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Comparative Effectiveness Review

Number xx

Diagnosis of Attention-Deficit/Hyperactivity Disorder in Adults: A Systematic Review

Prepared for:

Agency for Healthcare Research and Quality

U.S. Department of Health and Human Services

5600 Fishers Lane

Rockville, MD 20857

www.ahrq.gov

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Preface

The Agency for Healthcare Research and Quality (AHRQ), through its Evidence-based Practice Centers (EPCs), sponsors the development of systematic reviews to assist public- and private-sector organizations in their efforts to improve the quality of healthcare in the United States. These reviews provide comprehensive, science-based information on common, costly medical conditions, and new healthcare technologies and strategies.

Systematic reviews are the building blocks underlying evidence-based practice; they focus attention on the strength and limits of evidence from research studies about the effectiveness and safety of a clinical intervention. In the context of developing recommendations for practice, systematic reviews can help clarify whether assertions about the value of the intervention are based on strong evidence from clinical studies. For more information about AHRQ EPC systematic reviews, see https://effectivehealthcare.ahrq.gov/about/epc/evidence-synthesis

AHRQ expects that these systematic reviews will be helpful to health plans, providers, purchasers, government programs, and the healthcare system as a whole. Transparency and stakeholder input are essential to the Effective Health Care Program. Please visit the website (www.effectivehealthcare.ahrq.gov) to see draft research questions and reports or to join an e-mail list to learn about new program products and opportunities for input.

If you have comments on this systematic review, they may be sent by mail to the Task Order Officer named below at: Agency for Healthcare Research and Quality, 5600 Fishers Lane, Rockville, MD 20857, or by email to epc@ahrq.hhs.gov.

|  |  |
| --- | --- |
| Mamatha S. Pancholi, M.S.  Acting Director  Agency for Healthcare Research and Quality  Christine Chang, M.D., M.P.H.  Director  Evidence-based Practice Center Program  Center for Evidence and Practice Improvement  Agency for Healthcare Research and Quality | Therese Miller, Dr.P.H.  Director  Center for Evidence and Practice Improvement  Agency for Healthcare Research and Quality  Meghan Wagner, Pharm.D., M.B.A.  Task Order Officer  Center for Evidence and Practice Improvement  Agency for Healthcare Research and Quality |

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Key Informants

In designing the study questions, the EPC consulted several Key Informants who represent the end-users of research. The EPC sought the Key Informant input on the priority areas for research and synthesis. Key Informants are not involved in the analysis of the evidence or the writing of the report. Therefore, in the end, study questions, design, methodological approaches, and/or conclusions do not necessarily represent the views of individual Key Informants.

Key Informants must disclose any financial conflicts of interest greater than $5,000 and any other relevant business or professional conflicts of interest. Because of their role as end-users, individuals with potential conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any conflicts of interest.

The list of Key Informants who provided input to this report follows:

[to be inserted in the final report]

Technical Expert Panel

In designing the study questions and methodology at the outset of this report, the EPC consulted several technical and content experts. Broad expertise and perspectives were sought. Divergent and conflicted opinions are common and perceived as healthy scientific discourse that results in a thoughtful, relevant systematic review. Therefore, in the end, study questions, design, methodologic approaches, and/or conclusions do not necessarily represent the views of individual technical and content experts.

Technical Experts must disclose any financial conflicts of interest greater than $5,000 and any other relevant business or professional conflicts of interest. Because of their unique clinical or content expertise, individuals with potential conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any potential conflicts of interest identified.

The list of Technical Experts who provided input to this report follows:

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Peer Reviewers

Prior to publication of the final evidence report, EPCs sought input from independent Peer Reviewers without financial conflicts of interest. However, the conclusions and synthesis of the scientific literature presented in this report do not necessarily represent the views of individual reviewers. AHRQ may also seek comments from other Federal agencies when appropriate.

Peer Reviewers must disclose any financial conflicts of interest greater than $5,000 and any other relevant business or professional conflicts of interest. Because of their unique clinical or content expertise, individuals with potential nonfinancial conflicts may be retained. The TOO and the EPC work to balance, manage, or mitigate any potential nonfinancial conflicts of interest identified.

The list of Peer Reviewers follows:

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Diagnosis of Attention-Deficit/Hyperactivity Disorder in Adults: A Systematic Review

Abstract

**Objectives.** This evidence report synthesizes the results of evaluations of available tools for diagnosing attention deficit/hyperactivity disorder in adults to inform patients, clinicians, and policy makers.

**Review methods.** Following a detailed published protocol and informed by a technical expert panel, we reviewed the evidence for diagnostic tools. In October 2024, we searched nine research databases from inception, research and guideline registries, reference-mined existing reviews and practice guidelines, and consulted with experts to identify evaluations that compared tools used for the diagnosis of ADHD in people of 18 years or older to a clinical diagnosis. The review will be updated during peer review. Registration CRD42025638106.

**Results.** We identified 117 studies evaluating the diagnostic performance of self-report questionnaires, peer review questionnaires, neuropsychological tests, neuroimaging, electroencephalogram (EEG), diverse biomarkers, clinician tools, combinations of modalities, and tools to identify feigning ADHD.

We found few direct performance comparisons between tests; the strength of evidence (SoE) was often insufficient for evidence statements. There was low SoE for lower clinical misdiagnosis rates (false positive rate in clinical samples) for self-report versus both clinician tools and neuropsychological tests, and for combinations of input versus neuropsychological tests alone. For sensitivity, results favored self-report and combinations of input over neuropsychological tests alone and studies found no difference between self-reports and clinician tools. For specificity, results favored combinations of input over neuropsychological tests alone, and self-reports over clinician tools.

Combinations of input indicated a fair rate of clinical false positive rates, good sensitivity, and acceptable specificity. Self-reports showed good sensitivity and specificity, but often not both in the same study; administration time was short, but agreement with other raters was limited. Peer reports showed limited specificity. Neuropsychological tests reported substantial false positive rates in clinical samples, acceptable sensitivity and specificity, and short administration times. The small number of neuroimaging studies and EEG studies reported acceptable sensitivity and specificity, and short administration time. Clinician tools reported fair sensitivity. All results were rated low SoE. Results for all other key outcomes (e.g., diagnostic concordance between primary care clinicians and specialists) were rated insufficient, either due to lack of studies or wide variation in results.

**Conclusions.** A substantial volume of research for diagnostic performance of tests for ADHD in adults exists, in particular for self-report questionnaires and neuropsychological tests. Multiple different diagnostic modalities have been explored and combinations of input appear particularly promising. Despite the volume, evidence was insufficient for several key outcomes. Performance is associated with the comparator and whether diagnostic tools aim to distinguish between adults with ADHD and neurotypical adults, or adults with other clinical conditions.

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1. Introduction
   1. Background

Attention-deficit/hyperactivity disorder(ADHD) is characterized by persistent symptoms in the domains of inattention, hyperactivity, and impulsivity that often begin in childhood.1 Clinically significant symptoms, especially inattention, persist into adulthood in most individuals.1-5 The lifetime prevalence of ADHD is approximately 5.3%,6 although epidemiological studies that have not required a childhood onset have suggested that its prevalence in adults may be as high as seven percent.7-10 Many adults with ADHD adopt lifestyles that help compensate for their symptoms, they often need to exert excess energy to overcome impairments. Impaired productivity because of poor time management, procrastination, and distractibility can limit work productivity and lower overall quality of life.11 Affected adults are often distressed by their inability to realize their full potential and by persistent symptoms of restlessness, erratic moods, and poor self-esteem.11, 12

ADHD is most often first diagnosed in elementary or middle school age years or, less commonly, in high school or college when increasing academic demands surpass the attentional capacities of the affected person. ADHD can also be first diagnosed in adulthood, when impairments in attention, organization, and impulsivity produce recurrent problems with occupational, social, or family functioning. Adult diagnosis is often difficult because the outward manifestations most readily evident to others, especially hyperactivity and impulsivity, often improve during adolescence and no longer meet diagnostic criteria.13 The symptoms of inattention (e.g., easy distractibility, poor organization, being “spacey,” avoiding and trouble completing tasks that require sustained attention, losing things, forgetfulness) are more subtle and may not reach the level of obvious functional impairment until adulthood, within an occupational setting or a marriage.

The diagnosis of ADHD in adults, as in childhood, is complicated by the overlap of symptoms with other disorders.14, 15 Attention and concentration, for example, can be impaired in persons who have depression, bipolar disorder, anxiety, psychosis, post-traumatic stress disorder, or substance abuse, or in adults who need to perform well in an overdemanding environment or who are highly stressed16 or sleep-deprived. Hyperactivity can be confused with anxiety-related behaviors and the excessive movements of tic and obsessive-compulsive disorders. Impulsivity is often prominent in bipolar and substance use disorders. The accurate diagnosis of adult ADHD is further complicated by individuals who seek stimulant medications to aid cognitive performance, especially college students and highly driven working professionals.17 Stimulants have long been known to improve sustained attention and reduce distractibility in healthy individuals who do not have ADHD,18-22 which may prompt success-oriented individuals to feign symptoms in diagnostic interviews, self-reports, or neuropsychological test assessments to obtain stimulant medications, and some students feign illness to receive academic accommodations, such as extended time on tests, tutoring services, and alternative courses that can improve their grades.

Claims of exceptional diagnostic performance of these tools, the differing measures of performance, and the differing performance characteristics of different versions of a given tool,23 are controversial and often confusing to clinicians, patients, and other stakeholders. In addition, whether the performance of diagnostic tools varies with the characteristics of the participants with ADHD or comparator sample is unknown.24 These diagnostic challenges can complicate the accurate and reliable diagnosis of adult ADHD even for experienced mental health clinicians.

Thus, despite established criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), diagnosing ADHD in adults remains challenging due to the frequent absence of hyperactivity and impulsivity symptoms, the subtlety of inattention symptoms, the inaccuracy of recall in adults for their retrospective assessments of ADHD symptoms in childhood (required to meet DSM-5 diagnostic criteria), the common symptom overlap with other mental health conditions,13-15 and the large number of individuals,17-22 including healthy college students,25, 26 who feign symptoms to obtain stimulant medications. Moreover, the DSM-5 diagnostic criteria, developed primarily for children, may not be equally suitable for adult diagnosis, and its requirement that symptoms begin before age 12 has been debated.27-31 The absence of a true and undisputed “gold-standard” to verify an ADHD diagnosis, the variability in performance of diagnostic tools among clinicians and settings, and the lack of clear practice guidelines further add to diagnostic complexity.32-35

Furthermore, the diagnosis of ADHD in adults is often made not by mental health specialists, but by primary care physicians and nurse practitioners,36 who may benefit particularly from accurate diagnostic aids. Further, the dispensing of ADHD medications to adults has increased steadily over time.30 The accuracy of diagnosis directly affects the management and treatment of ADHD and may help prevent medication misuse, highlighting the need for effective diagnostic tools and guidelines. The existing standards and guidelines for diagnosing ADHD in adults are limited, however, and the use of diagnostic tools and assessments varies widely in practice.37-39 No clinical practice guidelines for the diagnosis of adults with ADHD have thus far been developed in the United States, though one is in development.40 Moreover, the diagnostic accuracy of tools and assessments used in adult ADHD diagnosis is unclear, and their performance may vary depending on the characteristics of the ADHD participants and comparator samples.23, 24

* 1. Purpose and Scope

This systematic review aims to provide a comprehensive and unbiased assessment of diagnostic tools used to diagnose ADHD in adults to inform patients, clinicians, and policy makers. Commissioned by the Food and Drug Administration (FDA), this Agency for Healthcare Research and Quality (AHRQ) report documents the evidence for the diagnostic performance of existing tools for ADHD. We explore the effects of setting and participant characteristics that may influence the diagnostic performance of available tools. A contextual question is which tools are frequently being used in current clinical practice.

1. Methods

The systematic review followed a protocol that outlines the methods in detail.41 The methodology followed the EPC Methods Guide.42 The review is registered as CRD42025638106. The project was supported by a technical expert panel (TEP) to provide different perspectives of a broad group of interest holders to ensure the evidence report is relevant to a large audience. The panel included multi-disciplinary experts in adult ADHD and well as advocates considering the needs of affected patients as well as family members.

2.1 Key Questions

The systematic review was guided by the following key questions:

* Key Question 1. What is the comparative diagnostic accuracy, unintended consequences, and impact of tools that can be used in the primary care practice setting or by specialists to diagnose ADHD among adults?
  + Key Question 1a: How does the comparative diagnostic accuracy of these tools vary by clinical setting, including primary care or specialty clinic, or patient characteristics, including age, sex, cultural background, and risk factors associated with ADHD?

In addition, a contextual question provided additional information:

* Contextual Question. How frequently are the various tools to diagnose ADHD in adults currently being used?

We addressed the key question in a systematic review documented in detail in the result chapter. Information pertaining to the context question was incorporated into the discussion.

2.2 Logic Model

Figure 1 illustrates the scope of the review.

Figure 1. Logic Model for Diagnosis of ADHD in Adults

A diagram of a diagram

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Notes: ADHD attention deficit hyperactivity disorder, KQ key question

The model shows the population of interest (adults with suspected ADHD) and depicts the key question (diagnostic test performance) and sub-question (effect modifiers). The model also shows outcomes, ranging from side effects of the testing modality (e.g., relevant for invasive tests), to intermediate outcomes such as the diagnostic accuracy established in the study, to final outcomes such as the impact of a diagnosing or misdiagnosing ADHD.

2.3 Search Strategy

The literature search used a combination of known tests to diagnose ADHD and general search terms for diagnostic accuracy studies to identify novel tools. In October 2024 we searched PubMed (biomedical literature), EMBASE (pharmacology emphasis), and PsycINFO (psychological research) without search date restriction and restricted to English language. The search strategy was peer reviewed within the EPC program. We used existing reviews for reference-mining; these were identified through the same databases plus searching the Cochrane Database of Systematic Reviews, Campbell Collaboration, and PROSPERO. We also searched the ECRI repository, G-I-N, and ClinicalKey for published guidelines and used these for reference-mining cited literature. All searches will be updated during the public comment period.

In addition, we leveraged technical experts to ensure that relevant research studies had been identified. We provided a list of included studies, together with all associated publications, and a list of excluded studies to facilitate this process. A Supplemental Evidence And Data for Systematic Reviews (SEADs) portal was available from January 10 to February 4 2025 for this review. Additional data and publications suggested to us from any source, including peer and public review, will be screened applying the outlined eligibility criteria. The search will be updated during peer review.

2.4 Inclusion/Exclusion Criteria

The eligibility criteria for this review are shown in Table 1.

Table 1. Eligibility Criteria

|  |  |  |
| --- | --- | --- |
|  | **Inclusion Criteria** | **Exclusion Criteria** |
| Population | Adults 18 years and older with symptoms of ADHD and without the diagnosis of ADHD; studies reporting on broader age samples, had to report separately for adults | Individuals 17 years of age or younger unless findings are reported separately for older participants |
| Intervention | Any ADHD diagnostic tool used for the diagnosis of ADHD in adults | Studies not reporting on diagnostic performance; non-English language questionnaires and interview guides |
| Comparator | Confirmation of diagnosis by a specialist (reference standard), such as a psychologist, psychiatrist or other healthcare provider using a well validated and reliable process of confirming a clinical diagnosis of ADHD | Comparison to diagnosis with another diagnostic instrument |
| Outcome | Diagnostic accuracy (e.g., sensitivity, specificity, accuracy, area under the curve, positive predictive value, negative predictive value, likelihood ratios, false positives, false negatives); unintended consequences and impact associated with diagnosing ADHD | Provider opinion of tests, cost without performance measure |
| Timing | Diagnostic follow-up must be completed before treatment is initiated | Any other timing |
| Setting | Primary or specialty care settings, including telehealth | Settings where diagnosis is for nonclinical or not research purposes |
| Study Design | Diagnostic accuracy studies | Editorials, nonsystematic reviews, letters, case series, case reports, pre-post studies.  Systematic reviews were not eligible for inclusion but were retained for reference mining |

Included ADHD tests were not limited to a set of pre-specified tools; instead, the review documents all tools that have been evaluated in the scientific literature and for which diagnostic accuracy evidence exists. Studies had to compare to a clinical diagnosis made by a clinician in a formal diagnostic interview, typically enhanced by information from patient questionnaires. We searched databases from inception and we did not apply any publication date restrictions. Studies with data exclusively published in non-English language publications were excluded to ensure transparency. We obtained all published reports providing data on a study (a study is defined by the included participants), including trial records and multiple publications, and consolidated the information into one study record.

2.4.1 Screening Process

We used an online database designed for systematic reviews to screen the literature search output. The team designed detailed citation and full text screening forms to ensure a transparent, consistent, and unambiguous approach. All citations were screened by two independent literature reviewers. Citations found to be potentially relevant by at least one reviewer were obtained as full text. All citations were also screened by a DistillerSR software machine learning algorithm trained by the human reviewers to ensure that no relevant citation was missed. Any citations identified as potentially relevant by the algorithm that were not selected for full text publication review were rescreened for relevance by an independent literature reviewer.

Full text screening applied the detailed eligibility criteria. Training ensured a shared understanding of all inclusion and exclusion criteria. Full text publications were screened by two independent reviewers to reduce errors and bias, and any discrepancy was resolved through discussion in the review team. The screening decisions and reasons for exclusion of publications were tracked in the online database and citation management software. These citations were shared with the technical expert panel and were documented with the review to ensure that the literature flow was transparent and objective.

2.5 Data Extraction and Abstraction

We captured detailed information about eligible studies. One literature reviewer extracted data and categorized information where relevant, and an experienced methodologist checked the data for accuracy and completeness. We designed and pilot tested a detailed form in the software DistillerSR to ensure accuracy and minimize ambiguity.

The data abstraction documented the targeted population and characteristics of all included participants (participants with ADHD and those without). We documented the clinical setting, method of establishing the reference standard (a clinical ADHD diagnosis), and diagnostic tool characteristics (format, name of the tool, employed cut offs, use of a training and validation set). We collected data for a diagnostic meta-analysis where possible (i.e., number of false positives, number of false negatives) along with the summary diagnosis accuracy measures reported by the authors such as sensitivity, specificity, area under the curve, positive predictive value. We differentiated between the diagnostic accuracy to diagnose ADHD and the diagnostic accuracy to detect faking ADHD. For all studies reporting multiple results, we selected the best accuracy performance model (either based on the authors’ opinion, accuracy data, or trying to maximize sensitivity and specificity simultaneously).

