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BEYOND WESTERN DIAGNOSES

Towards Indigenous understandings of ADHD in Australasia and the Pacific

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Abstract

This commentary critically examines the limitations of Western biomedical frameworks in diagnosing and conceptualising attention-deficit hyperactivity disorder (ADHD), with particular focus on their application to Indigenous communities in Australasia and the Pacific. Current diagnostic practices, shaped by Eurocentric assumptions about behaviour, attention and productivity, often misinterpret or marginalise Indigenous expressions of neurodivergence. Drawing on literature from Aotearoa New Zealand, Australia and the Pacific Islands, the commentary explores how Indigenous knowledge systems offer alternative ways to engage with ADHD. These approaches frame neurodivergent traits within collective, spiritual and intergenerational contexts rather than through deficit-based models. The commentary highlights structural and diagnostic barriers, cultural misdiagnosis and systemic exclusion, while calling for Indigenous-led research, culturally aligned diagnostic tools and policy transformation. In doing so, it argues for a shift towards strengths-based, relational and self-determined understandings of ADHD that reflect the lived realities of Indigenous neurodivergent individuals.

Keywords

attention-deficit hyperactivity disorder (ADHD), cultural misdiagnosis, decolonising mental health, Indigenous knowledge systems, Indigenous neurodivergence, Kaupapa Māori

Introduction

Attention-deficit hyperactivity disorder (ADHD) is commonly defined and diagnosed through Western biomedical frameworks informed by Eurocentric understandings of behaviour, attention and productivity. Although these frameworks provide established approaches to diagnosis and treatment, they may overlook cultural differences in how ADHD is experienced and understood. Māori, Aboriginal, Torres Strait Islander and Pacific communities are frequently excluded or misrepresented within these frameworks (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026).

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Mainstream diagnostic approaches generally classify ADHD as a neurodevelopmental disorder and emphasise the identification and treatment of symptoms. Indigenous knowledge systems may recognise some traits associated with ADHD, including impulsivity and restlessness, as expressions of energy, responsiveness and creativity. Māori understandings of whakapapa situate these characteristics within wider considerations of collective wellbeing, spiritual balance, and intergenerational relationships with land and ancestors (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026). Holistic approaches to learning and development also recognise the importance of movement, oral communication and emotional expression, which standardised assessments may interpret as signs of impairment. Failure to consider these cultural perspectives may contribute to misdiagnosis, disengagement from services and mistrust of clinical systems (Kingi, 2000; Tipene, 2023).

Evidence from Aotearoa New Zealand and Australia identifies inequities and evidence gaps in ADHD identification and care for Māori, Pacific, Aboriginal and Torres Strait Islander communities (Cargo et al., 2022; D'Souza et al., 2020; May et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026). Indigenous peoples often encounter significant barriers to diagnosis, including financial constraints, a shortage of culturally appropriate services and clinician misinterpretation of culturally informed behaviours. These challenges are exacerbated by the legacies of colonisation, notably institutional racism, systemic ableism, and the marginalisation of Indigenous worldviews in health and education (Rangiwai, 2024; Tipene, 2023; Tuisaula Cruice, 2023).

Focusing on the Australasian and Pacific region is crucial for addressing these disparities. Indigenous communities throughout the region offer perspectives that broaden current conceptions of neurodiversity. For instance, the pīwakawaka metaphor frames ADHD traits through the quick and perceptive movements of the fantail, underscoring the worth of attributes often deemed problematic in Western contexts (Rangiwai, 2024, 2026a, 2026b; Rangiwai et al., 2026). The Te Whare o Oro framework draws on mātauranga Māori and neuroscience to explore neurodevelopment through tapu, wairua and relational care (McLachlan et al., 2023). Meanwhile, in Aboriginal contexts, the Bigaagarri protocol interprets behaviours associated with ADHD as signals of relational or environmental disruption, guiding responses through community-based relationships and collective care (Orcher et al., 2024).

