



Short Screening Measures for Child Autism and AD/HD

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Abstract: (1) Background: The U.K.'s National Health Service has a large and growing problem with overdiagnosis of Autism and AD/HD in primary school children. General medical practitioners in the U.K. currently undertake the identification and screening of children suspected of having Autism or Attention Deficit/Hyperactivity Disorder, but the recommended screening questionnaires contain far too many extraneous symptoms and are likely to lead to overdiagnosis of the two disorders. The objective of this article is to provide two brief and conservative core symptom-based questionnaires that GPs can use to diagnose Autism and AD/HD. (2) Methods: Expert review of the DSM-IV and revised DSM-5 criteria for childhood Autism and AD/HD. Preparation of a core symptoms-based Child Autism Questionnaire and Child AD/HD Questionnaire for use by GPs to diagnose these two disorders in children without referral to a pediatrician or psychiatrist. (3) Results: The GPs firstly must conduct a comprehensive physical examination of the child to ensure that the child has no uncorrected hearing or eyesight problems or dyslexia. The GP should also order an IQ test from a qualified psychologist to assess the child's mental capacity. GPs can then use the Child Autism Questionnaire or the Child AD/HD Questionnaire, as appropriate, to interview the child's parent or guardian, have the child observed by a nurse in the case of suspected Autism or obtain a report from the child's primary teacher in the case of suspected AD/HD, then make a clear recommendation to the NHS as to whether the child qualifies for in-home support or in-school support. (4) Conclusion: Accurate screening by GPs will go a long way toward eliminating overdiagnosis of childhood autism and AD/HD at low cost to the NHS and to parents.

Keywords: Childhood Autism, Childhood AD/HD, National Health Service, GP or school counsellor diagnosis, Core-symptom questionnaires

INTRODUCTION

In the U.K., as in most Western countries, the reported prevalence of Autism and AD/HD, two neurological disorders that affect children's schoolwork and everyday life, is increasing rapidly [1]. For Autism, or Autism Spectrum Disorder as it is now called, the proportion of schoolchildren identified as qualifying for NHS support reached 3.1% in 2025, up from a fraction of a percent in 2000. For AD/HD, the teacher and parentally-reported prevalence among primary school children reached 5.2% in 2025, up from an estimated 0.8% in 2000. Whereas previous underdetection of Autism and AD/HD remains one explanation, the more likely explanation is overemphasis on mental health by the media, coupled with the loosening of diagnostic criteria in the American Psychiatric Association's highly influential fifth edition of the DSM mental disorder diagnostic system. Autism is greatly overdiagnosed because of the DSM-5's [2] introduction of the overly broad specification of Autism Spectrum Disorder to replace the separate Autism Disorder and Asperger's Disorder diagnoses used in the DSM-IV [3]. Attention Deficit/Hyperactivity Disorder, AD/HD, also is overdiagnosed, this time because clinicians are failing to rule out dyslexia and other causes of poor academic performance and misbehavior.

General medical practitioners in the U.K. are currently allowed to screen for Autism or Attention-Deficit/Hyperactivity Disorder in children but must refer the child to a pediatrician, child specialist psychiatrist, or educational psychologist for a confirming diagnosis [1]. Only in the U.S.A., among major Western countries, are GPs, or primary care physicians as they are called there, permitted to diagnose children's Autism and AD/HD, although Australia is moving toward allowing GPs to do so after special training. There is an urgent need for GPs to be allowed to perform these diagnoses in the U.K. because the specialists at present approved to diagnose them have long waiting lists and charge fees which, even after government health rebates, are far higher than GPs would charge [4]. The purpose of the present article is to show how GPs, without training, can efficiently and conservatively diagnose these two disorders by using the two new core symptom-based questionnaires provided here.

METHODOLOGY

The key to getting the NHS on board with GP diagnosis is firstly to expose what is wrong with the current method of assessing childhood Autism and AD/HD applicants, and to demonstrate why the use of GPs and the core-symptom diagnostic method is preferable.

Because the core-symptom approach is a new methodology, an explanation of it is in order. The core-symptom approach corresponds with the practical and efficient procedure recommended by leading U.S. psychiatrist Dr. Allen Frances, who was Chair of the DSM-IV Task Force and the most prominent critic of the changes made in the DSM-5 [5]. It is based on the proposition that if the presenting patient does not have the *core symptoms* of the disorder, then the patient cannot possibly *have* that disorder. The core symptoms are those few that are individually necessary and jointly sufficient to diagnose the disorder. Other symptoms are irrelevant and cannot substitute for the core symptoms.