2.6 Risk of Bias Assessment

The critical appraisal for individual studies applied criteria consistent with QUADAS 2.43 QUADAS-2 evaluates four domains: *patient selection*, *index test* characteristics, *reference standard* quality, as well as *flow and timing:*

* Patient selection: The domain addresses whether the selection of patients could have introduced bias, taking into account whether the study enrolled a consecutive or random sample, whether the data are not based on a retrospective case-control design, and whether the study avoided inappropriate or problematic exclusions from the patient pool.
* Index test: The domain evaluates whether the conduct or interpretation of the test could have introduced bias, taking into account whether the results of the test were interpreted without knowledge of the results of the reference standard and whether any thresholds or cut-offs were pre-specified (e.g., instead of determined during the study to maximize diagnostic performance).
* Reference standard: The domain evaluates whether the reference standard, its conduct, or its interpretation may have introduced bias, taking into account the quality of the reference standard in correctly classifying the condition and whether the reference standard test results were interpreted without knowledge of the results of the index test.
* Flow and timing: The last domain evaluates whether the conduct of the study may have introduced bias. The assessment takes into account whether the interval between the test and the reference standard was appropriate, whether all patients received the reference standard and whether they received the same reference standard, and whether all patients were included in the analysis.

For each domain, we assessed the potential risk of bias in the study to identify high risk of bias and low risk of bias studies. One literature reviewer assessed risk of bias, and a methodologist reviewed individual studies and rating across studies to ensure accuracy and consistency of ratings. As outlined in the applicability section, we also evaluated for each study and appraisal domain whether there were concerns regarding the applicability of the study results to the review question. This encompassed whether the patients included in the studies matched the review question; whether the test, its conduct, or interpretation differed from the review question; or whether the target condition as defined by the reference standard fully matched the review question. The information was incorporated into the strength of evidence assessment.

2.7 Assessing Applicability

Results are based on the international literature and applicability ratings provided assessments regarding the generalizability of samples, settings, and tool results for U.S. clinical practice. For each study, we assessed the population included in the study to identify studies with narrow eligibility criteria (e.g., looking for a specific subgroup of ADHD participants only), studies that excluded participants with comorbidities, or studies that had more complex participants than typically seen in the community (e.g., dually diagnosed participants). We assessed whether studies described tools not used as recommended or commonly used in practice, the presence of highly trained test team or set up (e.g., analysis via complex machine learning models), or assessors that were not qualified for the assessment. We assessed whether the reference standard was ambiguous, different from standard clinical practice, or insufficiently described.

2.8 Data Synthesis and Analysis

We answered the key question with the available evidence. We broadly differentiated diagnostic tools as

* Self-report questionnaires
* Peer report questionnaires
* Neuropsychological tests
* Neuroimaging
* EEG
* Biomarker
* Observational data
* Clinician tools
* Combination predictions using more than one modality
* Tests to detect feigning of ADHD

We documented comparative effect results where studies compared the performance of more than one tool. In addition, we documented the range of results reported in studies within each tool category (e.g., self-reports). We documented the diagnostic accuracy results for all outcomes as reported by the authors in the individual studies. Sensitivity estimates were documented together with specificity estimates given that the estimates are not independent. A detailed evidence table displays key characteristics, the reference standard, psychometric properties and diagnostic accuracy outcomes for all included studies. In addition, we identified the number of true positives, true negatives, false positives, and false negatives where clearly reported for use in a diagnostic meta-analysis. All studies were considered for the narrative synthesis accompanying the summary of findings table.

We documented the results for available diagnostic tools across studies in a comprehensive summary of findings table documenting all assessed outcomes related to the diagnostic accuracy, reliability, and impact of the tool. Key outcomes for the summary of findings table were determined with the help of the TEP:

* Clinical misdiagnosis (risk of missed condition that can appear as ADHD)
* Sensitivity
* Specificity
* Administration and scoring time
* Inter-rater reliability
* Costs
* Diagnostic concordance of primary care provider with specialist

The synthesis took study limitations and the risk of bias of individual studies contributing to estimates into account. We determined whether summary estimates corresponded to data reported in low risk of bias studies or were primarily based on high risk of studies.

To address the sub-question, we reported on subgroup results for different clinical settings (differentiating general and specialty care settings), patient characteristics (differentiating sex, age, cultural background, and comorbidity groups), and ADHD presentation (differentiating predominantly inattentive, hyperactive-impulsive, combined). We assessed whether these variables can explain heterogeneity identified in results across studies.

To address the contextual question, we documented the frequency of identified research for each individual tool. In addition, we summarized data sources that reported on the frequency of tool use in clinical practice with emphasis on the U.S. healthcare setting in the discussion.

2.9 Grading the Strength of the Body of Evidence

We applied the EPC strength of evidence criteria to evaluate the body of evidence. In determining the quality of the body of evidence, the following domains were evaluated:

* Study limitations: The extent to which studies reporting on a particular outcome for a specific test were likely to be protected from bias. The aggregate risk of bias across individual studies reporting an outcome was considered; graded as low, medium, or high level of study limitations.
* Inconsistency: The extent to which studies reported the same direction and/or magnitude of effects for a particular outcome; graded as consistent, inconsistent, or unknown (in the case of a single study or the absence of studies).
* Indirectness: Determines whether the test and the comparator were directly (i.e., within studies) or indirectly (e.g., across studies) compared. The domain was graded as direct or indirect.
* Imprecision: Describes the level of certainty of the estimate of effect for a particular outcome, where a precise estimate is one that allows a clinically useful conclusion. The domain was graded as precise or imprecise.
* Reporting bias: Publication bias, selective outcome reporting, and selective analysis reporting are types of reporting bias. Reporting bias is difficult to assess as systematic identification of unpublished evidence is challenging.

A final strength of evidence grade for each evidence statement was assigned by evaluating and weighing the combined results of the above domains. We formulated comparative evidence statements based on direct comparisons of tests within studies. For all other tests, we evaluated the magnitude of the effects for the outcomes of interest. Given that most outcomes showed some variation and a precise pooled estimate was not available, we broadly characterized the magnitude as follows based on the observed performance and published suggestions:

* Clinical misdiagnosis: low (<5%), fair (<20-5%), substantial (20-60%) rate
* Sensitivity and specificity: limited (<80%); poor (<69%), fair (70-79%), acceptable (80-89%), good (90-95%), excellent (96-100%)
* Administration and scoring time: short (<30 minutes)
* Rater agreement: limited (kappa <0.8, correlations <0.40)
* Costs and concordance: N/A

We differentiated an overall grade of high, moderate, low, or insufficient according to a four-level scale:

* High: We are very confident that the estimate of effect lies close to the true effect for this outcome. The body of evidence has few or no deficiencies. We believe that the findings are stable (i.e., another study would not change the conclusions).
* Moderate: We are moderately confident that the estimate of effect lies close to the true effect for this outcome. The body of evidence has some deficiencies. We believe that the findings are likely to be stable, but some doubt remains.
* Low: We have limited confidence that the estimate of effect lies close to the true effect for this outcome. The body of evidence has major or numerous deficiencies (or both). We believe that additional evidence is needed before concluding either that the findings are stable or that the estimate of effect is close to the true effect.
* Insufficient: We have no evidence, we are unable to estimate an effect, or we have no confidence in the estimate of effect for this outcome. No evidence is available, or the body of evidence has unacceptable deficiencies, precluding reaching a conclusion.

The summary of findings table included the reasons for downgrading or upgrading the strength of evidence. The strength of evidence assessment documented uncertainty and communicated our confidence in the evidence statements that can be drawn from the literature.

1. Results

The chapter is organized by the literature search results, the comparative diagnostic accuracy, results for individual tests, reporting on the diagnostic accuracy, unintended consequences, and information on the impact associated testing.

3.1 Results of Literature Search

The flow diagram documents the literature flow of the systematic review.

Figure 2. Literature Flow Diagram

Additional citations identified through other sources: n = 510

Citations identified through database searching for diagnosis and management: n = 10,371

Excluded citations

(not comparative study, not systematic review, not on topic): n = 7,681

Citations screened  
n = 10,881

Full-text publications assessed for eligibility  
n = 3,200

Full-text publications excluded,   
with reasons

Exclude-Population n = 516

Exclude-Intervention n = 701

Exclude-Comparator n = 90

Exclude-Outcome n = 79

Exclude-Timing n = 33

Exclude-Setting n = 3

Exclude-Design n = 388

Exclude-Language n = 93

Exclude-Duplicate n = 111

Background (for citing, reference mining, and context)

n = 550

Management of ADHD or misuse of stimulants

n = 515

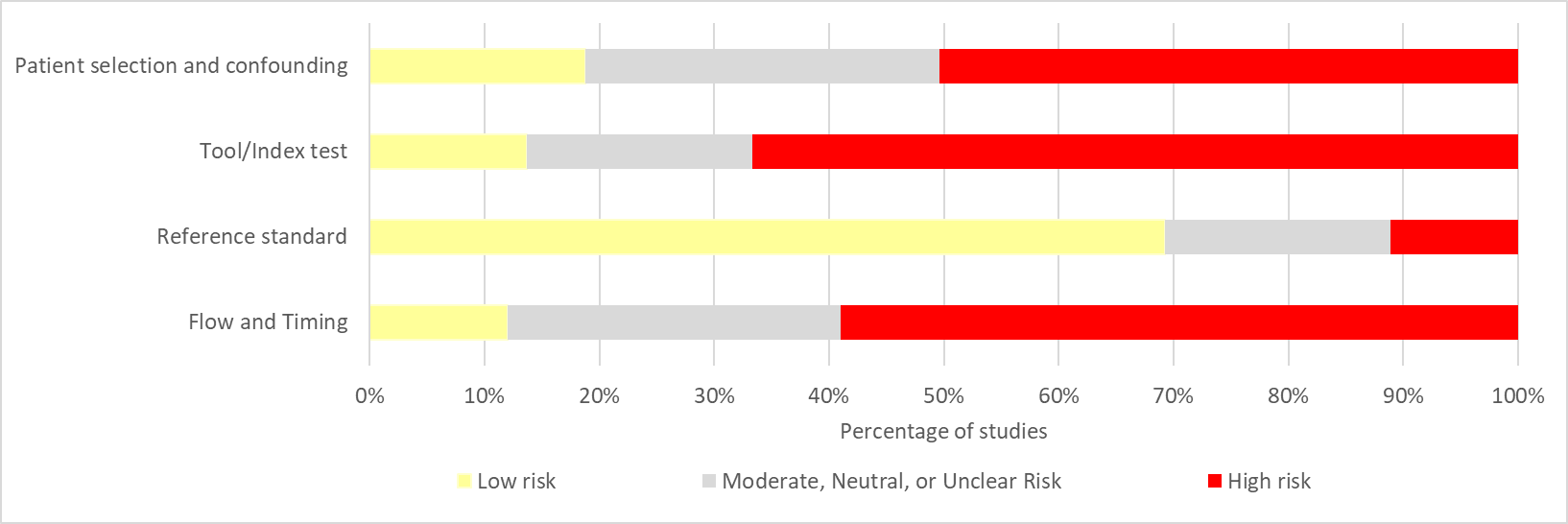
Included studies for diagnosis review n = 117 studies

(reported in 121 publications)

We identified 117 studies meeting inclusion criteria reported in 121 publications.44-164 The earliest identified study was published in 1997.135 Studies evaluated tools in Brazil, Canada, China, Denmark, Germany, Greece, India, Ireland, Israel, Korea, the Netherlands, Norway, Sweden, Switzerland, Turkey, UK, USA, or combined evaluations in multiple countries. Sample sizes varied widely, from a dozen participants to large samples with over a thousand participants.48, 121, 153 Studies included participants diagnosed with ADHD and compared to different non-ADHD samples. These included neurotypical adults not diagnosed with ADHD, adults from a clinical sample evaluated or diagnosed for another clinical condition, and/or adults feigning ADHD. Half of the included studies (51%) incorporated a neurotypical group of adults that did not meet criteria for ADHD, and in some cases, were also selected specifically because they also never had a childhood diagnosis of ADHD. Many studies (40%) compared participants with a diagnosis of ADHD to a clinical sample of participants who were being evaluated for another clinical condition. In addition, two studies each (1%) compared to participants with autism,78, 122 conduct disorder or anger dysregulation,88, 98 or depression,119, 130 respectively. A quarter (23%) of the identified studies included participants identified or specifically trained to pretend to have ADHD. Studies varied in whether they included an additional group (e.g., a neurotypical or clinical sample), but some studies included only participants feigning ADHD, which were compared to participants with a diagnosis of ADHD.44, 127, 133, 134

The risk of bias across studies is shown in figure 3.

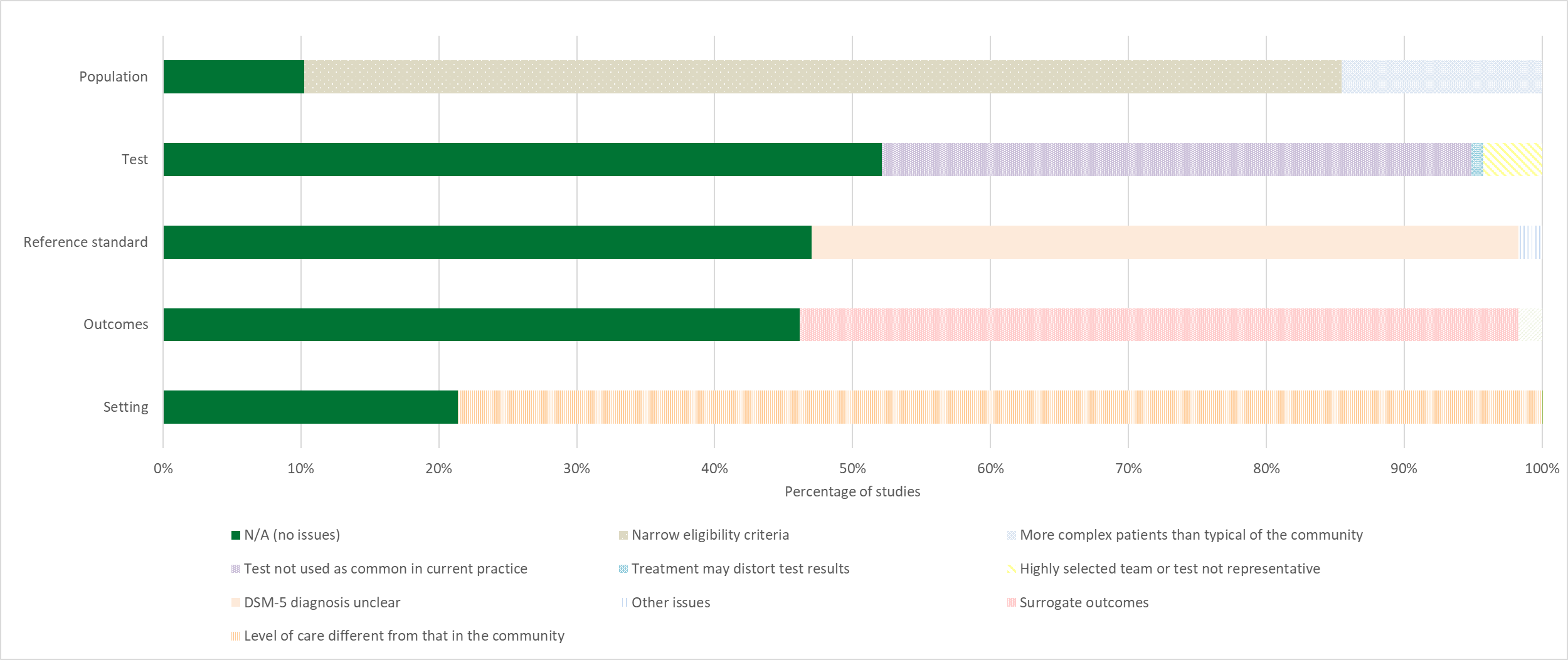
Figure 3. Risk of Bias



Nearly half of the identified studies demonstrated high risk of bias in patient selection, indicating prevalent issues with how participants were recruited and selected across the evidence base. Almost two thirds of studies exhibited high risk of bias in the index test domain, indicating widespread concerns about how diagnostic tools were applied and interpreted. The reference standard domain showed the most favorable profile, with about 60 percent of studies at low risk of bias and about 20 percent at high risk, suggesting relatively good quality in how the diagnostic “gold standard” was implemented. The flow and timing domain shows that nearly 60 percent of studies showed high risk of bias in flow and timing, indicating significant concerns about the sequence and intervals of test administration and analysis.

The applicability assessment assessing the generalizability of study results identified in this review is summarized in figure 4.

Figure 4. Applicability to Routine Practice of Reported Results



Few studies had no applicability concerns regarding population, with most studies having narrow eligibility criteria or including more complex patients than typical of community settings. Half the studies had no applicability concerns regarding the test, though many others used tests not common in current practice, or they employed highly selected teams not representative of typical clinical settings. About half of the studies had no applicability concerns for the reference standard, with the remaining studies showing unclear DSM-5 diagnostic criteria or other reference standard issues limiting generalizability. Half the studies indicated no applicability concerns regarding outcomes, with many others using surrogate outcomes that may not directly translate to clinical practice. Most studies had applicability concerns regarding setting, with the vast majority conducted in care levels different from community settings, limiting their generalizability to routine practice.

Identified studies reported on self-report questionnaires, peer review tools, neuropsychological tests, neuroimaging, electroencephalogram (EEG), diverse biomarkers, clinician tools, combinations of modalities, and tools to identify feigning ADHD. Studies reported on the success of identifying ADHD, success in identifying feigning and exaggerating of ADHD symptoms, or both.

3.2 Results of Key Question 1: What is the comparative diagnostic accuracy, unintended consequences, and impact of tools that can be used in the primary care practice setting or by specialists to diagnose ADHD among adults?

We identified numerous studies that included multiple tools used alone or in combination. However, not all studies reported diagnostic performance for all tools and combinations, and only selected studies allowed direct comparisons.

The 11 studies with head-to-head comparisons between modalities compared primarily self-report questionnaires with other modalities, including parent ratings,122 peer reports,65, 98 a combination of self and other ratings,65, 98, 154 neuropsychological tests,98, 145 a combination of self-report and EEG;132 and clinician tools.98, 100 Three studies compared neuropsychological test results to combinations of input;78, 119, 123 one compared a neuropsychological test and one compared EEG data under Go/NoGo task conditions with task performance indicators.54 Table 2 documents the results for key outcomes for the comparative studies.