Such approaches challenge clinical models that emphasise individualism, standardisation and deficit-based views. They offer culturally aligned, strengths-based ways of interpreting ADHD, affirming Indigenous authority in defining and responding to neurodivergence. Enhancing the visibility and practical implementation of these frameworks across research, education and mental health services is essential for promoting equity and supporting Indigenous neurodivergent identities.

The problem with Western ADHD models

Mainstream understandings of ADHD are heavily influenced by diagnostic frameworks such as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*; American Psychiatric Association, 2022). These frameworks rely on behavioural checklists and clinical observations informed by Euro-American norms relating to attention, productivity and self-control. Although the *DSM* is widely used in education and healthcare, it lacks cultural nuance and does not reflect the varied ways in which behaviour is understood, expressed or supported in different cultural contexts (McLachlan et al., 2023; Tipene, 2023). This diagnostic model therefore frequently marginalises those whose behaviours differ from Western expectations, including Indigenous children and families.

Within the *DSM*, ADHD is depicted as a series of deficits involving inattention, hyperactivity and impulsivity. These traits are viewed as problematic and are often addressed through pharmacological or behavioural interventions. This viewpoint aligns with a long-standing Western psychiatric tradition that deems cognitive and behavioural differences pathological when they deviate from prevailing norms around order, quietness, and institutional compliance (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026). ADHD is commonly regarded as a shortfall in meeting external benchmarks rather than a valid form of human variation that may be better served through culturally responsive or relational frameworks.

Western diagnostic paradigms have historically classified Indigenous and other non-Western groups as disordered or lacking, often on the basis of cultural variations rather than genuine clinical risk. In education settings, for instance, expressive or movement-focused behaviours commonly observed among Māori and Pacific

children may be deemed disruptive or inattentive, leading to unwarranted referrals for ADHD evaluation (Kingi, 2000; Stoicovy et al., 2012). Such behaviours conflict with institutional expectations favouring silence, independent work and passive learning—norms that are neither universal nor congruent with many Indigenous ways of learning (Tipene, 2023).

ADHD, as it is currently defined in the *DSM*, reflects the cultural values of societies that prioritise time-bound productivity, institutional conformity and behavioural control. Neurodivergence in these contexts is often interpreted as a disorder instead of an expression of variability. Indigenous frameworks, on the other hand, typically include relational, spiritual and intergenerational viewpoints. Concepts such as whakapapa and wairua position neurodivergent traits within broader insights related to balance, identity and collective wellbeing (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026). When diagnostic models neglect these perspectives, they sustain cultural hierarchies, maintain deficit-focused narratives and reduce opportunities for effective support.

Excluding Indigenous knowledge, alongside the enduring legacy of colonial values, has led to widespread misdiagnosis, mistrust and disengagement. Māori whānau, for example, frequently describe feeling judged, misunderstood or disregarded during assessment processes that fail to consider cultural requirements (Tipene, 2023). These experiences reveal the ongoing influence of Western clinical frameworks that continue to define health and disorder without meaningful input from the communities they evaluate.

Recognising these limitations paves the way for a more inclusive and culturally appropriate understanding of ADHD. Research and practice must move beyond the assumption that Western models are universally relevant. Indigenous frameworks propose alternative approaches to understanding neurodivergence, grounded in values of connection, reciprocity and whānau leadership. Incorporating these perspectives within education, healthcare and policy is crucial to overhauling existing systems and enhancing outcomes for Indigenous neurodivergent individuals.

Cultural misdiagnosis and systemic inequities

In Australasia and the Pacific, cultural misdiagnosis is a persistent concern in diagnosing and managing ADHD. Western clinical frameworks can misinterpret Indigenous behaviours through deficit-based perspectives, potentially contributing to both underdiagnosis and overdiagnosis. Underdiagnosis may result from barriers to assessment and services, while overdiagnosis can occur when culturally grounded behaviours are misinterpreted as ADHD symptoms (Australasian ADHD Professionals Association [AADPA], 2022). These outcomes reflect systemic inequities across education, healthcare and social services, where culturally specific views of neurodivergence are often overlooked or invalidated (Cole & Rangiwai, 2026; Gibbs et al., 2026; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026; Tipene, 2023).