The two core-symptom questionnaires (freely available in this article) take the form of a *semi-structured interview* conducted by the GP with the child's primary care-taking parent or carer. The interview is semi-structured in that the core-symptom questions are fixed but are answered in an open-ended manner, with the GP prompting for examples if the answer is not clear. This method is preferable to the typical fully-structured questionnaire favored by academic researchers and by the NHS because parents and carers are more comfortable with open discussion and they see that what they have to say about their child is listened to and valued [6]. In cases of suspected Autism, while the parent or carer is being interviewed, the child is observed and interacted with separately by a trained nurse in the adjoining doctor's office playroom. In cases of suspected AD/HD, the parent or carer, before being interviewed, is required to obtain for the GP a written report from the child's preschool or primary school detailing any concentration or behavioral problems the child seems to have that would lead to the suspicion of AD/HD, and then the GP must interview the parent or carer and the child *together* to check whether the problems are also occurring at home.

The emphasis in both questionnaires is on reaching a best-judgment Yes/No diagnosis. Partial or tentative diagnoses are of no help because a definite decision about support has to be made.

CHILDHOOD AUTISM DIAGNOSIS

Autism is an inborn, permanent, incurable disorder which is diagnosable only by observation because there are no neurological or other medical tests for it. Moreover, it cannot be treated other than by symptom-targeted behavior therapy. Genuine so-called Classic Autism has a worldwide prevalence of 0.8% [6] but is being diagnosed in the U.K. at a rate of more than 3% [1] following the publication in 2013 of the DSM-5.

In the DSM-5, Autism is now called Autism Spectrum Disorder and is considered to be on a “spectrum” or continuum of severity ranging from the usually high-functioning form of autism known as Asperger’s Syndrome (Level 1), to symptomatic but largely non-dysfunctional Mild to Moderate Autism (Level 2), to severely or profoundly dysfunctional Classic Autism (Level 3). Asperger’s Level 1 autism does not qualify for NHS support. Level 2 mild to moderate autism also does not qualify for NHS support. This leaves only Level 3 severe or profound autism as qualifying for NHS support, and reportedly what is happening is that parents or carers whose child has only Level 2 mild to moderate autism, and in some cases even only Level 1 Asperger’s, are pressuring specialists to say that the child has disabling Level 3 autism.

Criticism of the Current NHS Assessment of Autism

The questionnaire that the NHS recommends for GPs to use for an initial screening is the Childhood Autism Spectrum Test (CAST) developed 2002 by Cambridge University psychiatrists [7]. It was originally called the Childhood Asperger Syndrome Test and renamed later without any change to the questionnaire. This is its major problem because it does not differentiate between Asperger’s, which is usually high functioning, and Autism, which at a clinically severe level is always low functioning. Another problem is that the CAST questionnaire appears to contain 37 items but six of them are “filler items” that the user may not realize are not meant to contribute to the total score. Also, by the present author’s count, only three of the 37 items are relevant for diagnosing Autism and one of these is listed as a filler item! The CAST is entirely unsatisfactory and misleading.

Core Symptom-Based Child Autism Questionnaire

Autism diagnosis requires the parent or carer to bring the child to the GP’s office, which must be suitably equipped with a playroom and qualified nurse to observe the child while the GP is interviewing the parent or carer. For those GPs who are unfamiliar with childhood autism it is strongly recommended that they investigate autism videos available on YouTube before making a diagnosis. Recommended are the following three: firstly, “Autism vs. Asperger’s,” in which the presenter explains the basic difference between the two disorders and discusses the difference between the DSM-IV and the DSM-5 classifications; secondly, “5 Signs You Do NOT Have Autism,” which contrary to its title positively describes the core symptoms of Autism, although mention should have been made of the special abilities that some autistic children have, which include remarkable feats of memory as portrayed in the Dustin Hoffman movie “Rain Man” or prodigious musical ability as in the blind Japanese classical pianist Nobu Tsuji whose concerts can be seen on YouTube; and lastly, prototypical Asperger’s symptoms can be witnessed in the ABC TV series “Austin,” starring the very

likable Michael Theo, also available in the U.K. on BBC or ITV, or worldwide in excerpts on YouTube.