Table 2. Comparative Studies

| **Study ID**  **Participants** | **Self-report** | **Peer rating** | **Combined prediction** | **Neuropsychological tests** | **EEG** | **Clinician interview** |
| --- | --- | --- | --- | --- | --- | --- |
| Biederman, 201754  N = 60  n ADHD = 36  Specialty care | N/A | N/A | N/A | Go/NoGo task errors, participants were seated in a dimly lit room at a distance of 70 cm from a 17-inch CRT screen; Go stimuli were white letters appearing in equal proportions, the NoGo stimulus was a white x symbol, stimuli were presented on the center of a black background computer screen for 150 ms and were located between 2 vertical white lines, 10 trial practice block, analyzed reaction time, error rates (commission and misses)  **Clinical misdiagnosis**: N/A  **Sensitivity**:N/A  **Specificity**: N/A  AUC 0.67  **Admin time**: 12 minutes across all tests.  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | Event-related potential data to analyze brain activity patterns during Go/NoGo task, Go condition  **Clinical misdiagnosis**: 5%  **Sensitivity:** Go condition 86%; NoGo condition: 76%; cross-validation data: NoGo 68%, Go 62%  **Specificity**: Go condition 95%, NoGo condition: 91%; cross-validation data: NoGo 80%, Go 69%  **PPV**: cross-validation data: NoGo 0.77, Go 0.69  **NPV**: cross-validation data: NoGo 0.72, Go 0.65  **Admin time**: 12 minutes across all tests.  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A |
| Dvorsky, 201665  N = 86 college studients with suspected or previously diagnosed ADHD and interested in special accommodations.  n ADHD = 59  n non-ADHD with internalizing disorder = 27  College | BAARS-IV (Barkley Adult ADHD Rating Scale-IV) for self-reported assessment of ADHD symptoms on a 4-point scale (0 = never or rarely to 3 = very often), cut off > 3 symptoms presence  **Clinical misdiagnosis**: N/A  **Sensitivity**: 89%  **Specificity**: 30%  **Admin time**: N/A  **Rater reliability**: BAARS-IV self-report vs BAARS-IV parent ratings Parent ratings compared against student self-reports Current inattention ICC 0.43, current hyperactivity ICC  **Costs**: N/A  **Concordance**: N/A | BAARS-IV (Barkley Adult ADHD Rating Scale-IV) parent report  **Clinical misdiagnosis**: N/A  **Sensitivity**: 60%  **Specificity**: 77%  **Admin time**: N/A  **Rater reliability**: Parent ratings compared against student self-reports Current inattention ICC 0.43, current hyperactivity ICC 0.31, current impulsivity ICC 0.32, retrospective children inattention ICC 0.42, retrospective childhood hyperactivity/impulsivity ICC 0.37  **Costs**: N/A  **Concordance**: N/A | Combination prediction model with BAARS parent and self rating of current and childhood ADHD diagnosis  **Clinical misdiagnosis**: N/A  **Sensitivity**: 89  **Specificity**: 63  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A | N/A |
| Groom, 201678  N = 57  n ADHD = 33  n ASD = 25  College | CAARS-E (Conners Adult ADHD Rating Scale-subscale E)  **Clinical misdiagnosis**: N/A  **Sensitivity**:  **Specificity**:  AUC: 0.77  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | Integration of CAARS-E (Conners Adult ADHD Rating Scale - ADHD Index) with the AQ10 (Autism Quotient - 10), and the QbTest (computerized Continuous Performance Test with motion tracking)  **Clinical misdiagnosis**: 16% in Autism Spectrum Disorder sample  **Sensitivity**: 94%  **Specificity**: 84%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | QbTest is a computerized continuous performance test with infra-red motion tracking system, designed to assess attention, impulsivity, and activity levels; participants respond to stimuli on a screen while their movements are tracked, and scores are calculated based on attention accuracy, reaction time, and movement data  **Clinical misdiagnosis**: 20% in Autism Spectrum Disorder sample  **Sensitivity**: 84%  **Specificity**: 80%  UCC: 0.87  **Admin time**: Approximately 20 minutes.  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A |
| Kingston, 201398  N = 120, all in a forensic evaluation, 53.8% in the criminal justice system  n ADHD = 59  no ADHD = 61 | ASRS-v1.1 Part A, a scale based on nosological criteria and pertain to frequency, rather than severity, of ADHD symptoms; Part A comprises 6 screening questions and is considered to be the most predictive of symptoms consistent with ADHD; adminstered together with ASRS-v1.1 Part B, Brown ADD (attention deficit disorder) Scale, CAARS-Self ADHD Index (Connors Adult ADHD Rating Scale, Long Version, Self-Report), and WURS (Wender Utah Rating Scale)  **Clinical misdiagnosis**: 16%  **Sensitivity**: 76% ASRS-v1.1 Part B 66%, Brown ADD Scale 84%, CAARS-Self ADHD Index 63%, WURS 82%  **Specificity**: 84% ASRS-v1.1 Part B 93%, Brown ADD Scale.73%, CAARS-Self ADHD Index.91%, WURS.69%  **Admin time**: N/A  **Rater reliability**: rater agreement between self-report measures (ASRS-v1.1, CAARS-Self, WURS, and Brown ADD Scale) and observer-rated measures (CAARS-Observer) r 0.51  **Costs**: N/A  **Concordance**: N/A | CAARS-O ADHD Index (Observer), observer report  **Clinical misdiagnosis**: 25%  **Sensitivity**: 76%  **Specificity**: 75%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | Integration of ASRS-v1, CAARS-Self and CAARS-Observer, Brown ADD scale, and WURS in a discriminant function  **Clinical misdiagnosis**: 18%  **Sensitivity**: 91%  **Specificity**: 82%  **Admin time**: N/A  **Rater reliability**:  **Costs**: N/A  **Concordance**: N/A | IVA + Plus FSRCQ (Integrated Visual and Auditory Continuous Performance Test Full Scale Response Control Quotient), a computerized continuous performance test utilizing visual and auditory stimuli to assess response control; constant and sustained attention is required, as participants respond or inhibit their response to 500 counterbalanced trials; FSRCQ measures impulsivity and commission errors, normative quotient scores have a mean of 100 and a standard deviation of 15  **Clinical misdiagnosis**: 26%  **Sensitivity**: 30% IVA + Plus (FSAQ): .39 (.29–.54)  **Specificity**: 74% IVA + Plus (FSAQ): .69 (.53–.82)  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A |
| Kumar, 2011100  N = 110 psychiatric inpatients  n ADHD = 6  n not ADHD = 104 | CAARS-S:SV (Conners' Adult ADHD Rating Scales: Screening Version), 30-item self-report tool that screens for ADHD symptoms in adults, using a 4-point rating scale to assess the frequency of symptoms based on DSM-IV criteria, cut off point wasT score>70  **Clinical misdiagnosis**: 31%  **Sensitivity**: 83%  **Specificity**: 69%  **Admin time**: N/A  **Rater reliability**: Correlation self-report CAARS-S:SV and MINI r 0.58  **Costs**: N/A  **Concordance**: N/A | N/A | N/A | N/A | N/A | MINI (International Neuropsychiatric Interview), a short, structured diagnostic interview designed to assess a range of different mental health disorders  **Clinical misdiagnosis**: 48%  **Sensitivity**: 83%  **Specificity**: 52%  **Admin time**: 10-25 minutes  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A |
| Nikolas, 2019119  N = 246  n ADHD = 109  n Depression and no ADHD = 52  n controls with no ADHD or Depression = 85  Specialty care and community | N/A | N/A | Combination of self/informant symptom ratings (BAARS-IV), family history, and reactiontime variability from TOVA (Test of Variables of Attention)  **Clinical misdiagnosis**: N/A  **Sensitivity**:  **Specificity**:  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | TOVA ommission errors, cutoff <95 as part of a large battery with many exploratory analyses to differentiate ADHD and non-ADHD  **Clinical misdiagnosis**: 15%  **Sensitivity**: 50%  **Specificity**: 85%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A |
| Palmer, 2023122  N = 71 with Autism Spectrum Disorder  n ADHD and ASD = 40  n ASD but no ADHD = 31  Community | CAARS-S (Conners Adult ADHD Rating Scales Self-Report) ADHD Index assessed ADHD symptoms with a cutoff of ≥56; adminstered together with the SDQ (Strengths and Difficulties Questionnaire), cutoff of ≥9  **Clinical misdiagnosis**: N/A  **Sensitivity**: CAARS 57%; SDQ>9: 28%  **Specificity**: CAARS 81%; SDQ>9: 100%  **AUC**: CAARS 0.70; SDQ>9: 0.65  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | CAARS-P (Conners Adult ADHD Rating Scales Peer Report) parent report, ADHD Index cutoff >56; administered together with ABC (Aberrant Behavior Checklist) Hyperactivity/Non-compliance subscale (a cutoff of ≥3) parent-report  **Clinical misdiagnosis**: N/A  **Sensitivity**: 94% ABC scale: 91%  **Specificity**: 57% ABC scale: 42%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A | N/A | N/A |
| Pettersson, 2018123  N = 108 outpatients being evaluated for suspected ADHD  n ADHD = 60  n not ADHD = 48  Specialty care | ASRS Screener (Adult ADHD Slef-Report Scale Screener)  **Clinical misdiagnosis**: 8%  **Sensitivity:** 92%  **Specificity:** 27%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | Model with DIVA report, QbTest cardinal variable Acticity, QbTest cardinal variable Inattention, and CpT II Commission errors, combining neuropsychological tests, DIVA clinician report, and self-report ASRS Screener  **Clinical misdiagnosis**: 17%  **Sensitivity**: 90%  **Specificity**: 83%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | Model with CPT II Commission errors, QbTest cardinal variable Inattention, and QbTest cardinal variable Activity  **Clinical misdiagnosis**: 33%  **Sensitivity**: 80%; QBTest Act 77%; QBTest Ina 58%; QBTest Omi 73%, QBTest RT Var 43%; PASAT tot 33%; CPT II Com 33%, CPT II Var 27%  **Specificity**: 67%; QBTest Act 44%; QBTest Ina 67%; QBTest Omi 56%, QBTest RT Var 75%; PASAT tot 77%; CPT II Com 92%, CPT II Var 85%  **Admin time**: 20 minutes  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | DIVA (Diagnostic Interview for ADHD in Adults), dichotomized as ADHD if 6 or more symptom criteria in both adulthood and childhood, and in either or both of the domains Attention Deficit and Hyperactivity–Impulsivity, and as non-ADHD if fewer than 6 symptom criteria  **Clinical misdiagnosis**: 27%  **Sensitivity**: 90%  **Specificity**: 73%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A |
| Robeva, 2004132  N = 12 all female  ADHD n = 6 taking medication  Not ADHD n = 6  College students | WURS (Wender Utah Rating Scale), a 61-item retrospective questionnaire witha cutoff score of 30 on the short form with higher cutoff values  **Clinical misdiagnosis**: N/A  **Sensitivity**: N/A  **Specificity**: N/A  Accuracy: classification <85%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | Bayesian probability model integrated three diagnostic tools (WURS, ConsistencyIndex (EEG), Alpha Blockade Index (EEG)  **Clinical misdiagnosis**: N/A  **Sensitivity**: 100%  **Specificity**: 100%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | EEG-based physiological markers  **Clinical misdiagnosis**: N/A  **Sensitivity**: N/A  **Specificity**: N/A  Accuracy: classification <85%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A |
| Solanto, 2004145  N = 93 evaluated for suspected ADHD  n = 44 combined-type ADHD  n = 26 inattentive ADHD  n=33 mood or anxiety disorder  Specialty care | BADDS (Brown Attention-Deficit Disorder Scale), assesses executive and adaptive functioning across five clusters (Activation, Attention, Effort, Affect, and Memory), cutoff 50  **Clinical misdiagnosis**: 67%  **Sensitivity**: 92%  **Specificity**: 33%  **Accuracy**: 74%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A | C-CPT (Conners Continuous Performance Test), a 14-minute computerized task where participants respond to non-target stimuli; most CPT scores were in the clinically normal range for all groups; fFor Hit Reaction Time Inter-Stimulus Interval Change in discriminating inattentive ADHD from combined type ADHD  **Clinical misdiagnosis**: 14%  **Sensitivity**: 47%  **Specificity**: 86%  **Accuracy:** 70%  **Admin time**: 15 minutes  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A |
| Van Voorhees, 2011154  N = 269 evaluated for attnetion problems  n ADHD = 184 (n=71 Combined Type; n=89 Predominately Inattentive Type; n = 24 ADHD Not Otherwise Specified)  Specialty care | CAARS:S (Conners’ Adult ADHD Rating Scales, Self Rating, Long Version), 66-items rated on a 4-point scale (0 to 3) to assess ADHD symptoms  **Clinical misdiagnosis**: 39%  **Sensitivity**: 65%  **Specificity**: 61%  **Admin time**: N/A  **Rater reliability**: Self-reports (CAARS-S) and observer reports (CAARS-O including ratings from friends, parents, and spouses) Ranged from r 0.24 (“distractible”) through r 0.46 (“on the go/driven by a motor”)  **Costs**: N/A  **Concordance**: N/A | N/A | CAARS-LV combining self-report CAARS:S and observer-report CAARS-O; T-Scores >65 for Conners’ index  **Clinical misdiagnosis**: 17%  **Sensitivity**: 43%  **Specificity**: 83%  **Admin time**: N/A  **Rater reliability**: N/A  **Costs**: N/A  **Concordance**: N/A | N/A | N/A | N/A |

Notes: N/A not available, not applicable; N number of participants

Several identified studies compared multiple tests, but not all reported results for all outcomes of interest for every test. Two studies compared self-reports versus a clinician interview tool, both reported a lower rate of clinical misdiagnoses for in the direct comparison.100, 123 Two studies found no difference in sensitivity between self-report and a clinician tool.98, 100 Two studies reported higher sensitivity for self-reports versus neuropsychological tests.98, 145 Two studies reported higher specificity for self-reports over a clinician tool.98, 100

Three studies reported on sensitivity for combinations of input versus neuropsychological tests alone, all found higher values for the combination78, 98, 123 One study compared a combination to EEG marker alone and also reported results in favor of the combination.132 Four studies found higher specificity for combinations of input versus neuropsychological tests alone78, 98, 123 or EEG marker alone.132

Evidence for all other comparisons was insufficient and we were not able to make comparative evidence statement for the outcomes administration time, inter-rater reliability, costs, or concordance between primary and specialty care diagnoses. All available comparative results across test modalities (e.g., combinations of variables vs neuropsychological test results alone) are documented in the summary of findings table (Table 3).

3.2.1 Combination

Eight studies reported on a combination of input from different modalities.57, 65, 78, 98, 119, 123, 132, 154 Several included self and informant symptom ratings, and some also used demographic variables, neuropsychological assessment results, or EEG data. Studies varied in their complexity of the combination; one study, supported by machine learning, used 93 variables.57 The Appendix Table C.1 documents results for all studies that evaluated a combination.

Reported clinical false positive rate ranged from 16 percent in a study combining self-ratings and QBTest data to distinguish ADHD from Asperger’s syndrome78 to 18 percent in a study combining multiple self-reports and an observer report to distinguish from aggression.98 As illustrated in Figure 8, sensitivity was variable but mostly good, but not excellent. Reported sensitivity ranged from 94 percent (corresponding specificity 84%)78 to 43 percent (corresponding specificity 83%)154 in the identified studies. Specificity ranged from 84 percent (corresponding sensitivity 94%)78 to 82 percent (corresponding sensitivity 91%).98 We found no data for the outcomes administration time, inter-rater reliability, costs, or concordance between primary and specialty care diagnoses. The table shows the specific combinations used to diagnose ADHD. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.2 Self-Report Questionnaires

Forty-three studies reported at least one self-report measure evaluated for its performance in diagnosing ADHD. The studies reported on numerous self-report measures: ADHD Rating Scale, ADSA (Attention-Deficit Scales for Adults), AHA (Assessment of Hyperactivity and Attention), ALS-SF (Affective Lability Scale-Short Form), APQ (Adult Problem Questionnaire), ASRS (Adult ADHD Self-Report Scale), ASSET-BS (ADHD Symptom and Side Effect Tracking Baseline Scale), BAARS-IV Barkley Adult ADHD Rating Scale), BADDS (Brown Attention-Deficit Disorder Scale), CAARS (Conners Adult ADHD Rating Scale), CBS (Current Behavior Scale), EarlyDetect Questionnaire, IPDE-SQ (International Personality Disorder Examination screening questionnaire), PAI (Personality Assessment Inventory), PDI-4 (Provisional Diagnostic Instrument), SR-WRAADDS (Self-Report Wender-Reimherr Adult ADHD Scale), and WURS (Wender Utah Rating Scale). Nine studies reported on more than one questionnaire.62, 63, 92, 108, 111, 120, 130, 135, 142 The Appendix Table C.2 documents results for all studies that evaluated a written self-report for the diagnosis of ADHD.

Performance for clinical misdiagnosis varied across studies but was generally substantial: reported false positive rates in clinical samples ranged from 12 percent differentiating from depression or generalized anxiety using the WURS130 to 90 percent in students with academic or psychological difficulties using the CAARS-S.101 The ability to detect ADHD varied but was good for many questionnaires as illustrated in Figure 5.

Figure 5. Reported Sensitivity and Specificity of ADHD Self-Report Questionnaires in Adults Across Studies



Notes: ADSA (Attention-Deficit Scales for Adults), AHA (Assessment of Hyperactivity and Attention), ALS-SF (Affective Lability Scale-Short Form), APQ (Adult Problem Questionnaire), ASRS (Adult ADHD Self-Report Scale), ASSET-BS (ADHD Symptom and Side Effect Tracking Baseline Scale), BAARS-IV Barkley Adult ADHD Rating Scale), BADDS (Brown Attention-Deficit Disorder Scale), CAARS (Conners Adult ADHD Rating Scale), CBS (Current Behavior Scale), EarlyDetect Questionnaire, IPDE-SQ (International Personality Disorder Examination screening questionnaire), PAI (Personality Assessment Inventory), PDI-4 (Provisional Diagnostic Instrument), SR-WRAADDS (Self-Report Wender-Reimherr Adult ADHD Scale), and WURS (Wender Utah Rating Scale)

Neurotypical only = true indicates that the study differentiated ADHD from neurotypical adults, neurotypical only = false indicates that the study differentiated ADHD from other clinical conditions or a combination of neurotypical adults and adults with other clinical conditions

Figure 5 represents each study that reported on a self-report with one questionnaire, selecting the scale with the highest sensitivity and specificity where more than one tool was evaluated. In the individual studies sensitivity ranged from 100 percent at the expense of low specificity (CAARS-S corresponding specificity 10%101 or ASRS-v1.1 with specificity not reported)58 to only 14 percent (CAARS-S, corresponding specificity 92%).86 The ability of self reports to correctly rule out ADHD was good in many cases but also rarely excellent: Specificity ranged from 99 percent (CBS corresponding sensitivity 90%)71 to as low as 10 percent (CAARS-S, corresponding sensitivity 100%).101 Only one study explicitly reported on the administration time for the questionnaire, indicating short administration.105 Rater agreement was reported in multiple studies, with most studies indicating limited agreement between different raters.50, 65, 98, 100, 108, 109, 154, 163 We did not identify data on cost or correspondence between primary and specialty care. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.3 Peer Report Questionnaires

Three studies evaluated peer reports.65, 122, 124 One of the studies asked parents to rate their young adults with autism using the CAARS-P and the ABC (Aberrant Behavior Checklist).122 Another study included parent ratings of undergraduates using the BAARS-IV (Barkley Adult ADHD Rating Scale-IV).65 In both studies, the peer report was a parent rating of young adults. One study in a forensic outpatient clinic reported on CAARS-Observer ratings but did not state who served as the rater.98 The Appendix Table C.3 documents all results for the small number of studies that evaluated a written peer report for the diagnosis of ADHD.