In Aotearoa, research by Tipene (2023) has shown how Māori families encounter ADHD in systems that overlook cultural viewpoints. Families noted that mainstream diagnostic services rarely considered their cultural background or preferences. Some whānau stated they would have chosen referral to kaupapa Māori services, but these options were not presented. The lack of culturally aligned services contributes to feelings of exclusion and can discourage families from seeking formal support (Tipene, 2023).

These experiences raise questions about diagnosis-dependent access to support, particularly where clinical frameworks do not reflect cultural understandings or preferences. Jones et al. (2024) highlight how Māori may be required to adopt Western disability labels to access services, potentially undermining their self-determination. Providing support without requiring a formal diagnosis would uphold mana motuhake and whānau choice in determining whether diagnosis is meaningful and what assistance best meets their needs.

Stigma also significantly influences help-seeking behaviour. Subica et al. (2019) observed that in some Pacific Islander communities, neurodevelopmental and mental health conditions were interpreted as moral or social failings rather than viewed as medical or neurological issues. This outlook creates reluctance to seek clinical diagnoses, as families fear judgement, loss of mana or being deemed inadequate parents. Cultural norms emphasising familial responsibility and social harmony may further encourage families to address behavioural issues privately rather than consult external services (B. M. Smith, 2004; Subica et al., 2019).

In educational contexts, cultural misdiagnosis often stems from inadequate awareness of Indigenous learning preferences (Hetaraka, 2022, 2024) and behavioural norms. Stoicovy et al.

(2012) investigated the experience of a Chamorro student in Guam, whose classroom behaviour was interpreted through a Western lens and incorrectly classified as ADHD. In reality, the student's challenges stemmed from a mismatch between culturally shaped learning preferences and the classroom environment. This case emphasises how culturally unresponsive teaching approaches can result in unwarranted referrals for ADHD diagnosis, especially when behaviours such as oral storytelling, movement-based learning or collaborative interaction are misread as inattention or defiance (Stoicovy et al., 2012). While inappropriate referrals do not necessarily lead to misdiagnosis, failing to consider cultural and environmental contexts during assessment may contribute to overdiagnosis. The AADPA (2022) guideline identifies this risk among Aboriginal and Torres Strait Islander peoples, where culturally appropriate behaviours may be mistaken for ADHD symptoms.

Māori and Pacific children frequently face comparable risks in Aotearoa schools. Kingi (2000) noted that behaviours regarded as culturally typical, such as moving directly, being expressive or avoiding eye contact as a mark of respect, are sometimes interpreted as disruptive or inattentive by educators unfamiliar with these practices. This misunderstanding often leads to punitive discipline, exclusion or referral for clinical assessment (Kingi, 2000).

Further concerns about diagnostic accuracy are highlighted by Lau et al. (2025), who identified inconsistent estimates of ADHD prevalence among Māori children, partly reflecting differences in diagnostic methodologies. They also noted how Western frameworks may pathologise behaviours valued within Indigenous communities. While their findings do not establish overdiagnosis, they raise concerns about diagnostic accuracy, reinforcing the need for culturally responsive assessments that incorporate Indigenous worldviews (Lau et al., 2025). These examples highlight the layered consequences of cultural misunderstanding, bias and systemic exclusion. Diagnostic tools devised in Western settings are rarely modified for Indigenous use, and clinicians often lack the training to interpret behaviour within culturally relevant frameworks (Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026; Tipene, 2023). As a result, the healthcare and education systems continue to misclassify, marginalise or overlook Indigenous neurodivergent individuals. Stigma, inaccessibility and distrust compound these problems, sustaining a cycle in which Indigenous children and adults remain less likely to receive appropriate support while staying vulnerable to judgement and exclusion.

Structural change is crucial for addressing these inequities. Culturally responsive assessment protocols, investment in Indigenous-led services, and inclusion of Indigenous pedagogies and health frameworks are necessary for accurate diagnoses and meaningful support (Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026; Stoicovy et al., 2012; Tipene, 2023). Structural change must also enable whānau to access culturally appropriate support without requiring a formal diagnosis. Without such measures, ADHD will continue to be a site of misrecognition and marginalisation for many Indigenous communities across Australasia and the Pacific.