Autism Disorder: The three core symptoms of Autism Disorder, or Classic Autism, for the GP to ask the parent or carer about and the nurse to look for are: (1) extremely limited spoken language, (2) reluctance to acknowledge the presence of and respond to others, and (3) stereotyped, repetitive mannerisms. All three symptoms must be clearly observable and permanently present. This is Level 3 autism and is graded as severe or profound depending on the degree of dysfunction and the amount of support needed.

Asperger's Disorder: Asperger's Disorder is distinctly different from Autism Disorder and is at the other end of the autism "spectrum." It is distinguishable by the same core symptoms but at much lower levels, namely, (1) no spoken language problems, but with a tendency to be overly literal, (2) no social interaction failure, but with a tendency toward shyness, and (3) few if any unusual mannerisms. Technically this is Level 1 autism and no support is needed.

Mild to Moderate Autism: The overdiagnosis problem is with Level 2. If the child shows symptoms of Autism Disorder but only to a mild and non-dysfunctional degree, the child should *not* be diagnosed with Autism. There are two good reasons for this. One reason is stigma: the child will always be regarded as a bit strange and will often be rejected by other children if he or she becomes known as autistic and at the same time other people will almost unavoidably see the parents as somehow to blame for having produced an autistic child [8]. The second reason is that there is little or no school-based dysfunction, so to claim school support for it is essentially fraudulent.

IQ Testing for School Placement

The most useful contribution the GP can make in cases of genuine Autism Disorder is to decide whether the child has the *intellectual capacity* to be able to attend regular school. For this, the GP or nurse will need to arrange for the child to be given an IQ test unless a suitable IQ test has recently been given. This is a very important move because the most common problem that children with Autism have is that they have lower than average inborn intellectual ability, or innate IQ [9]. There is only one test suitable for measuring the child's innate IQ. This is the Raven's Colored Progressive Matrices test, a non-verbal, culture-free, pictorial puzzle-solving test that can be administered from about age 5 onwards [10]. The GP or nurse should contact Pearson Clinical, the company that now owns and supplies the Raven's tests, to find out which clinical psychology practitioners in the area are using Raven's tests and are experienced in doing children's IQ assessments. GPs are most likely to seeing children with an IQ above 70 (a score of 7 or more items correct on the 36-item Raven's CPM test) whose parents or carers are planning to send them to a regular school, while those children with an IQ below 70 will probably be headed for a special school or institutional care.

The Child Autism Questionnaire is given in Table 1.

Table 1: Child Autism Questionnaire.**CHILD AUTISM QUESTIONNAIRE**

CHILD _____

Age _____

PARENT/CARER _____

Date/time _____

CLINICIAN _____

Date/time

(if 2nd visit) _____

Preliminary note. To diagnose the full range of autism you need to have a child's playroom and supervisory nurse available at your practice. The nurse will need half an hour or so to interact with the child to assess verbal skills and social responsiveness, and to look for the presence of stereotyped, repetitive behavior. This is done while you are interviewing the parent or guardian.

Step 1. Call the parent or carer requesting the diagnosis and arrange a time to come in with the child, and be sure to record the child's first name so that you and the nurse can use it. Inform the parent or carer that you would like to have [first name] assessed by a psychologist to get an idea of _____'s mental ability (this is the Raven's IQ test). If this is refused, explain that you need this to make a proper assessment, and without it you cannot take the appointment.

When you receive the result (Raven's CPM score translated to an IQ range of mean 100, standard deviation 15), enter it here: _____

Step 2. While the child is in the playroom with the nurse for observation, interview the parent or carer about the Autism core symptoms. You can vary the wording a little if you think that will help, then listen carefully to the parent or carer's answer and ask for examples if the decision is not clear. After each question, make your judgment in one of the answer boxes below it.

- (1) "How would you say that _____'s speech development compares with others of the same age?"

☐ Below normal ☐ Normal ☐ Above normal

- (2) "What about _____'s ability to relate to other children or adults?"

☐ Very limited ☐ Somewhat limited ☐ Normal

- (3) "Lastly, does _____ have any unusual habits such as repetitive hand movements, or walking on tip-toes?"