Evidence for clinical misdiagnosis was determined to be insufficient due to lack of information on the observers in the single clinical sample. Sensitivity was determined to be insufficient due to the wide reported range (from poor to good). Specificity was limited and ranged from fair to poor (77% for BAARS-IV, corresponding sensitivity 60%,65 57% for CAARS-P, corresponding sensitivity 60%);122 both illustrated in Figure 8. For rater agreement, only one study reported results and none of the studies reported on costs, administration time, or concordance between primary and specialty care. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.4 Neuropsychological Assessment

Twenty-seven studies reported on the performance of neuropsychological assessment to diagnose ADHD. Studies evaluated test batteries such as AQT, BQSS, C-CPT, DII, IVA, MOXO-dCPT, QbTest, SCWT, SNST, or the performance of individual tasks such as the Go-NoGo task or WAIS-IV Processing Speed Index. Five studies reported diagnostic accuracy data for multiple tests and tasks.59, 107, 140, 151, 160 The Appendix Table C.4 documents results for all neuropsychological tests evaluated to diagnose ADHD. The index test description shows the evaluated test selection that showed the best performance, together with all administered tests.

Performance for clinical misdiagnoses showed a substantial false positive rate in most studies. Reported results ranged from 11 percent in a study using Stroop test variables for participants referred for neuropsychological evaluation95 to 60 percent in a model based on QbTest with motion tracking variables,144 Sensitivity was acceptable in most studies as illustrated in Figure 6, but reported sensitivity showed a wide range from 93 percent (corresponding specificity 100%) integrating AQT variables118 to 17 percent for an individual subtest of the C-CPT (corresponding specificity 90%).146

Figure 6. Reported Sensitivity and Specificity of Neuropsychological Tests for ADHD in Adults across Studies



Notes: AQT A Quick Test of Cognitive Speed; BQSS Boston Qualityative Scoring System for the Rey-Osterrieth Complex Figure; C-CPT Conners Continuous Performance Test; IVA Integrated Visual And Auditory Continuous Performance Test Full Scale Response Control Quotient; QbTest quantified behavioral test; SCWT Stroop Color and Word Test; TOVA Test of Variables of Attention

Figure 6 shows the different specific evaluated tests as well as the substantial number of studies that did not evaluate a specific tool but used variables in a test battery to develop a models that maximizes the ability to discriminate between ADHD and comparator characteristics. The figure also shows the wide variation in specificity, with some studies reporting excellent specificity, but most studies were characterized by acceptable or even poor specificity. Reported specificity ranged from 100 percent (corresponding sensitivity 93%) integrating AQT variables118 to 40 percent for a model integrating QbTest Plus variables (corresponding sensitivity 88%).144

There was some variation, but 7 studies estimated the duration of the neuropsychological test administration to be about 20 minutes.45, 55, 66, 69, 78, 123, 144 None of the studies reported on rater agreement, costs, or concordance between diagnostic settings. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.5 Neuroimaging

Five studies evaluated neuroimaging.48, 56, 136, 157, 161 Studies used brain perfusion single-photon emission computed tomography (SPECT),48 3-D SPECT,136 structural magnetic resonance imaging (MRI) and diffusion tensor imaging,56 and resting state functional MRI.157, 161 The Appendix Table C.5 documents results of studies that evaluated neuroimaging for the diagnosis of ADHD. The table provides details on the final selection model where reported.

Reported clinical misdiagnoses rates varied from a low three percent in a brain perfusion SPECT study analyzing a large psychiatric database48 to a substantial 24 percent false positive rate in a sample with various psychiatric and neuropsychiatric disorders using 3D thresholded SPECT.136 Studies reported sensitivity ranges from excellent to poor, but it was acceptable in most studies. Performance ranged from 100 percent in a large retrospective cohort study using brain perfusion SPECT (corresponding specificity 97%)48 to 54 percent in a clinical sample (SPECT, corresponding specificity 76%). Similarly, reported specificity ranged from 97 percent (SPECT, corresponding sensitivity 100%)48 to 65 percent (functional MRI, corresponding sensitivity 91%),161 but most studies reported acceptable specificity as illustrated in Figure 8. Studies varied in how much detail the often machine-learning generated discriminant function that achieved the best diagnostic performance was documented. Only one study reported on administration time; the study reported a procedure duration of 15 to 20 minutes.136 One study evaluated rater agreement, the study reported a kappa coefficient of 0.79 for agreement in visual interpretation of neuroimaging scans.48 None of the studies reported on costs or concordance of diagnostic results between different clinical settings. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.6 EEG

Twelve studies evaluated EEG (electroencephalogram) data used to distinguish ADHD from other clinical conditions or neurotypical developing adults.54, 80, 89, 91, 96, 97, 115, 116, 125, 126, 132, 139 Studies tested the diagnostic performance for very different conditions, ranging from analyzing resting state EEG,96, 125 and event-related potentials during neuropsychological tasks,54, 115 to EEG recording during transcranial magnetic stimulation.80 The Appendix Table C.6 documents results for the studies that evaluated the use of EEG data for the diagnosis of ADHD.

Only one study reported on misdiagnosis in a clinical sample; the study reported a low false positive rate of 3.8 percent using auditory brainstem response profiling test.89 Most studies were conducted in academic samples and did not involve clinical samples. Reported sensitivity results ranged from 100 percent achieved in a machine-learning assisted diagnostic study that utilized phase space reconstruction of brain signals during a continuous performance test (corresponding specificity 87%)91 to only 67 percent (resting state EEG, corresponding specificity 83%)125 with overall acceptable results. Specificity showed an even wider range from excellent to poor performance: Reported specificity ranged from 95 percent (event-related potential, corresponding sensitivity 86%)54 to 37 percent (resting state EEG, corresponding sensitivity 73%)96 but was generally good in identified studies. Reported session duration ranged from six minutes96 to 26 minutes116 with no information about the scoring or interpretation time. Studies did not report on rater agreement, costs, or concordance with diagnoses from other settings. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.7 Biomarker

Five studies evaluated biomarkers other than EEG or neuroimaging-based indicators.49, 79, 88, 138, 150 Studies evaluated very different markers, including genetic marker,79 eye tracking results,88 blood oxidative status,138 physiological data from a wearable device,49 or used MFNU (Motor Function Neurological Assessment)150 to diagnose ADHD. None of the same modality or type of biomarker was evaluated in more than one study. The Appendix Table C.7 documents all results for the small number of studies that evaluated the use of biomarkers other than neuroimaging or EEG to aid in the diagnosis of ADHD.

The clinical misdiagnosis rate varied widely: one study reported a false positive rate of 17 percent in an eye tracker study in sample of participants with conduct disorder,88 another study reported a false positive rate of 75 percent in a MFNU assessment in a psychiatric outpatient clinic where some patients were considered to have subthreshold ADHD.150 Sensitivity was acceptable in most studies and showed a range of 98 percent for MFNU (corresponding specificity 25%)150 to 80 percent in an eye tracker study (corresponding specificity 83%).88 Specificity varied widely, from 83 percent in the eye tracker study (corresponding sensitivity 80%)88 to only 25 percent in the MFNU assessment (corresponding sensitivity 98%). Only one study reported on the administration time, the study reported that the eye tracking task took about 15 minutes;88 none of the studies reported on test result processing, evaluation, or interpretation time. Studies did not report on rater agreement in interpreting the variables, costs, or concordance between settings. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.8 Clinician Tool

Three studies reported on a clinician interview or questionnaire that was assessed for congruence with an external reference standard.100, 121, 123 Studies evaluated the DIVA (Diagnostic Interview for ADHD in Adults),123 MINI (Mini-International Neuropsychiatric Interview),100 the MINI-Plus121 which were used by clinicians in clinical samples. The reference standards used to evaluate the diagnostic performance of the clinician tools were assessments from trained clinicians,121 the recorded chart diagnosis,100 or clinical case conferences.123 The Appendix Table C.8 documents study and participant details, and presents all reported results for these studies.

The results reported in the identified studies varied widely for the clinical misdiagnosis: false positive rates ranged from nine percent for the MINI-Plus in an addiction treatment center study121 to 48 percent in an inpatient psychiatric hospital unit for the CAARS-O.100 The sensitivity was acceptable, performance ranged from 83 percent (corresponding specificity 52%) to 73 percent (corresponding specificity 90%).123 Specificity showed a wider range, reported results included good as well as poor sensitivity: performance ranged from 91 percent (corresponding sensitivity 75%)121 to 52 percent (corresponding sensitivity 83%).100 The identified studies did not report on administration time, rater agreement, costs, or concordance with specialty care. Results for key outcomes are synthesized in the Summary of Findings table (Table 3).

3.2.9 Key Question 1a: How does the comparative diagnostic accuracy of these tools vary by clinical setting, including primary care or specialty clinic, or patient characteristics, including age, sex, cultural background, and risk factors associated with ADHD?

Because raw data for diagnostic accuracy were often not reported, we were not able to detect effect modifiers in meta-regressions by adding variables to the meta-analytic model. Results are based on subgroups as reported by the authors and analyses conducted within the original studies.

**Clinical setting**: Half of the identified studies were conducted in specialty care (n=55). The next most frequent setting was college (n=37). Very few studies were conducted in primary care (n=2). In addition, none of the identified studies analyzed the effect of the setting on the diagnostic process. Hence the question which tests should be used in primary care is difficult to answer. However, several studies addressed the effect of the reference standard and comparator sample, i.e., study characteristics. In addition, several studies addressed the effect of comorbidities. Although primarily a patient characteristic, participants evaluated for other clinical conditions was more typical of a specialty care clinical setting.

**Reference standard and comparator sample**: Three studies addressed the effect of the method of establishing a clinical ADHD diagnosis, but all addressed different aspects. One study comparing self-reported and neuropsychological tests highlighted that diagnostic accuracy measures were high when comparing ADHD-diagnosed participants to the general population but were less effective when distinguishing ADHD from other psychiatric conditions, with overlapping scores noted for anxiety and depression.145 Similarly, a self report study reported a high false-positive rate in patients with depression.64 Another study evaluating a self-report measure reported that comorbidities such as anxiety and depression were associated with elevated scores on scales which may overlap with ADHD symptoms and potentially contribute to misclassification and highlighted the importance of considering comorbid conditions during assessment.102 One study evaluating neuromuscular assessment reported that they found several patients with subthreshold ADHD in a clinical sample suggesting possible diagnostic overlap and the need for further evaluation.150

Figure 7 differentiates two diagnostic accuracy measures, overall accuracy and the area under the curve (AUC), for all diagnostic modalities. The figure stratifies studies by samples that identified ADHD in a sample of neurotypical adults, in a clinical sample, or in samples that included neurotypical adults, adults with other clinical conditions such as autism spectrum disorder, and/or adults feigning ADHD.

Figure 7. Reported Accuracy and Area Under the Curve (AUC) Across Tools



Figure 7 visualizes a trend toward higher diagnostic accuracy when tools distinguish between people with ADHD and neurotypical adults: diagnostic performance exceeded that of results in clinical samples in five out of six studies reporting on overall accuracy and in three out of four test modalities in studies that reported on AUC.

**ADHD presentation**: Four studies addressed diagnosis in different presentations of ADHD with some conflicting results. One-self-report study reported that diagnostic accuracy did not significantly vary across ADHD presentations/subtypes (inattentive, hyperactive-impulsive, and combined) but noted that combined type ADHD was the most frequently identified subtype, which could influence overall sensitivity and specificity estimates.141 Similarly, another study reported that sensitivity and specificity were consistent across ADHD presentation types (inattentive, hyperactive, and combined), but noted that misdiagnosis rates were slightly higher for the inattentive subtype in self reports compared to clinician diagnoses, and inter-rater reliability between self-reported and clinical ratings was fair, with higher concordance for combined presentation.70 Another self report study highlighted that sensitivity for the inattentive subtype was 100 percent on the Inattentive Symptoms subscale, with specificity at 25 percent.101 One self report study pointed out that inattention symptoms were more predictive of ADHD persistence into adulthood than hyperactivity-impulsivity symptoms; and individuals with the combined-type ADHD in childhood were more likely to retain a diagnosis in adulthood, whereas hyperactive-impulsive presentations were more likely to remit.94

**Participant age**: Several studies reported on the effect of the age of the participants or specifically on the age at diagnosis, but studies focused on different aspects. A self-report study reported that executive functioning impairments were more predictive of ADHD persistence in older adults, while hyperactivity-impulsivity symptoms were more prevalent in younger adults, suggesting age-related shifts in symptom expression and diagnostic criteria applicability; sensitivity and specificity of ADHD diagnoses were higher in younger adults (18–30 years) compared to older adults (31–44 years), likely due to better recall of childhood symptoms and reduced cognitive decline in memory-based reporting.94 A self report and neuropsychological test study reported that age was inversely correlated with scores on scales for attention and effort, suggesting that older participants exhibited fewer ADHD-related symptoms, potentially reflecting developmental improvements in executive functioning.145 One study did not comment on differential effects on the diagnosis, but suggested that a potential biomarker, oxidative stress, may increase with the duration of the disease.138 Another study found that age represented as independent variable in a multiple regression did not significantly influence parameters measured by the QbTest.55 A further study reported that ADHD diagnosis based on CAARS-S or MINI were not correlated with age.100

**Participant sex**: Several studies reported on the effect of the sex of the participants on the diagnostic performance, but studies reported conflicting results. One EEG study reported lower sensitivity in females compared to males.89 A neuroimaging study noted that classification performance was higher in the male-only subgroup compared to the mixed-gender subgroup, suggesting that male ADHD patients may have more significant neuroanatomical deviations from controls.56 A self-report study did not find lower sensitivity but lower specificity in females versus males.155 One study concluded that sex did not influence parameters of the neuropsychological test.55 A self-report study did not detect differences in sensitivity and specificity between sexes.163 A study reporting on a self-report and a clinician interview noted that ADHD diagnosis based on the tests were not correlated with sex.100

**Participant ethnicity**: None of the studies stratified diagnostic performance by race or ethnicity.

**Comorbidities**: Multiple studies reported on the effect of comorbidities in participants with ADHD on diagnostic performance, but results and conclusions differed. One college study reported that comorbidities contributed to challenges in specificity but not sensitivity and that functional impairment was higher in participants with comorbid conditions.101 Similarly, a study in addiction centers reported on variability in specificity values across subgroups while sensitivity remained similar.153 Another study reported reduced specificity in participants with overlapping symptoms of borderline personality disorder and bipolar disorder in neuropsychiatric clinics.66 One study reported lower sensitivity and higher specificity in participants with comorbidity in a mental health center.106 Two studies in outpatient centers reported that diagnostic performance was unaffected by comorbidities.55, 102 Some studies pointed out the high prevalence of comorbid conditions such as depression and anxiety.77, 94, 135, 141 One study suggested that participants with ADHD and depression reported higher levels of anxiety.64

3.2.10 Key Question 1 Summary of Findings

Despite the large number of studies, many did not report on the exact number of true positives, true negatives etc. The most common metrics were the author reported sensitivity. Given that sensitivity and specificity are not independent of each other, we plotted both for all reported tests in Figure 8. The tool indicates also whether studies differentiate adults with ADHD from neurotypical adults or adults with another clinical diagnosis.

Figure 8. Sensitivity and Specificity of ADHD Tests in Adults across Studies



Figure 8 visualizes the much larger evidence base for self-reports compared to all other modalities. The figure also illustrates the wide variability reported in the individual studies for the same modality. In addition, the visualization shows that tests were sometimes able to maximize sensitivity or specificity, but not both. Finally, with few exceptions, the evaluated tests were limited in their success of detecting a clinical diagnosis of ADHD.

The summary of findings table (Table 3) provides a synthesis of the results for the key outcomes. Direct comparisons between test modalities are shown first, followed by the test performance for individual tests, and the summary of the subquestion. The summary of findings table shows results for the key outcomes for which at least one study with data was identified. The clinical misdiagnosis results were limited to studies reporting on clinical samples and/or studies comparing to another clinical condition such as anxiety. We downgraded by one or by two, depending on the impact of the reasons for downgrading on our confidence in the summary estimate and resulting evidence statements. Results of individual studies for all abstracted outcomes beyond the key outcomes are shown in the evidence tables in Appendix C.