Indigenous understandings of neurodiversity in Australasia and the Pacific

Indigenous understandings of neurodiversity across Australasia and the Pacific present holistic, relational perspectives that challenge dominant clinical models based on deficit thinking. Neurodivergent traits are not isolated anomalies; they are viewed as intergenerational strengths, responsive to the environment and holding spiritual importance. These models prioritise collective wellbeing, ancestral relationships, and the interconnectedness of individual behaviour with social and ecological systems (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026).

In Aotearoa, Māori frameworks such as Te Whare o Oro demonstrate how mātauranga Māori can transform how neurodivergence is perceived. This approach draws from Māori cosmology, neuroscience and traditional concepts of balance and tapu to develop a relational view of the roro. ADHD-related traits are regarded not as dysfunction but as displays of energy, intuition or āhua, positioned within whakapapa and wairua. The brain is considered sacred and in need of nurturing rather than correction, and whānau are encouraged to support neurodivergent tamariki using pūrākau, karakia and manaakitanga (McLachlan et al., 2023).

Mahi a Atua, created by Diana and Mark Kopua, expands these ideas (Kopua et al., 2020). It uses pūrākau involving atua to interpret behaviour through stories of divine traits and relational dynamics. Traits such as impulsivity or restlessness are explored through narratives of atua such as Māui or Uepoto, allowing whānau to place neurodivergence within cultural meaning systems

rather than viewing it as pathology (Kopua et al., 2020). This process supports mana-enhancing, whānau-led approaches aligned with Māori knowledge systems (Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026).

Metaphorical frameworks are also significant. Rangiwai (2024, 2026a) introduces the pīwakawaka as a symbolic representation of ADHD. Known for its swift and unpredictable flight, the fantail exemplifies energy, responsiveness and lateral movement, qualities often misread as hyperactivity or lack of attention in clinical settings. Through the pīwakawaka metaphor, these traits are understood as adaptive, imaginative and ancestral. ADHD becomes a way of being that flourishes in environments guided by relationality and flexibility rather than compliance and stillness.

Whakapapa provides another key epistemology for understanding neurodiversity. Within this perspective, neurodivergent traits are not abnormalities but inherited characteristics that form part of a larger intergenerational narrative. Hyperactivity, curiosity and elevated sensitivity may reflect ancestral qualities and serve vital social or creative functions for the collective. McLachlan et al. (2023) refer to pūrākau of Uepoto, an atua whose impulsive, exploratory nature set the process of creation in motion—an allegory that challenges deficit-based interpretations and highlights the generative possibilities of difference.

Aboriginal Australian viewpoints reinforce these relational foundations. The Bigaagarri protocol, explained by Orcher et al. (2024), treats neurodivergence as a relational signal indicating an imbalance in an individual's social or environmental sphere rather than a disorder. The focus is on restoring links across kinship structures, cultural responsibilities and ecological ties. Neurodivergent behaviour becomes a prompt for community and Country to respond, encouraging Indigenous-led solutions that emphasise relationality, cultural autonomy and ecological balance.

Pacific Island communities similarly foreground collective values in their approaches to neurodiversity. Tamasese et al. (2005) found that Samoan perspectives of mental health emphasise familial relationships, spiritual balance and social harmony, while Pulotu-Endemann's (2001) Fonofale model positions family, culture and spirituality as interconnected dimensions of wellbeing. These perspectives highlight the limitations of clinical approaches that prioritise individual symptoms without broader considerations towards cultural and familial contexts. Although Pacific-centred ADHD research remains limited, approaches that recognise different worldviews and involve family are important for ADHD assessment and management (Best Practice Advocacy Centre New Zealand, 2026). Educational systems that do not account for Indigenous learning methods risk pathologising culturally appropriate behaviours. Oral storytelling, for example, supports engagement and memory for many Pacific learners but often goes unrecognised in conventional classrooms (Stoicovy et al., 2012). When these ways of learning are not understood, behaviours such as movement, verbal participation or collaborative engagement may be interpreted as inattentiveness or disruption. Such interpretations can lead to inappropriate referrals for ADHD assessment that could have been prevented with culturally informed education and teaching.

