a PAAC Certified Coach believes that a client might benefit from psychotherapy, the coach will communicate that impression to the client and refer the client to an appropriate mental health professional…. (https://paaccoaches.org/paac-ethics/)

Coaches in the present study were clear that they were not providing therapy, but some still spoke of a "fine line" between coaching and therapy. The Minnesota Health Department's (2017) "Guide for Emerging Professions" states that "overlap in scopes of practice between professions is unavoidable" (p. 51), a factor that speaks to this fine line. At the same time, the Guide states: "The extent to which a profession can delineate exactly what services and benefits it provides can determine how deeply the profession can integrate into the existing health care system" (p. 7). Buckley (2007) has suggested that "...one of the more important tasks facing the coaching industry is to develop a realistic and positive approach to the mental health/mental ill health boundary" as a

distinction between coaching and therapy (p. 20). He proposes that distinguishing the questions "What to do?" (coaching) from "What is wrong?" (therapy) might be a practical approach to drawing that distinction in a way supports ethical practice and clear boundaries for coaches. Several coaches in this study seemed to draw the line just as Buckley proposed.

Much of the literature on interprofessional teams focuses on the interaction between the practitioners. What is often overlooked is the influence of the client on a collaborative team's dynamics. In this regard, coaches need to delineate the distinctions between coaching and therapy for clients. Still, it is possible a client might find coaching "therapeutic" even though the coach is not providing therapy. While some overlap with therapy may be unavoidable, both a clearly delineated scope of practice and further delineation of the line between coaching and therapy might help other professions understand the distinctions and aid in the process of integrating ADHD coaching as part of multimodal care.

Theme V: Aspects of an emerging profession

According to Ahmann et al. (2018), "ADHD coaching is a specialized form of life coaching that has been employed since the early 1990s …" (p. 18). Jensen (2015) identifies key steps in the professionalization of an emerging field. The existence of professional organizations, such as the ADHD Coaches Organization (ACO) and the Professional Association for ADHD Coaches (PAAC), which offers several levels of credentialing, and the fact that PAAC has a code of ethics and set of competencies, are several such steps.

Despite these steps, coaches in this study spoke of the need to personally educate other professionals about ADHD coaching and what it can offer as part of multimodal treatment, as well as the need to distinguish trained and credentialed ADHD coaches from individuals who might just "hang out a shingle" without appropriate training. The Minnesota Health Department's (2017) "Guide for Emerging Professions" states that "integration of an emerging profession will likely not happen without intentional, consistent effort" (p. 55). Coaches in this study spoke of the need for such effort. Individual coaches, as well as training programs and coaching organizations, might well advocate for the profession in this regard.

Participants in this study's focus groups were also heard trying to carve out a clear professional/role identity, as well as articulate feelings of expertise. Wilson and Ozyer (2019) suggest that "professional identity" might be a useful topic to address in programs educating individuals in an emerging field.

Strengths and Limitations

The use of focus groups allowed for in-depth exploration of themes related to this topic. Limitations were typical to any focus group and qualitative study. For example, as focus groups are relatively small and not necessarily representative of the larger population under study, they can provide an initial look at an issue but findings cannot be generalized. It is also possible that certain participants might voice opinions more readily than others, slanting the data collected. The fact that many participants may have known, or at least known of, the focus group moderator (TR; President of the ADHD Coaches Organization), could have posed an unknown bias in what they shared or on group dynamics in this particular study (Roller & Lavrakas, 2015). Another limitation of this study was that participants were not asked for their own definitions of "interprofessional communication" or "interprofessional collaboration." This might have yielded valuable data if included.

Reliability of the data in this study was assured in several ways (per Gibbs, 2007): 1) coding directly on transcripts; 2) in-vivo coding through several rounds to avoid drift in definition of the codes; frequent communication between coders; 3) use of a third researcher whenever needed to assist in resolving discrepancies or clarifying themes.

