ICSI has endorsed with qualifications the American Academy of Pediatrics (AAP's) guideline, ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents, and Supplement. Both have been reviewed by the 2014 ICSI ADHD work group, utilizing the ICSI Endorsement Process: C. Dobie, W. Donald, K. Elhai, J. Hoffman-Jecha, J Huksahl, R. Karasov, C. Kippes, C. Myers, J. Peters, L. Steiner, M. Wild Crea. Additional work group information, including the members declared conflicts of interest.

Access this guideline and supplement through the links below:

American Academy of Pediatrics – ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

American Academy of Pediatrics – Implementing the Key Action Statements: An Algorithm and Explanation for Process of Care for the Evaluation, Diagnosis, Treatment, and Monitoring of ADHD in Children and Adolescents

The American Academy of Pediatrics (AAP) is not a sponsor of, affiliated with nor does it endorse ICSI or the ICSI ADHD work group. AAP has not reviewed ICSI’s process for endorsement of guidelines. The following ICSI endorsement and conclusions are solely the consensus of the ICSI ADHD work group using the ICSI Endorsement Process.

To fully utilize these materials and access their complete methodology, refer to AAP Classifying Recommendations for Clinical Practice Guidelines.

**THE ICSI ADHD WORK GROUP FULLY ENDORSED THE FOLLOWING RECOMMENDATIONS**

**Topic: Diagnosis**

<table>
<thead>
<tr>
<th>AAP recommendation is fully endorsed by the ICSI ADHD work group</th>
<th>Quality of Evidence and Strength of Recommendation as evaluated by AAP</th>
</tr>
</thead>
</table>
| “The primary care clinician should initiate 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.” | Quality of Evidence: B  
Strength of Recommendation: Strong |

**Benefits:**

In a considerable number of children, ADHD goes undiagnosed. Primary care clinicians’ systematic identification of children with these problems will likely decrease the rate of undiagnosed and untreated ADHD in children.

**Harms:**

Children in whom ADHD is inappropriately diagnosed might be labeled inappropriately, or another condition might be missed, and they might receive treatments that will not benefit them.

**Benefits-Harms Assessment:**

The high prevalence of ADHD and limited mental health resources require primary care pediatricians to play a significant role in the care of their patients with ADHD so that children with this condition receive the appropriate diagnosis and treatment. Treatments available have shown good evidence of efficacy, and lack of treatment results in a risk for impaired outcomes.”
### “In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorders or other neurodevelopmental disorders), and physical (e.g., tics, sleep apnea) conditions.”

**Quality of Evidence:** B  
**Strength of Recommendation:** Strong

**Benefits:**  
Identifying coexisting conditions is important for developing the most appropriate treatment plan.

**Harms:**  
The major risk is misdiagnosing the conditions and providing inappropriate care.

**Benefits-Harms Assessment:**  
There is a preponderance of benefit over harm.

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### Topic: Management

**AAP recommendation is fully endorsed by the ICSI ADHD work group**

**“The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home.”**

**Quality of Evidence:** B  
**Strength of Recommendation:** Strong

**Benefits:**  
The recommendation describes the coordinated services most appropriate for managing the condition.

**Harms:**  
Providing the services might be more costly.

**Benefits-Harms Assessment:**  
There is a preponderance of benefit over harm.

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**“For preschool-aged children (4-5 years of age), the primary care clinician should prescribe evidence-based parent and/or teacher-administered behavior therapy as the first line of treatment (Quality of Evidence: A/Strong Recommendation), and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child’s function. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (Quality of Evidence: B/Recommendation).”**

**Quality of Evidence:** A/B  
**Strength of Recommendation:** Strong/Recommendation

**Benefits:**  
Both behavior therapy and methylphenidate have been demonstrated to reduce behaviors associated with ADHD and improve function.

**Harm:**  
Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas methylphenidate has some potential adverse effects.

**Benefits-Harms Assessment:**  
Given the risks of untreated ADHD, the benefits outweigh the risks.

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**“For elementary school-aged children (6-11 years of age), the primary care clinician should prescribe FDA approved medications for ADHD (Quality of Evidence: A/Strong Recommendation) and/or evidence based parent and/or teacher administered behavior therapy as treatment for ADHD, preferably both. The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended release Clonidine (in that order). The school environment, program, or placement is a part of any treatment plan.”**

**Quality of Evidence:** B/A  
**Strength of Recommendation:** Strong/Strong
Benefits:
Both behavior therapy and FDA-approved medications have been demonstrated to reduce behaviors associated with ADHD and improve function.

Harms:
Both therapies increase the cost of care, and behavior therapy requires a higher level of family involvement, whereas FDA-approved medications have some potential adverse effects.

Benefits-Harms Assessment:
Given the risks of untreated ADHD, the benefits outweigh the risks.

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| “For adolescents (12-18 years of age), the primary care clinician should prescribe FDA-approved medications for ADHD with the assent of the adolescent and may prescribe behavior therapy as treatment for ADHD, preferably both.” | Quality of Evidence: A  
Strength of Recommendation: Strong |

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THE ICSI ADHD WORK GROUP ENDORSED WITH QUALIFICATIONS THE FOLLOWING AAP RECOMMENDATIONS

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| “To make a diagnosis of ADHD, the primary care clinician should determine that Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR)* criteria have been met (including documentation of impairment in more than 1 major setting), and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child’s care. The primary care clinician should also rule out any alternative cause.” | Quality of Evidence: B  
Strength of Recommendation: Strong |

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QUALIFICATION FOR ENDORSEMENT:
* The ICSI ADHD work group recognized the new release of the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition (DSM-5), and recommends that the primary care clinician should use the updated criteria.