Barriers to care remain widespread. Tipene (2023) observes that Māori whānau routinely encounter diagnostic pathways offering no kaupapa Māori options. Families are rarely asked about their cultural needs, and few services incorporate Indigenous worldviews into their practices. Many whānau consequently disengage from formal support channels, compounding misdiagnosis, underdiagnosis and mistrust of clinical systems. Excluding mātauranga Māori from ADHD assessment methods worsens these disparities and marginalises Māori who identify as neurodivergent (Tipene, 2023).

Stigma heightens these barriers. Subica et al. (2019) found that, in some Pacific Islander communities, neurodevelopmental conditions were interpreted as moral or social failings, discouraging families from seeking clinical guidance. B. M. Smith (2004) likewise found that Marshallese families often managed ADHD-like behaviours informally, concerned about potential shame or blame. These examples highlight how clinical models that neglect cultural, social and spiritual dimensions can alienate Indigenous families.

Collectively, frameworks like Te Whare o Oro, Mahi a Atua, the pīwakawaka metaphor, Bigaagarri and community-oriented Pacific knowledge systems illustrate a commitment to relationality, contextual insight and strengths-based support. Neurodivergent traits are seen in connection to roles, relationships and histories, rather than as problems to be fixed. Behavioural differences form part of an interconnected system involving whānau, whenua, atua and ancestors.

Incorporating these approaches into mental health, education and social services enhances cultural safety and calls for a shift in worldview. Systems that rely on standardisation, compliance

and individualism are incompatible with Indigenous perspectives that emphasise flexibility, complexity and collective wellbeing. Equitable support for Indigenous neurodivergent individuals involves not only cultural awareness but the active inclusion of Indigenous philosophies and leadership in diagnosis, service development and knowledge creation.

Structural barriers to equitable diagnosis and support

Across Aotearoa and the Pacific, Indigenous individuals seeking ADHD assessment and support face multiple structural barriers that intensify long-standing inequities. These obstacles arise not only from under-resourced systems but also from limited diagnostic pathways, financial constraints and inadequate, culturally unresponsive, services. The result can be underdiagnosis, delayed intervention and systemic exclusion from care.

In Aotearoa, diagnostic overshadowing has been documented as a significant concern. Cunningham et al. (2023) observe that Māori and other marginalised groups often have their physical or behavioural symptoms attributed solely to existing mental health diagnoses, rather than being evaluated comprehensively. Participants described clinical experiences characterised by dismissiveness, poor communication and lack of respect—conditions that may hinder further assessment, including co-occurring conditions such as ADHD. Cost poses another major barrier. Publicly funded pathways for ADHD assessment in Aotearoa are limited, particularly for adults. Tuisaula Cruice (2023) reported that all nine participants in one study on ADHD diagnosis accessed care through the private system, where assessments typically exceeded $1,000. For many, especially Māori and Pacific families, this cost is prohibitive, discouraging individuals from seeking formal diagnosis. Rangiwai (2023, 2024, 2026a, 2026b; Rangiwai et al., 2026) notes that many adults with undiagnosed ADHD cope with years of academic struggle and social challenges. Such barriers reflect the need for more accessible and adequately funded assessment pathways. Te Hiringa Mahara (2024) highlights gaps across Aotearoa's mental health sector. Staff reported growing difficulties in accessing diagnostic pathways for neurodivergent individuals, especially those with co-occurring conditions. Although social media has heightened awareness of ADHD among rangatahi Māori, services remain unprepared to meet rising demand, particularly where specialist capacity is limited.

Policy continues to influence access to ADHD assessment and support. Changes introduced in February 2026 expanded the range of those able to diagnose and treat ADHD in adults; however, these options remain outside general practice funding, with costs varying across providers (Ministry of Health, 2025, 2026). Therefore, funding arrangements continue to limit equitable access, particularly for whānau unable to afford private assessment. More broadly, the Waitangi Tribunal's (2019) findings reinforce the need for policy approaches that adequately resource kaupapa Māori services and enable Māori participation in the design, delivery and monitoring of healthcare.