Multiple validation strategies were used in this study (per Creswell, 2009; Creswell & Poth, 2018). Face validity was achieved by reporting participant experiences and perceptions in their own language. Multiple quotations, or "rich description" is used in reporting each theme (Creswell & Poth, 2018, p. 261). Having two experienced coaches (RF, EA) do the coding added validity through "prolonged engagement" with the field and topic (Creswell & Poth, 2018, p. 262); additional validity was incorporated by involvement in the analysis of a third researcher with a different background, (MS; social work). At several junctures, potential bias was overtly discussed in an effort to minimize the possibility of interpretation vs. reporting of participant perspectives.

Conclusions

In this study, ADHD coaches reported some communication, but less in the way of true collaboration, with other professionals on behalf of their clients. In general, study participants felt that their field is not well enough understood or appreciated, a factor that directly impacts the ability to successfully collaborate with other professionals. Rose (2011) identified the "importance [to collaboration] of understanding roles and contributions, particularly regarding areas of difference and overlap" (p. 159). Enhanced clarity regarding boundaries and scope of practice in the field of coaching may facilitate both improved role clarity for coaches themselves as well as a better understanding among other professionals of the unique skills and abilities ADHD coaches bring to the table.

Connecting across professional lines, through experiences such as case collaborations and roundtables, seems to be a natural approach coaches identified that varied professionals can use to build connections and enhance mutual understanding of each others' roles. Lynch et al. (2014) indicate that "communication related to ADHD treatment is far more complex than even theoretical models may conceptualize because of the number of involved parties .... [and] coordinating effective communication between them presents considerable challenges to all involved" (p. 15). For this reason, coaches and other professionals in the ADHD field may benefit from specific training in interprofessional collaboration to optimize effective multimodal care to support the needs of individuals with ADHD.

Additionally, as collaborative care involves a commitment by all parties, research directly exploring knowledge and perspectives other professionals have about ADHD coaching might elucidate fertile areas for cross-professional education about the unique contribution of coaches to the care of individuals with ADHD. Also, future research exploring experiences and perspectives that varied professionals - therapists, psychiatrists, and others - have about interprofessional communication and collaboration in care of individuals with ADHD might be useful in designing approaches to building effective interprofessional connections and collaboration.

This study offers an initial exploration and identification of ADHD coaches' perspectives on interprofessional communication and collaboration. This may serve as a useful step in helping all professionals who work with individuals having ADHD determine how to improve communication and collaboration; implement the most effective multimodal care; and, ultimately, provide optimal support for their shared clients.

References

Ahmann, E., Saviet, M., & Tuttle, L. J. (2017). Interventions for ADHD in children and teens: A focus on ADHD coaching. *Pediatric Nursing*, 4(3), 121–131.

Ahmann, E., Tuttle, L. J., Saviet, M., & Wright, S. D. (2018). A Descriptive Review of ADHD Coaching Research: Implications for College Students. *Journal of Postsecondary Education and Disability*, 31(1), 17-39.

Ahmann, E., Smith, K., Ellington, L. & Pille, R. (2020). Health and wellness coach collaboration with psychiatrist in multimodal intervention for ADHD. *Permanente Journal*, 24(1), 86-92.

American Academy of Child and Adolescent Psychiatry. (AACAP; 2010). *A guide to building collaborative mental health care partnerships in pediatric primary care*. Available at: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/guide_to_building_collaborative_mental_health_care_partnerships.pdf.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders*. 5th ed. American Psychiatric Association.

American Psychological Association. (2020). *Integrated health care*. Available at: https://www.apa.org/health/integrated-health-care.

Antshel, K. M. (2015). Psychosocial interventions in attention-deficit/hyperactivity disorder: Update. *Child and Adolescent Psychiatric Clinics of North America*, 24(1), 79-97. DOI: 10.1016/j.chc.2014.08.002.

Arora, P. G., Connors, E. H., Biscardi, K. A., & Hill, A. M. (2016). School mental health professionals' training, comfort, and attitudes toward interprofessional collaboration with pediatric primary care providers. *Advances in School Mental Health Promotion*, 9(3-4), 169-187. DOI: 10.1080/1754730X.2016.1181526.

Atkinson, I., & Shute, R. (1999). Managing ADHD: Issues in developing multidisciplinary guidelines. *Journal of Psychologists and Counsellors in Schools*, 9(2), 119-128. DOI: 10.1017/S1037291100003976.