Table 3. Summary of Findings Table Comparative Performance, Performance of Combinations, and Performance of Individual Tools against a Reference Standard

| **Key question**  **Outcome**  **Comparison or Test** | **Contributing studies** | **Results of the primary studies** | **Reasons for downgrading** | **Strength of Evidence and Conclusion** |
| --- | --- | --- | --- | --- |
| KQ1  Comparative clinical misdiagnosis  Combinations vs self-report | 2 studies98, 154 | Conflicting results: 1 study reported a 16% misdiagnosis rate for the ASRS compared to 18% for a combination of variables,98 while 1 study reported a misdiagnosis rate of 39% for the CAARS-S compared to 17% for a combination of self and observer reports154 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative clinical misdiagnosis  Combinations vs neuropsychological tests | 1 study123 | Favors combination: 1 study reported a clinical misdiagnosis rate of 17% for a combination from multiple sources compared to 33% for a neuropsychological test123 | Inconsistency (no replication) | Insufficient for comparative statements between tools |
| KQ1  Comparative clinical misdiagnosis  Self-report vs clinician tools | 2 studies98, 100 | Favors self-reports: 1 study reported a 16% clinical misdiagnosis rate for the ASRS compared to 25% for clinician rating tool;98 another study reported a 31% misdiagnosis rate for the CAARS-S compared to 48% for the MINI100 | Study limitation (studies assessed different tests) | Low for lower clinical misdiagnosis rate in self-report compared to clinician tool |
| KQ1  Comparative clinical misdiagnosis  Self-report vs neuropsychological tests | 2 studies98, 145 | Conflicting results: 1 study reported a 16% misdiagnosis rate for the ASRS compared to 26% for a CPT;98 1 study reported a 47% misdiagnosis rate for the BADDS compared to 14% for the C-CPT100 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative sensitivity  Combination vs self-report | 2 studies98, 154 | Conflicting results: 1 study reported a sensitivity of a combination of 91% (corresponding specificity 82%) vs 76% for the ASRS (corresponding specificity 84%),98 1 study reported a sensitivity of a combination of 43% (corresponding specificity 83%) vs 65% for the CAARS-S (corresponding specificity 61%);154 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative sensitivity  Combination vs neuropsychological tests | 3 studies78, 98, 123 | Favors combination: Estimates ranged for a combination from 94% (corresponding specificity 84%) vs QbTest 84% (corresponding specificity 80%)78 to 90% for a combination (corresponding specificity 83%) vs a CPT test with 80% (corresponding specificity 67%)123 | Study limitation (compared different tests and combinations) | Low for higher sensitivity when using combinations of tests compared to neuropsychological tests |
| KQ1  Comparative sensitivity  Self vs parent report | 2 studies65, 122 | Conflicting results: 1 study reported a sensitivity of 89% for the BAARS (corresponding specificity 30%) vs BAARS parent rating 60% (corresponding specificity 77%);65 1 study reported a sensitivity of 57% for CAARS-S (corresponding specificity 81%) vs 94% for a parent rating (corresponding specificity 57%)122 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative sensitivity  Self-report vs neuropsychological tests | 2 studies98, 145 | Favors self-report: 1 study reported a sensitivity of 92% for the BADDS (corresponding specificity 33%) vs 47% for the C-CPT (corresponding specificity 86%);145 1 study reported 76% for the ASRS (corresponding specificity 84%) vs 30% for a CPT (corresponding specificity 74%)98 | Study limitation (compared different tests and combinations) | Low for higher sensitivity for self-reports compared to neuropsychological tests |
| KQ1  Comparative sensitivity  Self-report vs clinician tool | 2 studies98, 100 | No difference: 1 study reported a sensitivity of 83% for CAARS-S (corresponding specificity 69%) vs 83% for MINI (corresponding specificity 52%);100 1 study reported 76% for the ASRS (corresponding specificity 84%) vs CAARS-O sensitivity of 76% (corresponding specificity 75%)98 | Study limitation (compared different tests and combinations) | Low for no difference in sensitivity between self-reports and clinician tools |
| KQ1  Comparative specificity  Combination vs self-report | 2 studies98, 154 | Conflicting results: 1 study reported a specificity of 83% for a combination (corresponding sensitivity 43%) vs 61% for the CAARS-S (corresponding sensitivity 65%);154 1 study reported a specificity of 82% for a combination (corresponding sensitivity 91%) vs 84% for the ASRS (corresponding sensitivity 76%)98 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative specificity  Combination vs neuropsychological tests | 3 studies78, 98, 123 | Favors combination: Estimates ranged from 84% for a combination (corresponding sensitivity 94%) vs 80% for the QbTest (corresponding sensitivity 84%)78 to 83% for a combination (corresponding sensitivity 90% (corresponding sensitivity 80%) vs 67% for CPT123 | Study limitation (compared different tests and combinations) | Low for higher specificity in combination tests compared to neuropsychological tests |
| KQ1  Comparative specificity  Self vs parent report | 2 studies65, 122 | Conflicting results: 1 study reported a specificity of 81% for the CAARS-S (corresponding sensitivity 57%) vs 57% for the CAARS-P (corresponding sensitivity 94%);122 1 study reported a specificity of 30% for the BAARS self-report (corresponding sensitivity 89%) vs 77% for the BAARS parent report (corresponding sensitivity 60%)65 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative specificity  Self-report vs neuropsychological tests | 2 studies98, 145 | Conflicting results: 1 study reported a specificity of 84% for the ASRS (corresponding sensitivity 76%) vs 74% for a CPT (corresponding sensitivity 30%);98 1 study reported a specificity of 33% for the BADDS (corresponding sensitivity 92%) vs 86% for the C-CPT (corresponding sensitivity 47%)145 | Inconsistency (conflicting results) | Insufficient for comparative statements between tools |
| KQ1  Comparative specificity  Self-report vs clinician tool | 2 studies98, 100 | Favors self-report: 1 study reported specificity of 84% for the ASRS (corresponding sensitivity 76%) vs 75% for the CAARS-O (corresponding sensitivity 76%);98 1 study reported a specificity of 69% for the CAARS-S (corresponding sensitivity 83%) vs 52% for the MINI (corresponding sensitivity 83%)100 | Study limitation (compared different tests and combinations) | Low for favoring self-reports over clinician tools |
| KQ1  Comparative administration and scoring time | 0 studies | N/A | N/A | Insufficient for comparative statements between tools |
| KQ1  Comparative inter-rater reliability | 0 studies | N/A | N/A | Insufficient for comparative statements between tools |
| KQ1  Comparative costs | 0 studies | N/A | N/A | Insufficient for comparative statements between tools |
| KQ1  Comparative diagnostic concordance of primary care provider with specialist | 0 studies | N/A | N/A | Insufficient for comparative statements between tools |
| KQ1  Combination  Combining self and informant symptom ratings, demographic variables, neuropsychological assessments and/or EEG data to diagnose ADHD  Clinical misdiagnosis | 3 studies78, 98, 123 | Reported clinical false positive rate ranged from 16% in a study combining self-ratings and QbTest data to distinguish ADHD from Asperger’s syndrome78 to 18% in a study combining multiple self-reports and an observer report to distinguish from aggression98 | Study limitation (cannot be replicated based on reported detail) | Low for fair clinical false positive rate |
| KQ1  Combination  Combining self and informant symptom ratings, demographic variables, neuropsychological assessments and/or EEG data to diagnose ADHD  Sensitivity | 6 studies65, 78, 98, 123, 132, 154 | Sensitivity ranged from 100% using a Bayesian probability model integrating 3 diagnostic tools (WURS and EEG variables, corresponding specificity 100%, n=12)132 to 43% combining CAARS self and observer reports (corresponding specificity 83%)154 with the majority of studies reporting good sensitivity | Imprecision | Low for good sensitivity |
| KQ1  Combination  Combining self and informant symptom ratings, demographic variables, neuropsychological assessments and/or EEG data to diagnose ADHD  Specificity | 6 studies65, 78, 98, 123, 132, 154 | Specificity ranged from 100% using a Bayesian probability model integrating 3 diagnostic tools (WURS and EEG variables, corresponding sensitivity 100%, n=12)132 to 63% in a prediction model that combined BAARS parent and self-ratings of current and childhood ADHD diagnosis (corresponding specificity 89%)65 with the majority of studies reporting acceptable sensitivity | Imprecision | Low for acceptable specificity |
| KQ1  Self-report  Clinical misdiagnosis | 23 studies46, 50, 51, 62, 77, 87, 98, 100-102, 106, 108, 109, 111, 112, 122, 123, 130, 131, 141, 145, 153, 163 | Reported clinical false positive rates ranged from 12% differentiating from depression or generalized anxiety using the WURS130 to 90% in students with academic or psychological difficulties using the CAARS-S101 | Imprecision (values ranged widely) | Low for substantial clinical false positive rate |
| KQ1  Self-report  Sensitivity | 40 studies46, 50, 51, 58, 62-65, 70, 71, 77, 86, 87, 92, 94, 98, 100-102, 105, 106, 108, 109, 111, 112, 122, 123, 130, 131, 135, 141, 142, 145, 152-155, 159, 163, 164 | Sensitivity ranged from 100% (CAARS-S corresponding specificity 10%101 or ASRS-v1.1 with specificity not reported)58 to 14% (CAARS-S, corresponding specificity 92%)86 | Imprecision (range from excellent to poor) | Low for good sensitivity |
| KQ1  Self-report  Specificity | 37 studies50, 51, 62-65, 70, 71, 77, 86, 87, 92, 94, 98, 100-102, 105, 106, 108, 109, 111, 112, 122, 123, 130, 131, 141, 142, 145, 152-155, 159, 163, 164 | Specificity ranged from 99% (CBS corresponding specificity 90%)71 to 10% (CAARS-S, corresponding specificity 100%)101 | Imprecision (range from excellent to poor) | Low for good specificity |
| KQ1  Self-report  Administration and scoring time | 1 study105 | 1 study explicitly stated that the newly developed ADHD rating scale took about 15 minutes to complete105 | Inconsistency (no replication) | Low for short administration and scoring time |
| KQ1  Self-report  Rater agreement | 8 studies50, 65, 98, 100, 108, 109, 154, 163 | 1 study reported on kappa and found 0.006 agreement between WURS-brief vs DIVA rating;50 1 study reported 89% agreement between self and informant report;108  1 study reported an ICC of 0.43 for self vs parent BAARS-IV ratings;65 6 studies reporting Pearson self-observer correlations reported ranges from r 0.24 for a CAARS subscale154 to r 0.58 for CAARS-S:SV vs MINI report100 | Inconsistency (reporting on different measures and questionnaires) | Moderate for limited rater agreement |
| KQ1  Peer report  Clinical misdiagnosis | 1 study98 | Reported clinical false positive rates was 48% in an inpatient psychiatric hospital unit for the CAARS-O98 | Inconsistency (no replication) | Insufficient |
| KQ1  Peer report  Sensitivity | 3 studies65, 98, 122 | Sensitivity varied widely from 94% (CAARS:P, corresponding specificity 57%)122 to 60% (BAARS-IV, corresponding specificity 77%)65 | Inconsistency (reporting on different questionnaires), imprecision (range from excellent to poor) | Insufficient |
| KQ1  Peer report  Specificity | 3 studies65, 98, 122 | Specificity ranged from 77% (BAARS-IV, corresponding sensitivity 60%)65 to 57% sensitivity (CAARS:P, corresponding sensitivity 94%)122 | Inconsistency (reporting on different questionnaires), imprecision (range from fair to poor) | Low for limited specificity |
| KQ1  Peer report  Rater agreement | 1 study65 | 1 study reported ICCs ranging from 0.43 to0.31 for BAARS-IV subscales65 | Inconsistency (no replication), study limitation (subscales only) | Insufficient |
| KQ1  Neuropsychological tests  Clinical misdiagnosis | 9 Studies45, 55, 78, 95, 98, 119, 123, 140, 145 | Reported clinical false positive rates ranged from 11% in a study using Stroop test variables for participants referred for neuropsychological evaluation95 to 60% in a model based on QbTest with motion tracking variables144 | Inconsistency (studies used different combinations of variables), Study limitation (unclear if conditions can be replicated | Low for substantial clinical false positive rate |
| KQ1  Neuropsychological tests  Sensitivity | 21 studies45, 55, 59, 66, 68, 69, 78, 95, 98, 104, 114, 118, 119, 123, 134, 137, 140, 144-146, 158 | Reported sensitivity ranged from 93% (corresponding specificity 100%) integrating AQT variables118 to 17% for an individual subtest of the C-CPT (corresponding specificity 90%)146 | Imprecision (wide range of results) | Low for acceptable sensitivity |
| KQ1  Neuropsychological tests  Specificity | 21 studies45, 55, 59, 66, 68, 69, 78, 95, 98, 104, 114, 118, 119, 123, 134, 137, 140, 144-146, 158 | Reported specificity ranged from 100% (corresponding sensitivity 93%) integrating AQT variables118 to 40% for a model integrating QbTest Plus variables (corresponding sensitivity 88%)144 | Imprecision (wide range of results) | Low for acceptable specificity |
| KQ1  Neuropsychological tests  Administration and scoring time | 15 studies45, 55, 59, 66, 68, 69, 75, 78, 99, 104, 114, 123, 144, 145, 151 | There was some variation, but 7 studies estimated the duration of the test to be 20 minutes45, 55, 66, 69, 78, 123, 144 | Study limitation (scoring / data interpretation not mentioned) | Low for short administration time |
| KQ1  Neuroimaging  Clinical misdiagnosis | 2 studies48, 136 | 1 study reported a 3% clinical false positive rate for a large psychiatric database;48 1 study reported a 24% rate in a sample with various psychiatric and neuropsychiatric disorders using 3D thresholded SPECT136 | Imprecision (range from low to substantial) | Insufficient |
| KQ1  Neuroimaging  Sensitivity | 5 studies48, 56, 136, 157, 161 | Performance ranged from 100% (SPECT, corresponding specificity 97%)48 to 54% in a clinical sample (SPECT, corresponding specificity 76%)136 | Imprecision (wide range of values) | Low for acceptable sensitivity |
| KQ1  Neuroimaging  Specificity | 5 studies48, 56, 136, 157, 161 | Performance ranged from 97% (SPECT, corresponding sensitivity 100%)48 to 65% (functional MRI, corresponding sensitivity 91%)161 | Imprecision (wide range of values) | Low for acceptable specificity |
| KQ1  Neuroimaging  Administration and scoring time | 1 study136 | 1 study reported a procedure duration of 15-20 minutes136 | Inconsistency (no replication, very specific test) | Low for short duration |
| KQ1  Neuroimaging  Rater agreement | 1 study48 | 1 study reported kappa 0.79 for agreement in visual interpretation of scans48 | Inconsistency (no replication, very specific task) | Insufficient |
| KQ1  EEG  Clinical misdiagnosis | 1 study89 | 1 study reported a clinical false positive rate of 3.8% using auditory brainstem response profiling test89 | Inconsistency (no replication, very specific test) | Insufficient |
| KQ1  EEG  Sensitivity | 10 studies54, 80, 96, 97, 115, 116, 125, 126, 135, 139 | Reported sensitivity ranged from 100% (machine learning assisted, corresponding specificity 87%)91 to 67% (resting state EEG, corresponding specificity 83%)125 | Imprecision (values ranged widely) | Low for acceptable sensitivity |
| KQ1  EEG  Specificity | 10 studies54, 80, 96, 97, 115, 116, 125, 126, 135, 139 | Reported specificity ranged from 95% (event-related potential, corresponding specificity 86%)54 to 37% (resting state EEG, corresponding specificity 73%)96 | Imprecision (values ranged widely) | Low for good specificity |
| KQ1  EEG  Administration and scoring time | 6 studies54, 91, 96, 97, 116, 125 | Reported session duration ranged from 6 minutes96 to 26 minutes116 | Imprecision (substantial variation) | Low for short duration |
| KQ1  Biomarkers  Clinical misdiagnosis | 2 studies88, 150 | 1 study reported a clinical false positive rate of 17% in an eye tracker study in sample of participants with conduct disorder;88 1 study reported a rate of 75% in a MFNU study in a psychiatric outpatient clinic (some participants had subthreshold ADHD)150 | Imprecision (value ranged widely), Inconsistency (very different biomarkers, only 1 study each) | Insufficient |
| KQ1  Biomarkers | 4 studies49, 79, 88, 150 | Performance ranged from 98% (MFNU, corresponding specificity 25%)150 to 80% (eye tracker, corresponding specificity 83%)88 | Imprecision (values varied), Inconsistency (no replication of the same marker) | Insufficient |
| KQ1  Biomarker  Specificity | 4 studies49, 79, 88, 150 | Performance ranged from 83% (eye tracker, corresponding sensitivity 80%)88 to 25% (MFNU, corresponding sensitivity 98%)150 | Imprecision (values ranged from acceptable to poor) | Insufficient |
| KQ1  Biomarker  Administration and scoring time | 1 study88 | 1 study reported that the eye tracking task took about 15 minutes88 | Inconsistency (no replication, very specific task) | Insufficient |
| KQ1  Clinician tools  Clinical misdiagnosis | 3 studies100, 121, 123 | Reported clinical false positive rates ranged from 9% for the MINI-Plus in an addiction treatment center121 to 48% for the MINI100 | Inconsistency (different tools), Imprecision (values ranged widely), Study limitation (likely dependent on specific patient population) | Insufficient |
| KQ1  Clinician tool  Sensitivity | 3 studies100, 121, 123 | Performance ranged from 83% (corresponding specificity 52%)100 to 73% (corresponding specificity 90%)123 | Imprecision (values varied), Inconsistency (different tools), Study limitation (likely dependent on patient population) | Low for fair sensitivity |
| KQ1  Clinician tool  Specificity | 3 studies100, 121, 123 | Performance ranged from 91% (corresponding sensitivity 75%)121 to 52% (corresponding sensitivity 83%)100 | Imprecision (values varied), Inconsistency (different tools), Study limitation (likely dependent on specific patient population) | Insufficient |
| KQ1  All tests  Costs | 0 studies | N/A | N/A | Insufficient |
| KQ1  All tests  Concordance primary care and specialty | 0 studies | N/A | N/A | Insufficient |
| KQ1a  Effect of clinical setting  All outcomes | N/A | N/A | Inconsistency (lack of primary care studies) | Insufficient |
| KQ1a  Effect of comparator sample  Clinical misdiagnosis | N/A | 4 studies noted that tests were less effective when distinguishing ADHD from other clinical conditions (rather than the general population) due to overlapping symptoms64, 102, 145, 150 | Study limitation (not all tests addressed) | Low for higher risk of clinical misdiagnosis in clinical samples\* |
| KQ1a  Effect of ADHD presentation  Sensitivity | N/A | Conflicting results across 4 studies70, 94, 101, 141 | Inconsistency (conflicting results) | Insufficient |
| KQ1a  Effect of age of participants and age at diagnosis  Sensitivity and specificity | N/A | 1 study reported that sensitivity and specificity were higher in younger adults (18-44) compared to older adults (31-44)94 | Inconsistency (no replication) | Insufficient |
| KQ1a  Effect of participant sex  Sensitivity and specificity | N/A | Conflicting results across 5 studies55, 56, 89, 100, 155, 163 | Inconsistency (conflicting results) | Insufficient |
| KQ1a  Effect of comorbidities  Sensitivity | N/A | Conflicting results: while 2 studies reported no effect of comorbidities on sensitivity,101, 153 1 study reported lower sensitivity,106 and 2 studies reported that diagnostic performance was unaffected by comorbidities55, 102 | Inconsistency (conflicting results) | Insufficient |
| KQ1a  Effect of comorbidities  Specificity | N/A | 3 studies reported challenges for specificity,66, 101, 153 1 study reported higher specificity in participants with comorbidities,106 2 studies reported that diagnostic performance was unaffected by comorbidities;55, 102 4studies pointed out the high prevalence of comorbid conditions such as depression and anxiety.77, 94, 135, 141 | Study limitation (not all tests addressed) | Low for lower specificity in participants with comorbidities |

Notes: We broadly categorized performance as follows: low (<5%), fair (<20-5%), substantial (20-60%) clinical misdiagnosis rate; limited (<80%), poor (<69%), fair (70-79%), acceptable (80-89%), good (90-95%), excellent (96-100%) sensitivity and specificity; short (<30 minutes) administration and scoring time; limited rater agreement (kappa <0.8, correlations <0.40); \*clinical samples defined as composed of participants undergoing diagnostic workup (as opposed to general, unselected, and/or neurotypical participant samples)

Abbreviations: ADHD Attention-Deficit/Hyperactivity Disorder; AQT Adult ADHD Quick Test; ASRS Adult ADHD Self-Report Scale; BAARS Barkley Adult ADHD Rating Scale; BADDS Brown Attention-Deficit Disorder Scales; C-CPT Conners continuous performance test; CAARS-O Conners Adult ADHD Rating Scale-Observer-Report; CAARS-P Conners Adult ADHD Rating Scale-Peer-Report; CAARS-S Conners Adult ADHD Rating Scale-Self-Report; CBS Current Behavior Scale; CPT continuous performance test; DIVA Diagnostic Interview for ADHD in Adults; EEG electroencephalogram; ICC intra-class correlation; GRADE Grading of Recommendations Assessment, Development and Evaluation; KQ key question, MINI Mini-International Neuropsychiatric Interview; MFNU Motor Function Neurological Assessment; MRI magnetic resonance imaging; N/A not applicable or not available; QbTest quantified behavioral test; SPECT single photon emission computed tomography; vs versus; WURS Wender Utah Rating Scale

The included studies did not report on the impact for participants of being correctly or incorrectly diagnosed. Studies reported only on the performance of the tests but not the effect a diagnosis (or a misdiagnosis) had on participants or similar.

