

Michigan Quality Improvement Consortium



DIAGNOSIS OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) FOR CHILDREN AND ADOLESCENTS

The following guideline recommends procedures for evaluation of attention-deficit/hyperactivity disorder.

Eligible Population	Recommendation and Level of Evidence
Children and adolescents to age 18 at risk for ADHD See MQIC Treatment of ADHD for Children and Adolescents guideline	Identification of patients who may have ADHD: Consider an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity when these symptoms have been present for at least six months to a degree that is maladaptive and inconsistent with developmental level [B]. - ADHD is underdiagnosed in Asian, African American and Latinx children. - Children < 4 years old: there is insufficient evidence to recommend diagnosis or treatment for ADHD other than parent training in behavior management. Diagnosis: Clinical diagnosis is based on observed behavior by those who are directly in contact with the individual, i.e. parents, caregivers, teachers, clinicians [B]. To make a diagnosis of ADHD, use criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5®): [B] - Six or more specific symptoms of inattention and/or six or more specific symptoms of hyperactivity and impulsivity (as listed in DSM-5®) five or more symptoms if age 17 or older. Several hyperactive-impulsive or inattentive symptoms should be present before 12 years of age and occur in at least two different settings (e.g., home, school, work, or social settings). - There should be clear evidence that the symptoms interfere with, or reduce the quality of social, academic, or occupational functioning. - Symptoms cannot be explained by a medical disorder, pervasive developmental disorder, psychotic disorder, anxiety disorder, substance use, learning disorder or intellectual disability, or other psychiatric disorder. Significant co-morbidity with other psychiatric/behavioral disorders (up to 75% of patients with ADHD) such as bipolar disorder, oppositional defiant disorder (ODD), substance abuse, anxiety, OCD, and depression. Tics and sleep problems are also common co-morbid conditions, as are language, learning, and autism spectrum disorders. Co-morbid conditions should be screened for, diagnosed and treated accordingly [B]. Indication for mental health referral may include evaluation of co-existing conditions and mental health disorders. In addition to a clinical interview, assessment should include use of standardized diagnostic rating scales that detect symptoms of ADHD, and screen for other causes of symptoms and/or co-morbid conditions. This would include parents, teacher, and when appropriate, child. Diagnostic tests should NOT be ordered routinely in the evaluation of children with suspected ADHD, e.g. neuroimaging, electroencephalogram, and continuous performance testing [C]. Psychological and neuropsychological testing may be useful in complicated clinical presentations; however, such tests are NOT typically indicated for routine diagnosis of ADHD and are not a substitute for the clinical interview. If provider suspects academic difficulty, consider referral to the school district for related testing. When school accommodations are indicated or additional testing considered, such as when evaluating potential learning disabilities, request for an Individualized Education Plan (I.E.P.) or 504 plan should be made in writing to the school district.

¹The American Academy of Pediatrics recommends using its [ADHD Toolkit](#) and stocking the office with questionnaires, diagnostic checklists and patient education materials.

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core assessment steps. It is based on The American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention Deficit/Hyperactivity Disorder in Children and Adolescents, Subcommittee on Attention-Deficit/Hyperactivity Disorder, Pediatrics October 2019, 144 (4). Individual patient considerations and advances in medical science may supersede or modify these recommendations.