Barbaresi, W. J., Colligan, R. C., Weaver, A. L., Voigt, R. G., Killian, J. M., & Katusic, S. K. (2013). Mortality, ADHD, and psychosocial adversity in adults with childhood ADHD: a prospective study. *Pediatrics*, 131(4), 637. DOI: 10.1542/peds.2012-2354.

Bradley-Klug, K. L., Jeffries-DeLoatche, K. L., Walsh, A. S. J., Bateman, L. P., Nadeau, J., Powers, D. J., & Cunningham, J. (2013). School psychologists' perceptions of primary care partnerships: Implications for building the collaborative bridge. *Advances in School Mental Health Promotion*, 6(1), 51-67. DOI: 10.1080/1754730X.2012.760921.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. DOI: 10.1191/1478088706qp063oa.

Briggs-Gowan, M. J., Horwitz, S. M., Schwab-Stone, M. E., Leventhal, J. M., & Leaf, P. J. (2000). Mental health in pediatric settings: distribution of disorders and factors related to service use. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(7), 841-849. DOI: 10.1097/00004583-200007000-00012.

Brooks, I., & Wright, S. (2007). A survey of executive coaching practices in New Zealand. *International Journal of Evidence Based Coaching and Mentoring*, 5(1), 30-41. Available at: https://radar.brookes.ac.uk/radar/items/0d7257ad-5854-42d7-8318-ef09a13a2df4/1/.

Brown, T. E. (2013). *A new understanding of ADHD in children and adults: Executive function impairments*. Routledge.

Buckley, A. (2007). The mental health boundary in relationship to coaching and other activities. *International Journal of Evidence Based Coaching and Mentoring* (S1), pp.17-23. Available at: https://radar.brookes.ac.uk/radar/items/69d51e6f-7b81-4312-898a-001caa5dc9ce/1/.

Coenen M., Stamm T., Stucki G., Cieza A. (2012). Individual interviews and focus groups in patients with rheumatoid arthritis: A comparison of two qualitative methods. *Quality of Life Research*, 21, 359–370. DOI: 10.1007/s11136-011-9943-2.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, mixed methods approaches* (3rd ed.). Sage.

Creswell, J. W. & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Fredriksen, M., Dahl, A. A., Martinsen, E. W., Klungsoyr, O., Faraone, S. V., & Peleikis, D. E. (2014). Childhood and persistent ADHD symptoms associated with educational failure and long-term occupational disability in adult ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, 6(2), 87-99. DOI: 10.1007/s12402-014-0126-1.

Gibbs, G. (2007). *The Sage qualitative research kit. Analyzing qualitative data*. Sage Publications Ltd.

Graham, A. P. & Carroccia, G. (2020, November). Applying the collaborative care model to create a better partnership among ADHD coaches and clinicians. Conference session presented at the *2020 ADHD Professionals Institute CHADD Conference*, virtual.

Guevara, J. P., Power, T. J., Blum, N. J., Reyner, J., Rustgi, A., & Leslie, L. K. (2009). Collaborative care interventions for ADHD for primary care. In *National Institute of Mental Health Conference on Mental Health Services Research*: Washington, DC.

Hallowell, E. M. & Ratey, J. J. (1994). *Driven to distraction*. Touchstone.

Heuer, B., & Williams, S. (2016). Collaboration between PNPs and school nurses: Meeting the complex medical and academic needs of the child with ADHD. *Journal of Pediatric Health Care*, 30(1), 88-93. DOI: 10.1016/j.pedhc.2015.09.001.

Hinshaw, S. P., & Arnold, L. E. (2015). Attention-deficit hyperactivity disorder, multimodal treatment, and longitudinal outcome: Evidence, paradox, and challenge. *Wires Cognitive Science*, 6(1):39-52. DOI: 10.1002/wcs.1324.

Jensen C. B. (2015). The Continuum of Health Professions. *Integrative Medicine (Encinitas, Calif.),* 14(3), 48–53.