Whānau feedback offers further insight into these systemic shortcomings. Tipene (2023) describes how Māori families were rarely asked about their cultural background during assessments, nor were they informed about kaupapa Māori service options. Many whānau indicated that they would have welcomed such an option had it been offered. These experiences highlight the importance of providing whānau with meaningful choices about culturally appropriate assessment and support.

In the wider Pacific region, consistent underinvestment in mental health limits diagnostic access. Charlson et al. (2015) projected a 74% rise in mental health burden across the Pacific by 2050, yet many countries lack sufficient workforce or infrastructure to meet even the current demand. These wider workforce and infrastructure constraints raise concerns about the capacity to provide accessible neurodevelopmental assessment and support. Loi-On and Tanuvasa (2022) add a community viewpoint from Native Hawaiian and Pacific Islander families in San Francisco. Around 40% of the 105 surveyed parents and caregivers reported supporting children with ADHD or learning differences, but most lacked the resources or guidance to navigate formal services. Families cited stigma, mistrust of clinical systems and the absence of culturally sensitive care as reasons for managing ADHD-related issues within the family or community. Although the study was situated outside the Pacific region, these findings offer a relevant comparison of the barriers experienced by Pacific communities in accessing support.

Progress requires more than improved diagnostic accuracy. Structural change is vital, including investment in publicly funded ADHD assessments, the integration of Indigenous health and education frameworks, and the development of tools and training co-designed with Māori, Pacific and Aboriginal communities. Services

must advance beyond cultural awareness to systems defined by equity, self-determination and Indigenous leadership. This includes strengthening access to support while recognising whānau choice and mana motuhake in decisions about assessment and care.

Research gaps and the need for Indigenous-led inquiry

Current ADHD research is overwhelmingly shaped by Western perspectives, with limited inclusion of Indigenous voices, experiences or epistemologies. This imbalance narrows the scope of existing knowledge and perpetuates clinical and academic frameworks that overlook cultural diversity and relational models of neurodivergence (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026). Indigenous communities across Australasia and the Pacific remain under-represented in epidemiological data and qualitative investigations of ADHD, resulting in continued diagnostic and support inequities (Tipene, 2023).

Most ADHD literature originates in North American and European contexts, where diagnostic criteria, behavioural norms and treatment approaches reflect specific cultural assumptions. Studies that do involve Indigenous participants often lack cultural specificity, community leadership or integration of Indigenous worldviews (McLachlan et al., 2023). Insights from Māori, Aboriginal, Torres Strait Islander and Pacific communities are seldom prioritised in academic discourse, limiting the development of culturally attuned assessment, intervention and policy (Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026; Tipene, 2023).

Community-led research is urgently needed. Indigenous researchers and communities are best positioned to examine how ADHD is perceived and experienced within their own settings. This requires research grounded in the priorities and knowledge systems of individual Indigenous communities, consistent with Indigenous research methodologies that emphasise self-determination and authority over research agendas (L. T. Smith, 2021). Research grounded in mātauranga Māori, Aboriginal knowledge systems and Pacific epistemologies offers perspectives absent from mainstream literature. Tipene (2023) highlights the importance of future studies that centre Māori experiences and employ culturally grounded methodologies. Rangiwai (2023, 2024, 2026a, 2026b; Rangiwai et al., 2026) similarly advocates for research frameworks that affirm Indigenous identity and make room for new conceptualisations of neurodivergence emphasising relationality and whakapapa. Such approaches are consistent with ethical frameworks that emphasise Indigenous values, leadership and accountability (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2020; Pūtaiora Writing Group, 2010).

Cross-community collaboration can also provide opportunities to identify shared structural barriers, exchange knowledge and inform wider policy responses. However, such collaboration must recognise the distinct histories, knowledge systems and aspirations of participating communities, rather than assuming a single Indigenous perspective. This requires communities to retain authority over their knowledge and research priorities, including how findings are interpreted and shared. Both locally grounded research and cross-community collaboration reflect broader Indigenous research principles, including self-determination, whānau involvement, and the use of narrative and metaphor (McLachlan et al., 2023; Rangiwai, 2023, 2024, 2026a, 2026b; Rangiwai et al., 2026).

