

Attention deficit hyperactivity disorder has come of age

John Kramer OAM

Attention deficit hyperactivity disorder (ADHD) has seemingly ‘come of age’ in the mid-2020s in Australia (Box 1). There is more than a touch of irony in that development, given that the genetic footprint for ADHD has perhaps been in place in our species since humans first walked this earth.

The general consensus regarding the origins of ADHD is that it is a predominantly inherited condition. It is thought that genetics accounts for 80% of the phenotypical expression, while environment contributes 20%.¹ That accounts for the variations

observed between closely related ADHD individuals, including identical twins.²

Estimates for the prevalence of ADHD vary widely,³ but my sense of it is that at least 10% of the population could be considered neurodiverse in some way, and ADHD is the most common form thereof. Perhaps one explanation for the general underestimates is that no one was really looking for it until recently.

The stereotypical perception of a hyperactive little boy creating havoc everywhere they go is but the most obvious clinical variety of ADHD. That incomplete understanding has perhaps led to it being regarded as a predominantly male preserve.

Increasing awareness of its myriad presentations is perhaps the prime cause of its apparently increasing incidence.

It is also essential to keep in mind that ADHD individuals can be found on a wide spectrum of phenotypical expression, ranging from mild to severe, and including everything in between.⁴ The extent of the negative impact on day-to-day executive function can also vary considerably, depending on the context of the individual.

Humans are extremely adept at developing ways to counteract any difficulties they might experience with performing important daily activities. These ‘workarounds’ are emblematic of our ability to adapt, in order to

Box 1. History of attention deficit hyperactivity disorder in Australia

1990	The Hidden Handicap book by Dr Gordon Serfontein
1994	Understanding ADHD book by Dr Christopher Green
1990s	Consumer group formation (Western Australia and New South Wales first)
1993–98	Divisions of GP projects (community- and school-based case conferences) (Western Australia, New South Wales, Queensland)
2001	Westmead Conference with Prof Russell Barkley
2011	First attempt at developing ADHD guidelines for Australia
2015	Queensland GPs approved to prescribe stimulants for paediatric patients
2016	AADPA formed
2019	Deloitte's report: The social and economic costs of ADHD in Australia. \$20 billion: The high cost of ADHD
2019	Henry review: Review of health services for children, young people and families within the NSW Health system (New South Wales)
2019–22	ADHD Guidelines developed by AADPA
2022	ADHD/ASD/ND SIG formation RACGP (within FSI)
2023	Senate Inquiry into ADHD
2024	ADHD Prescribing Guide produced by AADPA
2025	RACGP Position Statement on ADHD
2025	Jurisdictional reform planning begins on ADHD management in general practice
2026	Implementation of ADHD management in general practice begins variably in most jurisdictions

AADPA, Australasian ADHD Professionals Association; ADHD, attention deficit hyperactivity disorder; ASD, autism spectrum disorder; FSI, Faculty Specific Interests; GP, general practitioner; ND, neurodiversity; RACGP, The Royal Australian College of General Practitioners; SIG, Specific Interest Group.

survive and prosper. Neurodiversity might be considered the key to this process, given the recognised ability of that ‘tribe’ to problem solve, create new things and evolve to better perpetuate the species.

The large majority of human history has been spent in the ‘hunter-gatherer’ mode. It has only been perhaps in the last 10–15,000 years that humans came to live in small settlements which gradually became towns and cities.⁵ The existence of early humans was perforce nomadic. It needed the discovery of fire and the development of tools to begin the process of ‘civilisation’.

The distinctive positive traits possessed by ADHD individuals would have been essential to the survival of the human species. Many will have heightened sensory capacities in the basic areas of vision, hearing, smell etc, as well as less defined capacities such as intuition. These enhanced abilities must have provided great advantage in the quest for food and shelter and in the avoidance of danger. Creativity and problem-solving ability are frequently greater than that found among the neurotypical, however defined.⁶

By conferring significant survival advantage, the neurodiverse genotype would have been actively selected in the human species. A subset of early humans without these genes would have been at greater risk of harm because of lesser ability to find food, avoid danger and

create tools to solve problems. Nature has always been an unforgiving force!

The gradual transition to village and town life for much of humanity brought with it a need for systems and structure. Inevitably these must have evolved into ways that suited most of the population. That process has never stopped.

The first major clash between the neurodiverse and society typically begins with entry into formal education. The expectation that small children will quickly learn to sit still and follow instructions was never going to work with the ADHD cohort. Some individuals worked out ways to get by, the inattentive subtypes daydreamed and did not rock the boat, typically not reaching their potential and often developing anxiety due to the internalisation of their emotions. Those with multiple manifestations of neurodiversity such as autism, learning disorders and oppositional defiant disorder were struggling from the outset (Table 1).

When puberty arrived, the smouldering embers of many ADHD children erupted with the onset of seemingly flammable hormones. By then, a large range of adaptations had developed, some functional, many dysfunctional. Any firefighter can tell you that the best way to put out a fire is when it first begins, not when it has taken hold of the building.