Katkin, J. P., Kressly, S. J., Edwards, A. R., Perrin, J. M., Kraft, C. A., Richerson, J. E., ... & Wall, L. (2017). Guiding principles for team-based pediatric care. *Pediatrics*, 140(2). DOI: 10.1542/peds.2017-1489.

Kessler, R.C., Adler, L., Barkley, R., Biederman, J., Conners, C.K., Demler,O., Faraone, S.V., Greenhill, L.L., Howes, M.L., Secnick, K., Spencer, T., Ustun, T. B., Walters, E. E., and Zaslavsky, A. M. (2006). The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *American Journal of Psychiatry,* 163:716–723. DOI: 10.1176/ajp.2006.163.4.716.

Kitzinger J. (1995). Qualitative research: Introducing focus groups. *British Medical Journal*, 311, 299–302. DOI: 10.1136/bmj.311.7000.299.

Kolar, D., Keller, A., Golfinopoulos, M., Cumyn, L., Syer, C., & Hechtman, L. (2008). Treatment of adults with attention-deficit/hyperactivity disorder. *Neuropsychiatric Disease and Treatment*, 4(2), 389. DOI: 10.2147/NDT.S6985.

Kooij, S. J., Bejerot, S., Blackwell, A., Caci, H., Casas-Brugué, M., Carpentier, P. J., Edvinsson,D., Fayyad, J., Foeken, K., Fitsgerald, M., Gaillac, V., Ginsberg, Henry, C., Krause,J.,Lensing,M.B., Manor,I., Niederhofer, H., Nunes-Filipe, C., Ohlmeier, M.D. & Asherson, P. (2010). European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. *BMC Psychiatry*, 10(1), 67. DOI: 10.1186/1471-244X-10-67.

Leslie, L. K., & Wolraich, M. L. (2007). ADHD service use patterns in youth. *Journal of Pediatric Psychology*, 32(6), 695-710. DOI: 10.1093/jpepsy/jsm023.

Leslie, L. K., Weckerly, J., Plemmons, D., Landsverk, J., & Eastman, S. (2004). Implementing the American Academy of Pediatrics attention-deficit/hyperactivity disorder diagnostic guidelines in primary care settings. *Pediatrics*, 114(1), 129-140. DOI: 10.1542/peds.114.1.129.

Lynch, D., Madden, J., & Knight, B. A. (2014). Harnessing professional dialogue, collaboration and content in context: An exploration of a new model for teacher professional learning. *International Journal of Innovation, Creativity and Change*, 1(3), 1-15.

Minnesota Department of Health. (2017). *A Guide for Emerging Professions*. Available at: https://www.health.state.mn.us/facilities/ruralhealth/emerging/docs/2017emprofc.pdf.

Murphy, K. (2005). Psychosocial treatments for ADHD in teens and adults: A practice-friendly review. *Journal of Clinical Psychology*, 61(5), 607-619. DOI: 10.1002/jclp.20123.

Newacheck, P. W., Park, M. J., Brindis, C. D., Biehl, M., & Irwin Jr, C. E. (2004). Trends in private and public health insurance for adolescents. *JAMA*, 291(10), 1231-1237. DOI: 10.1001/jama.291.10.1231..

Philipsen, A., Jans, T., Graf, E., Matthies, S., Borel, P., Colla, M., ... & van Elst, L. T. (2015). Effects of group psychotherapy, individual counseling, methylphenidate, and placebo in the treatment of adult attention-deficit/hyperactivity disorder: a randomized clinical trial. *JAMA Psychiatry*, 72(12), 1199-1210. DOI: 10.1001/jamapsychiatry.2015.2146.

Power, T. J., Blum, N. J., Guevara, J. P., Jones, H. A., & Leslie, L. K. (2013). Coordinating mental health care across primary care and schools: ADHD as a case example. *Advances in School Mental Health Promotion*, 6(1), 68-80. DOI: 10.1080/1754730X.2013.749089.

Power, T. J., Hughes, C. L., Helwig, J. R., Nissley-Tsiopinis, J., Mautone, J. A., & Lavin, H. J. (2010). Getting to first base: Promoting engagement in family–school intervention for children with ADHD in urban, primary care practice. *School Mental Health*, 2(2), 52-61. DOI: 10.1007/s12310-010-9029-2.