There is also a stark lack of validated ADHD diagnostic tools in Indigenous languages or designed according to Indigenous worldviews. Current instruments are standardised for English-speaking, Western populations and do not consider the linguistic, social or behavioural norms common in Indigenous communities. Tipene (2023) and Kingi (2000) note that this mismatch leads to misdiagnosis or underdiagnosis, particularly when clinicians interpret culturally normative behaviours through a Western clinical framework. Tools that fail to account for collective learning styles, oral communication or non-verbal cues risk classifying culturally natural behaviours as signs of dysfunction.

Large-scale epidemiological studies focused on Indigenous communities are similarly scarce. Concerns about underdiagnosis continue to grow, especially in Aotearoa, yet reliable data on ADHD prevalence among Māori, Aboriginal and Pacific peoples is limited. This absence fosters the impression that ADHD is less prevalent in these groups, whereas the reality may involve under-recognition linked to stigma, access constraints and clinician bias (Loi-On & Tanuvasa, 2022; Tipene, 2023). Without robust data, arguments for targeted services, workforce development or policy change lack an evidence base.

Addressing these gaps calls for sustained investment in Indigenous-led research. Tipene (2023) emphasises the importance of giving Māori

the opportunity to define the research questions, lead the project design and interpret the findings using culturally relevant perspectives. Rangiwai (2023, 2024, 2026a, 2026b; Rangiwai et al., 2026) likewise underscores the value of reclaiming epistemological sovereignty when shaping ADHD frameworks that uphold Māori understandings of neurodiversity. Ensuring Indigenous communities direct the generation and interpretation of knowledge is essential for developing ethical, meaningful and transformative research that can inform more equitable diagnostic and support practices across the region.

Recommendations and future directions

Addressing the limitations of current ADHD frameworks requires structural change across research, clinical practice, education and policy. A move towards culturally grounded, strength-based approaches must place Indigenous knowledge systems and leadership at the centre to ensure diagnosis and support align with the lived realities and values of Indigenous communities throughout Australasia and the Pacific.

Developing diagnostic tools and assessment models that are culturally anchored is an important starting point. Existing tools, based on Western behavioural norms, do not adequately capture Indigenous ways of expressing, interpreting or responding to cognitive and behavioural variation. Diagnostic criteria must be adapted or, where necessary, reimagined to reflect cultural understandings of neurodiversity. This includes designing assessments in Indigenous languages, using metaphors and concepts that resonate with local worldviews, and validating tools through direct community engagement instead of applying them without context.

Investment in Indigenous-led ADHD research is equally crucial. Indigenous scholars and community researchers, including Indigenous neurodivergent researchers and knowledge holders, are best positioned to design and guide studies that acknowledge cultural knowledge, values and priorities. Indigenous neurodivergent people must also have meaningful decision-making roles in setting research priorities, developing methodologies, interpreting findings and determining how knowledge is shared, rather than being positioned solely as research participants. Research founded in frameworks such as Kaupapa Māori or Critical Indigenous Disability Studies can broaden the evidence base while remaining accountable to the communities it is intended to support. Funding bodies should prioritise this work and recognise the expertise held within Indigenous communities—both academic and non-academic.

Training for mental health professionals must extend beyond cultural awareness to practical cultural competence and a decolonising approach to practice. Clinicians, educators and allied professionals need not only an understanding of cultural difference but also the ability to question the assumptions embedded in Western diagnostic systems. Decolonising practice involves reconsidering the foundations of assessment and care, recognising how colonial histories have shaped current models, and working collaboratively with communities to provide more equitable services.

Including Indigenous scholars, practitioners and community leaders in policy development is vital. ADHD policy and planning often advance without substantive input from those directly affected by its shortfalls. Ensuring Indigenous representation at all levels of decision-making supports more relevant, inclusive and effective strategies for neurodivergent individuals and their whānau. Policy must acknowledge that services cannot be truly effective if they disregard the cultural contexts in which people live.