☐ Yes, often ☐ Rarely ☐ Never

Step 3. After they have left, meet with the nurse and ask the same three questions, discussing and resolving any differences from your judgments.

Interpretation of ratings. Autism only if all left boxes are ticked. Asperger's disorder if left box for symptom 1 is *not* ticked, and *middle* box is ticked for symptom 2 and symptom 3. Decide these first and then classify any other pattern of answers as "mild autism only."

Diagnosis (CHOOSE ONE): ☐ Classic Autism ☐ Asperger's Disorder ☐ Mild autism only

CHILDHOOD AD/HD DIAGNOSIS

The DSM-5 requires the attention-deficit or hyperactivity-impulsivity symptoms to be present in *two different settings*, most importantly the home setting as well as the school setting. The difficulty here is that parent and teacher judgments of AD/HD symptoms often differ and really the only way for the GP to resolve this is to interview the parent or carer and the child *together* about what happens at home. As we will see, however, school attention and behavior problems are much more likely to be due to causes other than the mysterious "ADHD."

Criticism of the Current Assessment of AD/HD

The NHS recommends the use of two measures to screen for AD/HD. The first is the Swanson, Nolan and Pelham Teacher and Parent Rating Scale, the SNAP-IV developed by University of California, Irvine psychologist James Swanson and colleagues in 2011 [11]. The full version has 90 questions - far too long for any health professional, let alone a GP, to administer. It could be used as a 20-item version because items 1-10 are inattention symptoms and items 11-20 are hyperactivity-impulsivity symptoms, but the scoring of each item ranges from 0 (not at all) to 3 (very much) which means that the cut-off score of 17+ for parental report and 20+ for teacher report could be ascertained in many different ways - for example the latter score could be obtained with 20 ratings of 1 (just a little) or 10 ratings of 2 (quite a bit) on just the AD symptoms only or on the HD symptoms only. The other measure recommended to be used in conjunction with the SNAP is the Conners Comprehensive Behaviour Rating Scale, CBRS, developed in 1969 by a Harvard University psychologist [12]. Initially consisting of 73 items, it was reduced by factor analysis to 39 items. Inspection shows, however, that there is only one item, item 8, that measures inattention, and only one item, item 5, that measures hyperactivity, with the other 37 items measuring other completely ADHD-irrelevant behaviors. This terrible measure should not be used.

Ruling Out Other Likely Causes of AD/HD

All children showing learning difficulties at school should, if they have not already, be tested for possible sensory problems. These include uncorrected *poor eyesight*, noting that myopia is increasing with children's years of peering at phones and computer screens both at home and at school [13], and uncorrected *poor hearing* which has probably increased in prevalence with children's use of music headphones. These problems can be checked by ordering an optometric or audiometer test. Once eyesight and hearing problems are ruled out, the child should then be tested for *dyslexia*, or "word blindness," which is a surprisingly prevalent and uncorrectable neurological problem estimated to affect one in 10 school-aged boys and one in 20 school-aged girls regardless of their intelligence [14]. Dyslexia, it should be noted, is the *only* disability for which extra time for tests and exams should be allowed.

Next to be checked are what the DSM-5 [2] describes as “intellectual development disorders.” These are made up of specific learning disorders, called specific because they refer to the child’s consistently below-average performance in *either* arithmetic, or reading, or written composition. But what has to be realized is that by far the most likely cause of problems with school learning and academic performance is that the child is among those approximately one third of children who are born with a *well below-average innate IQ* - which will *not* improve or “develop” over time and will place a lifelong limitation on the child’s ability to learn at school and afterwards will determine the level of employment that he or she will be capable of handling [15]. The most valid test for innate IQ in children below the age of eight is again the Raven’s Colored Progressive Matrices test, described earlier in conjunction with Autism. What the GP should be alert for is kindergarten or first-grade children with a Raven’s CPM score well below 18 out of 36, which would translate to the current U.K. average IQ of 99 as measured by a conventional IQ test such as the Stanford-Binet or the Wechsler.

Only if the child has no sensory limitations, no dyslexia, and no IQ problems can the GP then consider possible Attention-Deficit Disorder or Hyperactivity-Impulsivity Disorder.