Prevatt, F. A., & Young, J. (2014). Recognizing and treating Attention Deficit/Hyperactivity Disorder in college students. *Journal of College Student Psychotherapy*, 28(3), 182-200. DOI: 10.1080/87568225.2014.914825.

Rice, K., Zwarenstein, M., Conn, L. G., Kenaszchuk, C., Russell, A., & Reeves, S. (2010). An intervention to improve interprofessional collaboration and communications: a comparative qualitative study. *Journal of Interprofessional Care*, 24(4), 350-361. DOI: 10.3109/13561820903550713.

Roller, M. R. & and Lavrakas, P. J. (2015). *Applied qualitative research design: A total quality framework approach*. Guilford Press.

Rose, L. (2011). Interprofessional collaboration in the ICU: How to define? *Nursing in Critical Care*, 16(1), 5-10. DOI: 10.1111/j.1478-5153.2010.00398.x.

Schwab, N. & Gelfman, M. H. (2005). *Legal issues in school health services: A resource for school administrators, school attorneys, and school nurses*. iUniverse.

Shahidullah, J. D., Carlson, J. S., Haggerty, D., & Lancaster, B. M. (2018). Integrated care models for ADHD in children and adolescents: A systematic review. *Families, Systems, & Health*, 36(2), 233-247. DOI: 10.1037/fsh0000356.

Shaw, S. R., & Brown, M. B. (2011). Keeping pace with changes in health care: Expanding educational and medical collaboration. *Journal of Educational and Psychological Consultation*, 21(2), 79-87. DOI: 10.1080/10474412.2011.571549.

Sime, C., & Jacob, Y. (2018). Crossing the line? A qualitative exploration of ICF master certified coaches' perception of roles, borders and boundaries. *Coaching Psychology Review*, 13(2), 46-61.

Sprich, S. E., Safren, S. A., Finkelstein, D., Remmert, J. E., & Hammerness, P. (2016). A randomized controlled trial of cognitive behavioral therapy for ADHD in medication-treated adolescents. *Journal of Child Psychology and Psychiatry*, 57(11), 1218-1226. DOI: 10.1111/jcpp.12549.

Tausch, A. P., & Menold, N. (2016). Methodological aspects of focus groups in health research: Results of qualitative interviews with focus group moderators. *Global qualitative nursing research*, 3, 2333393616630466. DOI: 10.1177/2333393616630466.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357. DOI: 10.1093/intqhc/mzm042.

Weinstein, J. (2006). School-based health centers and the primary care physician: an opportunity for collaborative care. *Primary Care: Clinics in Office Practice*, 33(2), 305-315. DOI: 10.1016/j.pop.2006.01.010.

Weiss, M., Safren, S. A., Solanto, M. V., Hechtman, L., Rostain, A. L., Ramsay, J. R., & Murray, C. (2008). Research Forum on Psychological Treatment of Adults With ADHD. *Journal of Attention Disorders*, 11(6), 642–651. DOI: 10.1177/1087054708315063.

Wilson, B. G., & Ozyer, A. (2019). The role of graduate programs in fostering IDT identities: reflections on an emerging profession. *Journal of Computing in Higher Education*, 31(3), 557-572. DOI: 10.1007/s12528-019-09211-4.

Wodrich, D. L. (2004). Professional beliefs related to the practice of pediatric medicine and school psychology. *Journal of School Psychology*, 42(4), 265–284. DOI: 10.1016/j.jsp.2004.04.002.

Wolraich, M. L., Hagan, J. F., Allan, C., Chan, E., Davison, D., Earls, M., ... & Holbrook, J. R. (2019). Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. *Pediatrics*, 144(4). DOI: 10.1542/peds.2019-2528.

World Health Organization, Department of Human Resources for Health. (2010). *Framework for action on interprofessional education and collaborative practice*. World Health Organization. Available at: https://www.who.int/hrh/resources/framework_action/en/.

Zwart, L., & Kallemeyn, L. (2001). Peer-based coaching for college students with ADHD and learning disabilities. *Journal of Postsecondary Education and Disability*, 15, 1-15.

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