Shifting from deficit-based models to strength-based neurodiversity frameworks is needed at all levels of ADHD discourse. Traits linked to ADHD, such as energy, creativity, responsiveness and lateral thinking, are commonly viewed as disruptive when interpreted through a colonial lens. Reframing these traits as valuable assets, illustrated by metaphors like the pīwakawaka, affirms the importance of cognitive diversity and encourages environments in which Indigenous neurodivergent individuals can flourish.

These recommendations outline a path towards more inclusive, culturally informed ADHD models that honour Indigenous ways of being, knowing and relating. Enacting them requires a systemic commitment, but the result is a more equitable and responsive approach to neurodiversity—one that recognises the strengths of all communities rather than prioritising those who fit within dominant clinical norms.

Conclusion

Western frameworks of ADHD have guided research, diagnosis and treatment for decades, yet they remain limited in providing effective support for Indigenous neurodivergent individuals. These models often rest on cultural assumptions about behaviour, self-regulation and institutional conformity that differ significantly

from Indigenous modes of knowing, relating and learning. This misalignment perpetuates high rates of misdiagnosis, disengagement, and the marginalisation of Indigenous perspectives in clinical, educational and policy arenas.

Indigenous approaches throughout Australasia and the Pacific offer alternative ways of understanding ADHD. They draw on collective values, ancestral narratives, relational interpretations and spiritual meaning. Whether in Te Whare o Oro and Mahi a Atua in Aotearoa, Bigaagarri in Aboriginal Australia or culturally integrated pedagogies in the Pacific, these frameworks centre neurodiversity as a valued aspect of community life. They emphasise support through whānau, community and land, and view traits such as impulsivity, creativity and responsiveness as integral expressions to be understood rather than symptoms to be controlled.

Achieving the potential of these frameworks requires systemic change. Diagnostic tools must be revised or newly devised to meaningfully integrate Indigenous worldviews. Indigenous scholars and communities need to shape research through relational, culturally specific methods. Clinicians and educators must move beyond cultural awareness towards actively challenging colonial assumptions in everyday practice. Crucially, Indigenous communities should be empowered to define neurodivergence according to their own principles.

Moving past Western diagnoses is not merely a question of inclusion—it is a matter of justice. A more equitable and culturally attuned approach to ADHD must recognise the full range of human variation and honour the knowledge systems that have sustained it. Embracing Indigenous understandings can shift current practice, minimise harm and create supportive pathways that are relevant, affirming and guided by local realities.

Authors' biographies

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Byron Rangiwai (Ngāti Manawa, Ngāti Whare, Ngāti Porou, Ngāi Tūhoe) is an Associate Professor of Māori and Indigenous Research at Unitec and an Adjunct Associate Professor at Edith Cowan University, Australia. He holds two PhDs and has published 77 peer-reviewed journal articles. His research specialises in Kaupapa Māori methodology, Māori ADHD and neurodivergence, critical Indigenous disability studies, and Indigenous theology. His pioneering Pīwakawaka framework offers a Māori conceptualisation of ADHD. In November 2026, he co-presented research on rongoā Māori and ADHD at the International Network of Indigenous Health, Knowledge and Development Conference in Rarotonga, Cook Islands.

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Glossary

āhua	individual expression
Aotearoa	New Zealand
atua	ancestral deities
karakia	prayer
kaupapa Māori	guided by Māori principles, values, and worldviews
Kaupapa Māori	research approach that is informed by Māori philosophy and principles and is by Māori, for Māori
mana	prestige, authority, spiritual power
manaakitanga	hospitality
mana motuhake	self-determination, autonomy, sovereignty
Māori	Indigenous peoples of New Zealand
mātauranga Māori	Māori knowledge
Māui	demigod and trickster figure known for courage, ingenuity and challenging norms
pūrākau	ancestral narratives, stories
rangatahi Māori	Māori youth
roro	brain

tamariki	children
tapu	sacred, restricted
Uepoto	atua associated with resilience, overcoming adversity, and transformation
wairua	spirit, spirituality
whakapapa	genealogy
whānau	family
whenua	land

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