The lucky ones were blessed with above average intelligence and stable home lives. The less fortunate were often on a fast train to socioeconomic and health disadvantage. Society is now trying to work out what to do, while the fire is blazing on many fronts!

In this issue readers will learn that ADHD management can begin with a wide range of non-pharmacological strategies.⁷ In a significant number, their implementation can prevent the need to utilise stimulants or at least defer their introduction until further along the child’s educational journey.

The use of stimulants brings an additional responsibility to the prescriber.⁸ Stimulants are classified as Schedule 8 medications, with an additional layer of regulatory monitoring that varies between jurisdictions. The development of real time prescription monitoring has made this aspect of clinical care much safer for all concerned.

The initiation of stimulants is a new activity for almost all Australian general practitioners (GPs). Readers will find the detailed advice on this topic extremely useful.

General practice is the most varied clinical environment in our society. Here you can read about some of the innovative models of GP-centric ADHD care that have sprung up in recent years, including my own on the Mid North Coast of New South Wales.^{9,10} It is true that ‘there is more than one way to skin a cat’!

Table 1. Strengths and challenges of attention deficit hyperactivity disorder

Strength (superpower)	Challenge (Achilles heel)
Hyperfocus	Time blindness/procrastination
Multitasking	Task completion/loses things
Creativity	Extreme distractibility
Curiosity	Boredom/fidgeting
Willingness to try new things	Aversion to change
Heightened senses	Does not notice the obvious
Problem-solving	Short-term memory problems
Responds to deadlines	Forgets appointments
Strong sense of justice	Interrupts others
Total work immersion	Burnout
Profound empathy	Emotional dysregulation and rejection sensitive dysphoria (RSD)
Mentally energetic	Mentally drained (ie ‘having only two gears’)
Manually skilful	Clumsy

Author

John Kramer OAM, MB, BS, FRACGP, FACRRM, General Practitioner, Beach Street Family Practice, Woolgoolga, NSW; Chair of The Royal Australian College of General Practitioners ADHD, Autism spectrum disorder and Neurodiversity Specific Interest Group, Woolgoolga, NSW

Competing interests: JK declares: payment or honoraria from GPCE 2025 ADHD Keynotes in Sydney and Melbourne, NSW RDN ADHD Master Class Facilitation 2025–26, North Coast PHN Presentations on ADHD at two dinner meetings in 2025; participated in NSW Health Dept ADHD Reforms Working Party 2025–26; Board Member NSW Rural Doctors Network Ltd 2008–26; Medical Advisor with NSW Rural Doctors Network; upcoming delivery of ADHD Training workshops for ACT Health; Shares in CSL, NAB, ANZ, WES, BHP, TEL.

AI declaration: The author confirms that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript and no images were manipulated using AI.

References

References are available online only.

correspondence ajgp@racgp.org.au

References

1. Stein M. The War on ADHD – A selective history of the last 40 years [keynote address]. Presented at AADPA Annual Conference, July 2025, Sydney, Australia.
2. Tistarelli N, Fagnani C, Troianiello M, Stazi MA, Adriani W. The nature and nurture of ADHD and its comorbidities: A narrative review on twin studies. *Neurosci Biobehav Rev* 2020;109:63–77. doi: 10.1016/j.neubiorev.2019.12.017.
3. Popit S, Serod K, Locatelli I, Stuhec M. Prevalence of attention-deficit hyperactivity disorder (ADHD): Systematic review and meta-analysis. *Eur Psychiatry* 2024;67(1):e68. doi: 10.1192/j.eurpsy.2024.1786.
4. Nigg JT. The evolving ADHD phenotype in the externalizing context. *Am J Psychiatry* 2026;183(1):18–30. doi: 10.1176/appi.ajp.2025.1165.
5. Harari YN. *Sapiens: A brief history of humankind*. HarperCollins, 2015.
6. Kalogeratos G, Anastasopoulou E, Tsagri A, Tseremegklis C, Asimakopoulou S. Interpersonal skills with a focus on creativity in attention deficit hyperactivity disorder. *Technium Soc Sci J* 2023;52:197–211. doi: 10.47577/tssj.v52i1.10251.
7. Nowinska E, Savage SV. Non-pharmacological strategies in the management of attention deficit hyperactivity disorder. *Aust J Gen Pract* 2026;55(9):589–92. doi: 10.31128/AJGP-03-26-8044.
8. Bradfield O, Fernando D. Balancing care with compliance: Medicolegal issues for general practitioners treating attention deficit hyperactivity disorder. *Aust J Gen Pract* 2026;55(9):595–601. doi: 10.31128/AJGP-01-26-7995.
9. Poulton A, Bedford J, Heiler S, et al. New model of management of attention deficit hyperactivity disorder by trained general practitioners: Prospective cohort study in 207 children. *Aust J Gen Pract* 2026;55(9):603–07. doi: 10.31128/AJGP-04-26-8090.
10. Tognarini K, Leong HK, Nahamkes V, Kramer J, Errington W. Medication initiation and optimisation in attention deficit hyperactivity disorder: A practical approach for general practice. *Aust J Gen Pract* 2026;55(9):609–14. doi: 10.31128/AJGP-04-26-8124.