None of the included studies reported on unintended consequences, adverse events, adverse effects, or side effects of the diagnostic tools, including blood-based biomarker, EEG, neuroimaging, and neuropsychological test studies.

Finally, we identified numerous studies reporting on the performance of tests for detecting feigning ADHD. All studies also reporting also on the diagnostic performance of diagnosing ADHD are included in the respective test sections earlier in this chapter and the evidence tables C1 to C8. Studies used subjective tests such as self-report questionnaires as well as objective tests such as neuropsychological test batteries. Results of all studies reporting on feigning ADHD are shown in the evidence table in the appendix (Appendix Table C9).

4. Discussion

This evidence report synthesizes the results of evaluations of available tools for diagnosing attention deficit/hyperactivity disorder in adults. The systematic review reveals a complex landscape with varying levels of evidence across assessment approaches. We identified over 100 studies evaluating the diagnostic performance of self-report questionnaires, peer review questionnaires, neuropsychological tests, neuroimaging, electroencephalogram (EEG), diverse biomarkers, clinician tools, combinations of modalities, and tools to identify feigning ADHD. Despite the research volume, direct comparisons between tests were limited, often resulting in insufficient strength of evidence for definitive evidence statements.

As part of the review, we also addressed a context question regarding the relative frequency of use of tools, given that the use of tools in routine care can be quite different from the scientific research literature. The current frequency of use of the various tools for diagnosing ADHD in adults by primary care and specialty mental health clinicians is unknown. Nevertheless, some published reports suggest that their use is common and widespread. For example, the American Academy of Family Practitioners recommend obtaining rating scales for ADHD from both the patient and significant others in the patient’s life (spouse, a close relative, employer, or colleague). Likewise, the American Psychiatric Association advises the use of ADHD rating scales in addition an in-depth clinical interview for the ADHD diagnosis.165

Large surveys suggest that primary care physicians, psychiatrists, and psychologists commonly, but nurse practitioners less often, rely on one or more of these tools when diagnosing ADHD. An online survey of 1,924 U.S. physicians completed a survey about care of adults for ADHD; 83 percent of primary care physicians and 97 percent of psychiatrists screened for adult ADHD in adults who complained of typical ADHD symptoms, with 64 percent of primary care physicians and 57 percent of psychiatrists using an ADHD rating scale to aid their screening.166 However, only 20 percent of primary care physicians and 25 percent of psychiatrists conducted an extended interview to confirm the diagnosis. Once initiating stimulant treatment, however, 69 percent reported using a rating scale to help titrate the dose. Another survey of 400 primary care physicians surveyed indicated that 85 percent would take a more active role in making an ADHD diagnosis if they had a screening tool that was appropriately developed and validated and both easy to use and quickly administered.167 Studies of diagnostic reports submitted by young adults who were seeking academic accommodations at postsecondary schools or on medical licensing exams showed that most relied primarily or exclusively on current self-reported symptoms on rating scales, suggesting their widespread use by psychologists. Those studies also reported, however, that the clinicians failed to obtain collateral reports, confirm childhood onset, establish functional impairment, or rule out other potential causes for the reported symptoms.168-171 A survey mailed to 262 nurse practitioners in Alaska indicated that only 12 percent were likely to diagnose ADHD in practice; 38 percent of the 68 who responded to a question about methods used to diagnose ADHD in adults reported using a diagnostic screening tool.172

Neuropsychological test measures and specialized rating scales are also commonly used for both diagnostic and clinical assessment of ADHD in adults. This is particularly true with the recent promulgation of commercial, computer-based platforms for administering various versions of the Continuous Performance Task (CPT), such as the QB test, that claim diagnostic utility for adults with ADHD. An indirect indication of the frequency of use of these tests, at least by psychologists and neuropsychologists, is a Delphi consensus study published in 2019. The study surveyed 27 clinician researchers from around the world who were experienced in working with adults who have ADHD and asked them to rate, over four rounds of questioning that progressively honed a list of most highly prioritized tests, the importance of neuropsychological functions in assessing adults who have ADHD, with the aim of composing a list of the most relevant neuropsychological functions to assess and the corresponding tools to assess them.173 The top five domains identified and the tools recommended to assess them with strong group consensus were: (1) sustained attention (assessed using Conners Continuous Performance Test III), (2) distractibility (Conners CPT III), (3) inhibitory control (Go/NoGo test), (4) task planning and organization (the BRIEF self-report survey), (5) working memory (digit span test). ADHD symptoms identified to assess included impulsivity and hyperactivity. The assessments were not considered to be diagnostic per se, because poor scores on the measures can have multiple causes. The tools were instead recommended for clinical assessment to characterize neuropsychological functioning in adults already diagnosed with ADHD.

4.1 Comparative diagnostic performance of tools to diagnose ADHD among adults

We identified over 100 studies that assessed putative tools to aid the diagnosis of ADHD in adults. Although this is a substantial number of studies, we deemed the strength of evidence for the reported performance measures across each of categories of diagnostic tools to be generally low because of large performance variability across studies, the use of widely varying non-ADHD comparison populations, reporting practices that precluded meta-analyses across studies, and statistical analyses that were often exploratory across a large number of variables.

4.1.1 Measures Reported for Diagnostic Performance

As outlined in detail in the introduction, diagnosing Adult ADHD is complex and in addition to issues surrounding the reference standard, this review also highlighted limitations associated with reported measures. Most studies reported sensitivity (true positive rate), specificity (true negative rate), and diagnostic accuracy (how many are correctly diagnosed). Although these are standard performance statistics for diagnostic classification, they have the important limitation of being dependent on an arbitrary threshold that is applied to scores from a diagnostic tool that defines whether individual participants do or do not have ADHD – for example, the percent of symptoms endorsed, the numerical score on a rating of symptom severity or measure of cognitive performance, or the power in an EEG frequency band. Studies that use the same diagnostic tool often apply different thresholds to the scores from that tool, which will necessarily alter the reported sensitivities and specificities. Comparing sensitivities and specificities across studies that use differing thresholds is therefore like comparing apples and oranges.

Moreover, sensitivity and specificity, because of how they are defined and calculated, inherently have an inverse relationship to one another, such that raising the diagnostic threshold for a score on a tool will reduce sensitivity (i.e., it will identify fewer people who truly have ADHD) but increase specificity (i.e., falsely identify fewer people as having ADHD who do not in fact have it), and vice versa for lowering the diagnostic threshold. This inherent trade-off between sensitivity and specificity establishes an operational limit for plots of sensitive versus specific as shown in the figures along the y = -x line, i.e., from the upper left to lower right corner of the plot, which would identify diagnostic tests that perform at no better than chance. Tools in the upper right quadrant of that plot improve in overall performance as they approach the upper right corner, or perfect accuracy (100% true positives and 100% true negatives). Identified research shows that, for categories of tools such as rating scales and neuropsychological test measures that have the most data points, many studies perform little better than chance (they lie close to the y = -x line; studies that lie to the left of it perform worse than chance) and, moreover, because they lie on or near the diagonal, the findings suggest that variability in performance likely derives from differences in the thresholds applied to the scores from the diagnostic tools. Unfortunately, adjusting sensitivity and specificity through use of the same diagnostic threshold is impossible without having the scores from the tool for each study participant. Reports of diagnostic accuracy suffer the same limitation of depending inherently on the diagnostic threshold applied to the tool’s score.

One index of diagnostic performance that addresses these limitations of sensitivity and specificity metrics is AUC (area under the curve), a measure from receiver operating characteristic (ROC) curves that was first developed by engineers during World War II to detect enemy objects in the battlefield. An ROC curve is a plot of sensitivity vs specificity across the entire range of possible diagnostic thresholds. The area under this ROC curve provides a single, overall index of performance that is independent of diagnostic threshold. AUC values range of 0.5 (corresponding to the y=x line) indicate that the tool provides no information above chance for diagnostic classification. Values of 1.0 (corresponding to the vertical x=0 line) indicate that the tests performs perfectly, correctly classifying all participants who have ADHD as having it and all non-ADHD participants as not having it. Intermediate AUC values of 90 to 100 are commonly classified as *excellent* performance; 80 to 90 as *good*; 70 to 80 *fair*; 60 to 70 *poor*; and 50 to 60 as *failed*. Studies of diagnostic tools are increasingly reporting performance in terms of AUC, in addition to the more traditional measures of sensitivity and specificity.

A minority of studies reported other measures of diagnostic performance, including positive predictive value (PPV) and negative predictive value (NPV). They are calculated as PPV = True Positives / (True Positives + False Positives), and NPV = True Negatives / (True Negatives + False Negatives). PPV is the probability that a person with a positive test result has the condition; NPV is the probability that a person with a negative test result does not have the condition. False positives will increase and false negatives will decline with lower base rates in the population – if no one has the condition, all positive results are false, and all negative results are correct then PPV will decrease to 0.00 (no one with a positive test result has the condition) and NPV will increase to 1.00 - everyone with a negative test result does not have the condition (and the reverse is true if everyone has the condition). Thus, these metrics represent the utility of diagnostic tools in a particular setting that has a specific base rate of ADHD in population sampled. They will differ across varying diagnostic settings because the base rates of ADHD differ across those settings (the base rate may be, for example, 60-70% in a clinic where patients assessed for suspected ADHD, it may be 50% in a study designed to have equal numbers of ADHD and healthy control participants, or it may be 5% in an epidemiological sample of the general population). Very few studies that we identified for inclusion reported PPV and NPV values, generally without providing accurate and independent estimates of the base rates of ADHD in the study’s specific diagnostic setting.

4.1.2 The Importance of the Comparator Sample

Measures of diagnostic accuracy will vary with the characteristics of the non-ADHD participants from which the diagnostic tool is attempting to discriminate the study’s ADHD participants. For example, if the non-ADHD participants are patients who have more symptoms that overlap those of ADHD, as occurs commonly with patients who have autism, depression, or anxiety, false positives will tend to be higher than in studies where the non-ADHD participants have few or no symptoms that overlap, as happens when the comparator group is a sample of neurotypical controls.

In real-world clinical practice, clinicians rarely if ever need to determine whether a patient has ADHD or is healthy and symptom-free (the clinical equivalent of a neurotypical control in many research studies). The patient has presented to the clinician with some kind of clinical problem, or they would not be seeing the clinician. That problem likely has symptoms that overlap those of ADHD, or ADHD would not be considered as a clinical possibility. For these reasons, the much more clinically relevant studies of performance for tools that aid the diagnosis of ADHD are those that employ a comparator group of participants who have mental health problems and symptoms that may overlap those of ADHD. The *most* clinically relevant comparison are from studies in which all participants were presenting for evaluation of possible ADHD, because real-world clinicians are asked to diagnose ADHD in patients who are presenting for an ADHD assessment.33 These comparator samples will tend to produce more false positives in diagnostic testing, thus lowering specificity metrics.168

4.1.3 Rating Scales

Numerous studies reported on performance for at least one self-report measure in diagnosing ADHD (Figure 5). The number of different scales was large (17), but the most commonly reported measures were the CAARS, ASRS, and WURS. Studies that used the same measure often applied different diagnostic cut-offs to the score the measure generates. Self-reports were generally able to correctly rule out ADHD, with good but rarely excellent performance and substantial variation across studies.71, 86, 101

Examination of the plotted sensitivity versus specificity suggests that sensitivity and specificity measures are similarly distributed around the y=x line, indicating that self-rating scales are similarly likely to under-identify individuals who truly have ADHD (reflecting sensitivity) and to over-identify individuals who do not have ADHD (reflecting specificity).168 Closer examination also suggests that the measures of CAARS performance tended to lie along the y = -x line or close to it, suggesting poorer performance independent of the specific diagnostic threshold used. Measures of the ASRS tended to cluster closer to the upper right corner, suggesting overall better performance, independent of the diagnostic threshold used. Only three studies reported performance for peer ratings, but the characteristics of the studies preclude interpretation.

4.1.4 Neuropsychological Tests

A considerable number of studies have been published that report on the performance of various neuropsychological tests to diagnose ADHD in adults. Most of these studies assessed performance of a wide range of measures in a highly exploratory way, without specific hypotheses for which measures would perform best. All the studies reported on performance of some form of CPT, but the CPT, like most of the individual neuropsychological tests, itself generates many measures, and which of those measures was reported and performed best varied widely across studies. These approaches to the analysis and reporting of results greatly complicate comparison of performance across studies and the interpretation and generalization of findings. The best performing of the neuropsychological tests are reported here, which risks a positive bias for assessing overall performance of neuropsychological tests, but which nevertheless seems to be the most efficient way to report findings.

With all these caveats, results indicated a substantial false negative rate in most studies.95, 144 Sensitivity varied widely, from excellent for the AQT118 to very poor,146 with most sensitivity measures in the fair range or poorer, indicating that neuropsychological tests often missed the diagnosis in those who truly had ADHD. Specificity likewise varied widely, from perfect specificity for the AQT118 to poor specificity for QbTest Plus variables,144 though in general, specificity was fair at best, indicating that tests often incorrectly identified non-ADHD controls as having ADHD.

Comparing sensitivity and specificity measures across categories of diagnostic tools, neuropsychological tests do not seem to perform better than self-report measures (self-report measures have more frequent clusters near the upper right corner of the plots, indicating better combinations of sensitivity and specificity). Recent systematic reviews of the diagnostic utility of continuous performance measures for adults with ADHD have concluded that these tests are vulnerable to practice effects and the feigning of symptoms, and they alone do not sufficiently dis­criminate persons who have ADHD from clinical controls.38, 39

4.1.5 Other Diagnostic Tools

With a couple of exceptions, overall diagnostic performance of EEG measures was fair to good for the dozen studies that reported them, although, similar to the limitations of neuropsychological test studies, the EEG measures varied widely across studies and were often highly exploratory in assessing performance across many measures. Measures, for example, ranged from resting state EEG,96, 125 to event-related potentials during neuropsychological tasks,54, 115 to EEG recordings during transcranial magnetic stimulation.80 Several of the studies used machine learning or other techniques to combine various EEG measures into a highly complex test measure that would be difficult or impossible to replicate in future studies. Most employed a non-clinical comparator sample, which likely contributed to the reasonable performance measures. Sensitivities ranged from perfect performance during a CPT and using machine learning-derived EEG measure91 to fair performance using resting state EEG measures.125 Specificity showed an even wider range from excellent for event-related potential54 to poor performance in a study evaluating resting state EEG96 but was generally good in identified studies. Most clinical practices and even research centers do not have EEG capability, let alone under the complex testing conditions employed in these studies. The real-world applicability of these measures is therefore currently extremely limited.

The studies that assessed diagnostic performance for neuroimaging measures used a wide range of imaging technologies, including SPECT,48 3-D SPECT,136 structural MRI, DTI,56 and resting state fMRI.157, 161 Limitations of these studies are similar to those for EEG measures, with diagnostic test measures highly ad hoc and complex, precluding generalizability and opportunities for replication. Comparator samples were often non-clinical, and analyses were often exploratory across multiple test measures. Sensitivities ranged from perfect in a large retrospective cohort SPECT study48 to poor in a SPECT study136 with a clinical comparator sample. Specificities ranged from excellent in the retrospective SPECT study48 to fair in an fMRI study).161 Also similar to EEG, the real-world applicability of using neuroimaging methods to aid diagnosis is limited by the practical challenges in acquiring the imaging measures.

Five studies reported on performance of putative biomarkers in diagnosing ADHD. Each used a different technology, including a genetic marker,79 eye tracking,88 blood oxidative status,138 physiological data from a wearable device,49 and Motor Function Neurological Assessment (MFNU).150

4.2 Direct Comparisons of Diagnostic Performance

Because measures of diagnostic performance, especially measures of sensitivity and specificity, vary with the diagnostic threshold applied to the score that the diagnostic tool generates, as well as sample characteristics, interpreting differences in measures of diagnostic performance across studies is exceedingly difficult. All these differences in study characteristics undoubtedly contributed to the scatter of data points in the plots of sensitivity versus specificity shown in the figures; disentangling all of these effects on measures of diagnostic performance across studies is impossible.

For these reasons, studies that directly compare measures of performance across diagnostic tools in the same sample of participants are most valuable to identify better performing tools. We identified 11 such studies. Of those, two had only six participants each who had ADHD100, 132 and preclude interpretation. One study reported performance metrics only for EEG measures.54 Of the remaining studies, seven were discriminating participants with ADHD from participants with other clinical conditions65, 78, 98, 122, 123, 145, 154 and one was discriminating from participants with a mix of patients and neurotypical controls.119 They all assessed performance of self-rating scales for ADHD symptoms. Those that attempted to make very difficult clinical discriminations reported the poorest performance (e.g., ADHD+ASD vs ASD alone: sensitivity 57%, specificity 81%;122 combined type ADHD vs predominantly Inattentive ADHD: sensitivity 65%, specificity 61%).154 The other studies generally reported sensitivities ranging from the mid-70’s to low 90’s, but those with the highest sensitivities had the lowest specificities, in the high 20’s and low 30’s, as expected given the inherent trade-off between sensitivity and specificity that depends on the diagnostic threshold applied to scores from the rating scale. Peer ratings were also assessed in three of the studies:65, 98, 122 one reported substantially lower sensitivities but higher specificities than for the self-ratings;65 one reported performance comparable to self-ratings; 98 and one reported substantially higher sensitivity and specificity when using both an ADHD scale and an ASD scale in discriminating ASD+ASD from ASD alone.122 Combining the self-ratings and peer ratings in two of these studies yielded comparable sensitivity in one study,65 improved sensitivity in the other,98 and improved specificity in both, compared with self-ratings alone.