Core Symptom Diagnosis of AD and HD

Attention-Deficit Disorder. Attention-Deficit Disorder, the “AD” of AD/HD, has two jointly necessary core symptoms, which are (1) inability to concentrate on assigned tasks followed by (2) failure to finish tasks once begun. These symptoms must be jointly and constantly present not only at school but at home as well. Genuine attention-deficit disorder is quite rare, but if it is definitely present with dyslexia ruled out, a short-term prescription of medication may help. The preferred medication according to some recent research is a methylphenidate stimulant such as Ritalin, which seems to be safer than amphetamine stimulants because of much lower risk of long-term usage causing psychosis or mania [16]. But GPs should know that the risk of dependency on stimulants is great and so it is better to try in the first instance a so-called *informed placebo*, where the parent or guardian is truthfully informed that in many cases placebo treatment has been shown to be effective [17].

Hyperactivity-Impulsivity Disorder. Hyperactivity-Impulsivity Disorder, the “HD” of AD/HD, on the other hand, is becoming more prevalent with mothers returning to work earlier and divorces also occurring at an earlier age. This suggests that hyperactivity-impulsivity, unlike attention-deficit, is a learned problem rather than a neurological disorder and, consequently, medication should *not* be considered. Thankfully, most children who are hyperactive from a young age, and this is mostly boys, eventually grow out of it and learn to keep their impulsiveness under control [5]. Sedative medication may reduce hyperactivity but it is clearly unethical to “dope kids down” and this is not a solution. A much better procedure for teachers with problem children in the class is to use a classroom *token reward system* which applies learning theory principles to reward good classroom behavior [18]. Classroom-learned control of hyperactivity will hopefully carry over to the home setting, and for persistent problems with individual children there are usually parental support groups in the area where helpful suggestions can be obtained.

The Child AD/HD core-symptom questionnaire is given in Table 2.

Table 2: Child AD/HD Questionnaire.**CHILD AD/HD QUESTIONNAIRE**

CHILD _____

Age _____

PARENT/CARER _____

Date/time _____

CLINICIAN _____

Date/time
(if 2nd visit) _____Step 1. For suspected AD or HD, the following conditions need to be ruled out:

- | | | |
|--|------------------------------|-----------------------------|
| a. IQ of 70 or below (or Raven's equivalent) | ☐ Yes | ☐ No |
| b. Poor eyesight even with glasses (eyechart test) | ☐ Yes | ☐ No |
| c. Poor hearing (audiometer test) | ☐ Yes | ☐ No |
| d. Dyslexia (request test if in doubt) | ☐ Yes | ☐ No |

Interpretation: If YES to any, STOP HERE. (This is because any of these problems is sufficient to cause AD or HD symptoms.) Otherwise, proceed with Step 2.

Step 2. Ask the parent/carer on the phone to get a short report emailed to you by the pre-school or school on whether the child has persistent difficulty maintaining attention or behaves disruptively during lessons and group activities. (WITHOUT this report, you CANNOT proceed.)

Then make an appointment with the parent or carer, and after the usual preliminaries, ask:

- (1) "Does _____ have problems at home concentrating on and finishing whatever he (or she) is supposed to be doing?" ☐ Yes ☐ No
- (2) "Or is _____ restless, always on the go, and often seeming to act impulsively?" ☐ Yes ☐ No

Ask any further questions necessary to decide which is the main problem: Attention-Deficit Disorder or Hyperactivity-Impulsivity Disorder.

Interpretation: Check that the same main disorder is reported by the parent or carer AND the preschool or school. Only if you have this confirmation can you issue a main disorder diagnosis.

Main Disorder: (CHOOSE ONE): ☐ Attention-Deficit Disorder ☐ Hyperactivity-Impulsivity Disorder ☐ Neither

It is important to emphasize that children with AD/HD are not going to benefit from extra teaching or special consideration during tests and exams. AD/HD-diagnosed children should therefore *not* qualify for the NHS or be given support by the school.

CONCLUSIONS

There are far too many schoolchildren in the U.K. wrongly being diagnosed with Autism or so-called “ADHD” for which they are receiving in-school assistance from the government. This problem can go a long way toward being solved by allowing general medical practitioners, GPs, to more conservatively diagnose these disorders by using the Child Autism Questionnaire and Child AD/HD Questionnaire provided here.

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