Neuropsychological measures were assessed in five of these studies.78, 98, 119, 123, 145 Sensitivities ranged from 30 percent (corresponding specificity 74%) 98to 84 percent (corresponding specificity 80%),78 and specificities ranged from 56 percent (corresponding sensitivity 73.3%)123 to 86 percent (corresponding sensitivity 47%).145 Generally, however, performance of these as stand-alone measures was poorer than for self-ratings, and studies were inconsistent in identifying which of the numerous measures from the continuous performance measurement (e.g., omission errors, commission errors, reaction time variability) provided the best performance. Three of these studies assessed diagnostic performance when combining self-ratings with continuous performance measures.78, 119, 123 One found substantially better sensitivity than for the neuropsychological test alone and better specificity than for the self-rating alone, one found better sensitivity and specificity than for the continuous performance test alone,78 and one did not report sensitivity or specificity for the combination.119

These findings from head-to-head comparisons, taken together, suggest that the combination of self-ratings, peer ratings, and continuous performance test scores may one day prove more useful than either measure alone in accurately diagnosing ADHD. Currently, however, self-ratings combined with peer ratings offer the best evidence for improving diagnostic performance over either rating alone.

4.3 Implications

Self-report scales are easy to use tools to aid the diagnosis of ADHD in both primary and specialty care settings. They are prone, however, to both false positive and false negative findings, especially when used in a setting where adults present for evaluation of suspected ADHD. A negative test is reassuring but not conclusive, and it likely prompts in a patient complaining about ADHD symptoms an assessment of current symptoms, as well as retrospective assessment of symptoms earlier in childhood (when symptom expression may have been more complete) from other sources – including spouses, significant others, parents, siblings, and teacher comments in school records. A negative test also prompts questions about other mental health problems whose symptoms overlap those of ADHD, especially depression, anxiety, substance abuse, stress, and trauma.

Self-report scales are also prone to false positives, most often from the presence of one or more of these conditions with overlapping symptoms. Therefore, assessing the validity of positive responses to questions on the scale helps in deciding how likely the test result is to be a true positive. Thus, patients with a positive test results should elaborate on experiences of symptoms in their own words, noting when the symptoms first began to discern if they were present in childhood, reviewing the trajectory of the symptoms over time, the settings or experiences that exacerbate them, and what kind of functional impairment they produce, if any.16 ADHD symptoms in childhood can be assessed by asking patients and parents to complete retrospective symptom reports on standard checklists, such as the ADHD rating scale174 or the Conners 3 rating scale.175 Similar to a negative test, positive tests also raise questions about overlapping symptoms from other conditions. Assessing symptoms of other conditions that can overlap with ADHD symptoms can be done even in a busy clinical practice through the use of existing scales for depression and anxiety (such as the PHQ-9176 and GAD-7177). It is critical to assess whether positive responses truly represent ADHD or instead the symptoms of another clinical condition.16

Neuropsychological tests, including the CPT, are not routine in diagnosing ADHD in adults, and both sensitivity and specificity for these tests are on average lower than for self-report measures. Certainly, the long and expensive batteries of traditional neuropsychological testing will not aid diagnosis of ADHD, though they may serve other clinical purposes. Prior reviews of CPT performance as a diagnostic tool in adults with ADHD have yielded these same conclusions.38, 39 Whether the combination of a CPT with self-report measures can improve diagnostic performance is at present unclear. In addition, symptom validity tests and performance validity tests can detect some invalid presentations in self-reports and inadequate effort in neuropsychological tests and many experts have recommended the use of these tools as part of a comprehensive assessment of ADHD in adults.178-184 Identified studies varied regarding the inclusion of validity tests. In addition, an individual’s effort during testing can fluctuate significantly over the course of an assessment, and individuals differ in what cognitive abilities they choose to exaggerate or feign deficits.110, 185

Finally, the quality of evidence for objective tests that are not vulnerable to impression management such as EEG, neuroimaging, and biomarkers, as tools to diagnose ADHD in adults is low. None of the performance findings have been replicated, and no clinical effectiveness studies have been conducted to assess use of these tools in the real world to diagnose ADHD. From a practical perspective, very few primary care or specialty mental health clinicians have access to these technologies. Thus, these tools are not even remotely close to being ready for clinical application to aid diagnosis, even though the FDA has approved one EEG measure as a purported diagnostic aid.186, 187

4.4 Strengths, Limitations, and Applicability

A strength of this review is its scope and inclusiveness - publications did not have date restrictions, and they were not limited to use of any pre-specified tools, which led to inclusion of novel EEG, neuroimaging, and biomarker studies in the diagnosis of ADHD. Nonetheless, this review was limited to diagnostic accuracy studies and did not focus on psychometric considerations such as the validity of symptoms supporting a diagnosis. In addition, we restricted the review to English-language studies, which will have missed some tools used locally outside of the U.S. and other English-speaking countries.

The conclusions of this review are limited by the poor quality of evidence for performance of every category of diagnostic tool and by the paucity of reporting findings that would support meta-analysis across studies, including AUCs, false positive and negative rates, and the thresholds applied to scores from the diagnostic tools. Furthermore, limiting to studies reporting on a reference standard added focus to the review, but given the issues surrounding a clinical diagnosis of ADHD in adults also needs to acknowledge that there is no true and universally accepted gold standard in this research area.

Finally, several included studies reported multiple exclusions for eligible participants, which hinders the generalizability of the findings to patients seen in routine practice, in particular in primary care. Furthermore, some studies used sophisticated and resource-intense assessment methods, as well as advanced analytic procedures to optimize diagnostic performance. Hence, diagnostic performance may not translate from the favorable effects shown in the documented research to real world practice and likely represent a best-case scenario.

4.5 Next Steps

Despite the limitations of studies thus far, it seems clear from their findings that no single rating scale or neuropsychological test, and probably no single neuroimaging algorithm or biomarker, will provide the desired combination of high sensitivity and high specificity in diagnosing adults who have ADHD in real-world settings, where the clinical question is whether a given individual who is suspected of having ADHD actually has it. The relatively few studies that have directly compared the performance of diagnostic tools with one another provide some early indication that the combination of tools may yield may improve both sensitivity and specificity in diagnosing ADHD compared with the use of any single tool alone. Future studies should compare the performance of tools within and across categories, both singly and in combination. The methods for optimally combining measures across different tools should be made explicit and have a clear rationale. Algorithms for combining measures that are based on machine learning, neural networks, or other similar “black box” technologies should be made publicly available to facilitate validation, replication, and dissemination. Much more research is needed to determine how to combine data optimally across informants or tools.16, 33

Future studies should move past the use of neurotypical comparator groups, which have little or no real-world clinical relevance, and instead assess diagnostic performance only in clinical samples. Further, future studies should assess diagnostic performance in clinically important participant subgroups, including subgroups defined by age, sex, race, ethnicity, and the presence of disorders that commonly co-occur with ADHD, if only to be able to say with more confidence that there are no differences. We cannot assume that the absence of research equates to the absence of evidence and we had to note several times that the evidence was simply insufficient for more concrete evidence statements. Because the diagnosis of ADHD requires childhood onset, studies are needed to assess how best to assess and validate the presence of symptoms in childhood.168 It is often difficult to obtain childhood educational and medical records and adults’ recall of childhood symptoms is limited.16, 168, 169, 188-193 More research is also needed on measures to detect invalid responses in completing self-report ADHD rating scales and inadequate effort on neuropsychological tests.33

Future studies of diagnostic tools should report their findings in much more detail to support meta-analyses across studies. This would include reporting false positive and negative rates, the thresholds applied to scores from the diagnostic tools, and any data manipulation used to produce the finding. Studies should also report ROC analyses to support comparisons of test performance across studies that are independent of diagnostic thresholds. Studies should also make available their individual-level data in public repositories to support future efforts at replication, synthesis, and new discovery.

Although currently available “objective” measures of neurocognitive performance are not likely to be useful tools in diagnosing ADHD in adults, continued search for and development of better objective, performance-based measures is warranted. Candidate tools will need to overcome the limitations identified for prior continuous performance tests and other neuropsychological tests. New, better-performing tools will need to correlated better with ADHD symptom ratings, have better test-retest reliability, have fewer ceiling effects that likely contribute to false negative diagnoses, and have greater ecological validity – i.e., better simulate the effects of external and environmental distractions that disrupt attention in everyday life. 33, 38, 39, 173

Finally, studies are needed to assess the consequences of being correctly or incorrectly diagnosed as having ADHD and any unintended consequences and adverse effects of diagnostic tools.

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Abbreviations and Acronyms

ABC Aberrant Behavior Checklist

ADHD Attention-Deficit/Hyperactivity Disorder

AHRQ Agency for Healthcare Research and Quality

AQ10 Autism Quotient - 10

BAARS-IV Barkley Adult ADHD Rating Scale-IV

DSM-5 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

EEG Electroencephalogram

EPC Evidence-based Practice Center

FDA Food and Drug Administration

N/A Not available

SEADs Supplemental Evidence And Data for Systematic Reviews

SOE Strength of Evidence

TEP Technical Expert Panel

TOVA Test of Variables of Attention

Appendixes

Appendix A. Search Strategy

Appendix B. List of Included, Background, and Excluded Studies

Appendix C. Evidence Tables

Appendix D. Critical Appraisal and Applicability Tables

Appendix A. Search Strategy

**Date: October 14, 2024**

**PubMed**

|  |
| --- |
| "Attention Deficit Disorder with Hyperactivity"[Mesh] OR "attention deficit hyperactivity disorder"[tiab] OR "ADHD"[tiab] OR "attention deficit disorder"[tiab])  AND  Adult[MESH] OR Aged[MESH] OR Middle Aged[MESH] OR Young Adult[MESH] OR Adult[Title/Abstract] OR Adults[Title/Abstract]  AND  "Attention Deficit and Disruptive Behavior Disorders/diagnosis"[Majr] OR mass screening[mesh] OR questionnaires[mesh] OR Interviews as Topic[Mesh] OR Psychometrics[Mesh] OR Psychiatric Status Rating Scales[Mesh] OR diagnosis[mesh:noexp] OR "Diagnostic Techniques and Procedures"[Mesh] OR "Referral and Consultation"[Mesh] OR questionnaire[tiab] OR questionnaires[tiab] OR screening[tiab] OR screen[tiab] OR scale[tiab] OR instrument[tiab] OR instruments[tiab] OR interview[tiab] OR interviews[tiab] OR diagnosis[tiab] OR diagnostic[tiab] OR diagnosed[tiab] OR Measure [tiab] OR test[tiab] OR tests[tiab] OR testing[tiab] OR "Attention Deficit Disorder with Hyperactivity/diagnostic imaging"[Majr] OR ((("Adaptive Behavior Assessment System"[Title/Abstract] OR "ABAS-3"[Title/Abstract] OR "Advanced Clinical Solutions"[Title/Abstract] OR "Word Choice Test"[Title/Abstract] OR "Test of Premorbid Functioning"[Title/Abstract] OR "Social Cognition"[Title/Abstract] OR "Beck Anxiety Inventory"[Title/Abstract] OR "BAI"[Title/Abstract] OR "Beck Depression Inventory"[Title/Abstract] OR "BDI-2"[Title/Abstract] OR "Behavioral Assessment System for Children"[Title/Abstract] OR "Self-Report of Personality"[Title/Abstract] OR "BASC-3 SRP Adolescent"[Title/Abstract] OR "Behavioral Assessment System for Children"[Title/Abstract] OR "Parent Rating Scales"[Title/Abstract] OR "BASC-3 PRS Adolescent"[Title/Abstract] OR "BASC-3 SRP College"[Title/Abstract] OR "Teacher Rating Scales"[Title/Abstract] OR "BASC-3 TRS Adolescent"[Title/Abstract] OR "Brown Executive Function/Attention Scales"[Title/Abstract] OR "Brown EF/A Self"[Title/Abstract] OR "California Verbal Learning Test"[Title/Abstract] OR "CVLT-3"[Title/Abstract] OR "Standard Form California Verbal" "CVLT-3 Brief"[Title/Abstract] OR "California Verbal Learning Test"[Title/Abstract] OR "CVLT-C"[Title/Abstract] OR "Childhood Autism Rating Scale"[Title/Abstract] OR "CARS-2"[Title/Abstract] OR "Childhood Autism Rating Scale"[Title/Abstract] OR "High-Functioning Version"[Title/Abstract] OR "CARS-2 HF"[Title/Abstract] OR "Clinical Evaluation of Language Fundamentals"[Title/Abstract] OR "CELF-5"[Title/Abstract] OR "Comprehensive Executive Function Inventory"[Title/Abstract] OR "CEFI Adult Observer"[Title/Abstract] OR "Comprehensive Executive Function Inventory"[Title/Abstract] OR "CEFI Adult Self-Report"[Title/Abstract] OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV"[Title/Abstract] OR "CAADID Part 1"[Title/Abstract] OR "CAADID Part 2"[Title/Abstract] OR "CAARS–O:L"[Title/Abstract] OR "CAARS–S:L"[Title/Abstract] OR "CAARS-2 Observer"[Title/Abstract] OR "Conners’ Adult ADHD Rating Scales"[Title/Abstract] OR "CAARS-2 Self-Report"[Title/Abstract] OR "Delis-Kaplan Executive Function System"[Title/Abstract] OR "D-KEFS"[Title/Abstract] OR "Dot Counting Test"[Title/Abstract] OR "Grooved Pegboard Test Kaufman Test of Educational Achievement"[Title/Abstract] OR "KTEA-3"[Title/Abstract] OR "Neuropsychological Assessment Battery"[Title/Abstract] OR "Attention, Language, Memory, Spatial, and Executive Functions Modules"[Title/Abstract] OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search"[Title/Abstract] OR "NIH EXAMINER"[Title/Abstract] OR "Personality Assessment Inventory"[Title/Abstract] OR "PROMIS Sleep Assessments Pediatric Parent Proxy"[Title/Abstract] OR "Repeatable Battery for the Assessment of Neuropsychological Status"[Title/Abstract] OR "RBANS"[Title/Abstract] OR "Rey-Osterrieth Complex"[Title/Abstract] OR "Wechsler Abbreviated Scale of Intelligence"[Title/Abstract] OR "WASI-2"[Title/Abstract] OR "Wechsler Adult Intelligence Scale"[Title/Abstract] OR "WAIS-4"[Title/Abstract] OR "WAIS-IV"[Title/Abstract] OR "Wechsler Individual Achievement Test"[Title/Abstract] OR "WIAT-4"[Title/Abstract] OR "Wechsler Intelligence Scale "[Title/Abstract] OR "Wechsler Memory Scale"[Title/Abstract] OR "WMS-4"[Title/Abstract] OR "Wide Range Achievement Test"[Title/Abstract] OR "WRAT-5"[Title/Abstract] OR "Adult ADHD Rating Scale"[Title/Abstract] OR "ADHD-RS"[Title/Abstract] OR "Brown ADD scales"[Title/Abstract] OR "Continuous Performance Tests"[Title/Abstract] OR "Conners CPT"[Title/Abstract] OR "QB Test"[Title/Abstract] OR "TOVA"[Title/Abstract] OR "Wender Utah Adult ADHD Scale"[Title/Abstract]))  AND  "Sensitivity and Specificity"[Mesh] OR "Diagnostic Errors"[Mesh] OR sensitivity[tiab] OR specificity[tiab] OR (accura\*[tiab] AND (diagnos\*[tiab] OR classif\*[tiab])) OR "ROC curve"[tiab] OR "positive predictive value"[tiab] OR "negative predictive value"[tiab] OR "false positive"[tiab] OR "false negative"[tiab] OR "likelihood ratio"[tiab]  NOT |
| Editorial[ptyp] OR Letter[pt] OR Case Reports[pt] OR Comment[pt] address[pt] OR "autobiography"[pt] OR "bibliography"[pt] OR "biography"[pt] OR "case report"[tw] OR "case reports"[tw] OR "case series"[tw] OR "comment on"[All Fields] OR congress[pt] OR "dictionary"[pt] OR "directory"[pt] OR "festschrift"[pt] OR "historical article"[pt] OR lecture[pt] OR "legal case"[pt] OR "legislation"[pt] OR "news"[pt] OR "newspaper article"[pt] OR "patient education handout"[pt] OR "periodical index"[pt]  NOT |
| "animals"[mesh] NOT "humans"[mesh]) |

**EMBASE**

(((('adaptive behavior assessment system':ti OR 'abas-3':ti OR 'advanced clinical solutions':ti OR 'word choice test':ti OR 'test of premorbid functioning':ti OR 'social cognition':ti OR 'beck anxiety inventory':ti OR 'bai':ti OR 'beck depression inventory':ti OR 'bdi-2':ti OR 'self-report of personality':ti OR 'basc-3 srp adolescent':ti OR 'behavioral assessment system for children':ti OR 'parent rating scales':ti OR 'basc-3 prs adolescent':ti OR 'basc-3 srp college':ti OR 'teacher rating scales':ti OR 'basc-3 trs adolescent':ti OR 'brown executive function/attention scales':ti OR 'brown ef/a self':ti OR 'california verbal learning test':ti OR 'cvlt-3':ti OR 'standard form california verbal':ti) AND 'cvlt-3 brief':ti OR 'california verbal learning test':ti OR 'cvlt-c':ti OR 'cars-2':ti OR 'childhood autism rating scale':ti OR 'high-functioning version':ti OR 'cars-2 hf':ti OR 'clinical evaluation of language fundamentals':ti OR 'celf-5':ti OR 'cefi adult observer':ti OR 'comprehensive executive function inventory':ti OR 'cefi adult self-report':ti OR 'conners adult adhd diagnostic interview for dsm-iv':ti OR 'caadid part 1':ti OR 'caadid part 2':ti OR 'caars–o:l':ti OR 'caars–s:l':ti OR 'caars-2 observer':ti OR 'conners adult adhd rating scales':ti OR 'caars-2 self-report':ti OR 'delis-kaplan executive function system':ti OR 'd-kefs':ti OR 'dot counting test':ti OR 'grooved pegboard test kaufman test of educational achievement':ti OR 'ktea-3':ti OR 'nepsy-ii developmental neuropsychological battery':ti OR 'neuropsychological assessment battery':ti OR 'attention, language, memory, spatial,':ti) AND 'ex- ecutive functions modules':ti OR 'nih executive abilities–measures':ti) AND 'instruments for neurobehavioral evaluation':ti AND 're search':ti OR 'nih examiner':ti OR 'personality assessment inventory':ti OR 'promis sleep assessments pediatric parent proxy':ti OR 'repeatable battery for the assessment of neuropsychological status':ti OR 'rbans':ti OR 'rey-osterrieth complex':ti OR 'wechsler abbreviated scale of intelligence':ti OR 'wasi-2':ti OR 'wechsler adult intelligence scale':ti OR 'wais-4':ti OR 'wais-iv':ti OR 'wechsler individual achievement test':ti OR 'wiat-4':ti OR 'wechsler intelligence scale':ti OR OR 'wechsler memory scale':ti OR 'wms-4':ti OR 'wide range achievement test':ti OR 'wrat-5':ti OR 'adult adhd rating scale':ti OR 'adhd-rs':ti OR 'brown add scales':ti OR 'continuous performance tests':ti OR 'conners cpt':ti OR 'qb test':ti OR 'tova':ti OR 'wender utah adult adhd scale':ti OR 'diagnostic interview for adult adhd':ti

AND

"Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder")

OR

(#1 'attention deficit disorder with hyperactivity':ab,ti OR 'attention deficit hyperactivity disorder':ab,ti OR 'adhd':ab,ti OR 'attention deficit disorder':ab,ti 61194

#2 ((adult:ab,ti OR aged:ab,ti OR middle:ab,ti) AND aged:ab,ti OR young:ab,ti) AND adult:ab,ti OR adult:ab,ti OR adults:ab,ti 2231374

#3 ((('attention deficit and disruptive behavior disorders/diagnosis':ab,ti OR mass:ab,ti) AND screening:ab,ti OR questionnaires:ab,ti OR interviews:ab,ti) AND as:ab,ti AND topic:ab,ti OR psychometrics:ab,ti OR psychiatric:ab,ti) AND status:ab,ti AND rating:ab,ti AND scales:ab,ti OR 'diagnostic techniques and procedures':ab,ti OR 'referral and consultation':ab,ti OR questionnaire:ab,ti OR questionnaires:ab,ti OR screening:ab,ti OR screen:ab,ti OR scale:ab,ti OR instrument:ab,ti OR instruments:ab,ti OR interview:ab,ti OR interviews:ab,ti OR diagnosis:ab,ti OR diagnostic:ab,ti OR diagnosed:ab,ti OR measure:ab,ti OR test:ab,ti OR tests:ab,ti OR testing:ab,ti OR 'attention deficit disorder with hyperactivity/diagnostic imaging':ab,ti 11386521

#4 'sensitivity and specificity':ab,ti OR 'diagnostic errors':ab,ti OR sensitivity:ab,ti OR specificity:ab,ti OR (accura\*:ab,ti AND (diagnos\*:ab,ti OR classif\*:ab,ti)) OR 'roc curve':ab,ti OR 'positive predictive value':ab,ti OR 'negative predictive value':ab,ti OR 'false positive':ab,ti OR 'false negative':ab,ti OR 'likelihood ratio':ab,ti 2280552

#5 #1 AND #2 AND #3 AND #4 814

#6 #5 AND [humans]/lim 787

#7 #6 AND ([article]/lim OR [article in press]/lim) 509)

**APA PsycINFO**

(((title: ("Adaptive Behavior Assessment System") OR title: ("ABAS-3") OR title: ("Advanced Clinical Solutions") OR title: ("Word Choice Test") OR title: ("Test of Premorbid Functioning") OR title: ("Social Cognition") OR title: ("Beck Anxiety Inventory") OR title: ("BAI") OR title: ("Beck Depression Inventory") OR title: ("BDI-2") OR title: ("Behavioral Assessment System for Children") OR title: ("Self-Report of Personality") OR title: ("BASC-3 SRP Adolescent") OR title: ("Behavioral Assessment System for Children") OR title: ("Parent Rating Scales") OR title: ("BASC-3 PRS Adolescent") OR title: ("BASC-3 SRP College") OR title: ("Teacher Rating Scales") OR title: ("BASC-3 TRS Adolescent") OR title: ("Brown Executive Function/Attention Scales") OR title: ("Brown EF/A Self") OR title: ("California Verbal Learning Test") OR title: ("CVLT-3") OR title: ("Standard Form California Verbal" "CVLT-3 Brief") OR title: ("California Verbal Learning Test") OR title: ("CVLT-C") OR title: ("Childhood Autism Rating Scale") OR title: ("CARS-2") OR title: ("Childhood Autism Rating Scale") OR title: ("High-Functioning Version") OR title: ("CARS-2 HF") OR title: ("Clinical Evaluation of Language Fundamentals") OR title: ("CELF-5") OR title: ("Comprehensive Executive Function Inventory") OR title: ("CEFI Adult Observer") OR title: ("Comprehensive Executive Function Inventory") OR title: ("CEFI Adult Self-Report") OR title: ("Conners' Adult ADHD Diagnostic Interview for DSM-IV") OR title: ("CAADID Part 1") OR title: ("CAADID Part 2") OR title: ("CAARS–O:L") OR title: ("CAARS–S:L") OR title: ("CAARS-2 Observer") OR title: ("Conners' Adult ADHD Rating Scales") OR title: ("CAARS-2 Self-Report") OR title: ("Delis-Kaplan Executive Function System") OR title: ("D-KEFS") OR title: ("Dot Counting Test") OR title: ("Grooved Pegboard Test Kaufman Test of Educational Achievement") OR title: ("KTEA-3") OR title: ("NEPSY-II Developmental Neuropsychological Battery") OR title: ("Neuropsychological Assessment Battery") OR title: ("Attention, Language, Memory, Spatial, and Ex- ecutive Functions Modules") OR title: ("NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search") OR title: ("NIH EXAMINER") OR title: ("Personality Assessment Inventory") OR title: ("PROMIS Sleep Assessments Pediatric Parent Proxy") OR title: ("Repeatable Battery for the Assessment of Neuropsychological Status") OR title: ("RBANS") OR title: ("Rey-Osterrieth Complex") OR title: ("Wechsler Abbreviated Scale of Intelligence") OR title: ("WASI-2") OR title: ("Wechsler Adult Intelligence Scale") OR title: ("WAIS-4") OR title: ("WAIS-IV") OR title: ("Wechsler Individual Achievement Test") OR title: ("WIAT-4") OR title: ("Wechsler Intelligence Scale ") OR title: ("Wechsler Memory Scale") OR title: ("WMS-4") OR title: ("Wide Range Achievement Test") OR title: ("WRAT-5") OR title: ("Adult ADHD Rating Scale") OR title: ("ADHD-RS") OR title: ("Brown ADD scales") OR title: ("Continuous Performance Tests") OR title: ("Conners CPT") OR title: ("QB Test") OR title: ("TOVA") OR title: ("Wender Utah Adult ADHD Scale") OR title: ("diagnostic interview for Adult ADHD")))

AND

((title: ("Attention Deficit Disorder with Hyperactivity") OR title: ("attention deficit hyperactivity disorder") OR title: ("ADHD") OR title: ("attention deficit disorder")) OR (abstract: ("Attention Deficit Disorder with Hyperactivity") OR abstract: ("attention deficit hyperactivity disorder") OR abstract: ("ADHD") OR abstract: ("attention deficit disorder"))))

OR

(((title: ("Attention Deficit Disorder with Hyperactivity") OR title: ("attention deficit hyperactivity disorder") OR title: ("ADHD") OR title: ("attention deficit disorder")) OR (abstract: ("Attention Deficit Disorder with Hyperactivity") OR abstract: ("attention deficit hyperactivity disorder") OR abstract: ("ADHD") OR abstract: ("attention deficit disorder"))) AND ((title: (Adult) OR title: (Aged) OR title: (Middle Aged) OR title: (Young Adult) OR title: (Adult) OR title: (Adults)) OR (abstract: (Adult) OR abstract: (Aged) OR abstract: (Middle Aged) OR abstract: (Young Adult) OR abstract: (Adult) OR abstract: (Adults))) AND ((title: ("Attention Deficit and Disruptive Behavior Disorders/diagnosis") OR title: (mass screening) OR title: (questionnaires) OR title: (Interviews as Topic) OR title: (Psychometrics) OR title: (Psychiatric Status Rating Scales) OR title: (diagnosis) OR title: ("Diagnostic Techniques and Procedures") OR title: ("Referral and Consultation") OR title: (questionnaire) OR title: (questionnaires) OR title: (screening) OR title: (screen) OR title: (scale) OR title: (instrument) OR title: (instruments) OR title: (interview) OR title: (interviews) OR title: (diagnosis) OR title: (diagnostic) OR title: (diagnosed) OR title: (Measure) OR title: (test) OR title: (tests) OR title: (testing) OR title: ("Attention Deficit Disorder with Hyperactivity/diagnostic imaging")) OR (abstract: ("Attention Deficit and Disruptive Behavior Disorders/diagnosis") OR abstract: (mass screening) OR abstract: (questionnaires) OR abstract: (Interviews as Topic) OR abstract: (Psychometrics) OR abstract: (Psychiatric Status Rating Scales) OR abstract: (diagnosis) OR abstract: ("Diagnostic Techniques and Procedures") OR abstract: ("Referral and Consultation") OR abstract: (questionnaire) OR abstract: (questionnaires) OR abstract: (screening) OR abstract: (screen) OR abstract: (scale) OR abstract: (instrument) OR abstract: (instruments) OR abstract: (interview) OR abstract: (interviews) OR abstract: (diagnosis) OR abstract: (diagnostic) OR abstract: (diagnosed) OR abstract: (Measure) OR abstract: (test) OR abstract: (tests) OR abstract: (testing) OR abstract: ("Attention Deficit Disorder with Hyperactivity/diagnostic imaging"))) AND ((title: ("Sensitivity and Specificity") OR title: ("Diagnostic Errors") OR title: (sensitivity) OR title: (specificity) OR (title: (accura\*) AND (title: (diagnos\*) OR title: (classif\*))) OR title: ("ROC curve") OR title: ("positive predictive value") OR title: ("negative predictive value") OR title: ("false positive") OR title: ("false negative") OR title: ("likelihood ratio")) OR (abstract: ("Sensitivity and Specificity") OR abstract: ("Diagnostic Errors") OR abstract: (sensitivity) OR abstract: (specificity) OR (abstract: (accura\*) AND (abstract: (diagnos\*) OR abstract: (classif\*))) OR abstract: ("ROC curve") OR abstract: ("positive predictive value") OR abstract: ("negative predictive value") OR abstract: ("false positive") OR abstract: ("false negative") OR abstract: ("likelihood ratio"))) AND Population Group: Human AND Publication Type: Peer Reviewed Journal)

**Cochrane Database of Systematic Reviews** (CDSR)

(#1 ("Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR "High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS–O:L" OR "CAARS–S:L" OR "CAARS-2 Observer" OR "Conners’ Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Ex- ecutive Functions Modules" OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search" OR "NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD"):ti,ab,kw (Word variations have been searched)

#2 ("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"):ti,ab,kw (Word variations have been searched)

#3 #1 AND #2 )

OR

(#1

MeSH descriptor: [Attention Deficit Disorder with Hyperactivity] explode all trees

#2

("attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"):ti,ab,kw

(Word variations have been searched)

#3

#1 OR #2

#4

MeSH descriptor: [Adult] explode all trees

#5

MeSH descriptor: [Aged] in all MeSH products

#6

MeSH descriptor: [Middle Aged] explode all trees

#7

(Young Adult OR Adult OR Adults):ti,ab,kw

(Word variations have been searched)

#8

#4 OR #5 OR #6 OR #7

#9

MeSH descriptor: [Mass Screening] explode all trees

#10

MeSH descriptor:[Surveys and Questionnaires] explode all trees

#11

MeSH descriptor: [Interviews as Topic] explode all trees

#12

MeSH descriptor: [Psychometrics] explode all trees

#13

MeSH descriptor: [Psychiatric Status Rating Scales] explode all trees

#14

MeSH descriptor: [Diagnosis] this term only

#15

MeSH descriptor: [Diagnostic Techniques and Procedures] explode all trees

#16

MeSH descriptor: [Referral and Consultation] explode all trees

#17

("Attention Deficit and Disruptive Behavior Disorders" AND diagnosis):ti,ab,kw

(Word variations have been searched)

#18

("Attention Deficit and Disruptive Behavior Disorders" AND "diagnostic imaging"):ti,ab,kw

(Word variations have been searched)

#19

(questionnaire OR questionnaires OR screening OR screen OR scale OR instrument OR instruments OR interview OR interviews OR diagnosis OR diagnostic OR diagnosed OR Measure OR test OR tests OR testing):ti,ab,kw

#20

#9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18 OR #19

#21

("Sensitivity and Specificity" OR "Diagnostic Errors" OR sensitivity OR specificity OR (accura\* AND (diagnos\* OR classif\*)) OR "ROC curve" OR "positive predictive value" OR "negative predictive value" OR "false positive" OR "false negative" OR "likelihood ratio"):ti,ab,kw

#22

#3 AND #8 AND #20 AND #21)

**Campbell Collaboration**

("Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR

"High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS–O:L" OR "CAARS–S:L" OR "CAARS-2 Observer" OR "Conners’ Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Executive Functions Modules" OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search" OR "NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD")

OR

("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder")

**PROSPERO** (https://www.crd.york.ac.uk/prospero/)

(#1 ("Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR "High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer"):TI

#2 ("Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS?OL" OR "CAARS?SL" OR "CAARS-2 Observer" OR "Conners Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Ex- ecutive Functions Modules" OR "NIH Executive Abilities?Measures and Instruments for Neurobehavioral Evaluation and Re-search"):TI

#3 ("NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD"):TI

#4 #3 OR #2 OR #1

#5 (MeSH DESCRIPTOR Attention Deficit Disorder with Hyperactivity EXPLODE ALL TREES):TI

#6 MeSH DESCRIPTOR Attention Deficit Disorder with Hyperactivity EXPLODE ALL TREES

#7 ("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"):TI

#8 #7 OR #6

#9 #8 AND #4)

OR

#1 MeSH DESCRIPTOR Attention Deficit Disorder with Hyperactivity EXPLODE ALL TREES

#2 "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"

#3 #2 OR #1

#4 MeSH DESCRIPTOR Aged, 80 and over EXPLODE ALL TREES

#5 MeSH DESCRIPTOR Adult EXPLODE ALL TREES

#6 MeSH DESCRIPTOR Middle Aged EXPLODE ALL TREES

#7 Young Adult OR Adult OR Adults

#8 #4 OR #5 OR #6 OR #7

#9 MeSH DESCRIPTOR Mass Screening EXPLODE ALL TREES

#10 "interviews as topics"

#11 psychometrics

#12 MeSH DESCRIPTOR Psychiatric Status Rating Scales EXPLODE ALL TREES

#13 MeSH DESCRIPTOR Diagnosis EXPLODE ALL TREES

#14 MeSH DESCRIPTOR diagnosis EXPLODE ALL TREES

#15 MeSH DESCRIPTOR diagnosis

#16 MeSH DESCRIPTOR Diagnostic Techniques and Procedures EXPLODE ALL TREES

#17 MeSH DESCRIPTOR Referral and Consultation EXPLODE ALL TREES

#18 attention deficit and disruptive behavior disorders

#19 "attention deficit and disruptive behavior disorders" AND diagnosis

#20 "attention deficit and disruptive behavior disorders" AND "diagnostic imaging"

#21 questionnaire OR questionnaires OR screening OR screen OR scale OR instrument OR instruments OR interview OR interviews OR diagnosis OR diagnostic OR diagnosed OR Measure OR test OR tests OR testing

#22 #9 OR #10 OR #11 OR #12 OR #15 OR #16 OR #17 OR #19 OR #20 OR #21

#23 "Sensitivity and Specificity" OR "Diagnostic Errors" OR sensitivity OR specificity OR (accura\* AND (diagnos\* OR classif\*)) OR "ROC curve" OR "positive predictive value" OR "negative predictive value" OR "false positive" OR "false negative" OR "likelihood ratio"

#24 #3 AND #8 AND #22 AND #23

**ECRI Guidelines Trust** https://guidelines.ecri.org/

('"Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR "High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS–O:L" OR "CAARS–S:L" OR "CAARS-2 Observer" OR "Conners’ Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Executive Functions Modules" OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search" OR "NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD"')

OR

("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"

FILTER: Patient Age

Adolescent (13 to 18 years), Adult (19 to 44 years), Middle Age(45 to 64 years), Aged(65 to 79 years), Aged (80 and over)

**Guidelines International Network Library** (G-I-N, https://guidelines.ebmportal.com/)

("Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR "High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS–O:L" OR "CAARS–S:L" OR "CAARS-2 Observer" OR "Conners’ Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Ex- ecutive Functions Modules" OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search" OR "NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD")

OR

("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder")

**ClinicalKey**

("Adaptive Behavior Assessment System" OR "ABAS-3" OR "Advanced Clinical Solutions" OR "Word Choice Test" OR "Test of Premorbid Functioning" OR "Social Cognition" OR "Beck Anxiety Inventory" OR "BAI" OR "Beck Depression Inventory" OR "BDI-2" OR "Behavioral Assessment System for Children" OR "Self-Report of Personality" OR "BASC-3 SRP Adolescent" OR "Behavioral Assessment System for Children" OR "Parent Rating Scales" OR "BASC-3 PRS Adolescent" OR "BASC-3 SRP College" OR "Teacher Rating Scales" OR "BASC-3 TRS Adolescent" OR "Brown Executive Function/Attention Scales" OR "Brown EF/A Self" OR "California Verbal Learning Test" OR "CVLT-3" OR "Standard Form California Verbal" "CVLT-3 Brief" OR "California Verbal Learning Test" OR "CVLT-C" OR "Childhood Autism Rating Scale" OR "CARS-2" OR "Childhood Autism Rating Scale" OR "High-Functioning Version" OR "CARS-2 HF" OR "Clinical Evaluation of Language Fundamentals" OR "CELF-5" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Observer" OR "Comprehensive Executive Function Inventory" OR "CEFI Adult Self-Report" OR "Conners’ Adult ADHD Diagnostic Interview for DSM-IV" OR "CAADID Part 1" OR "CAADID Part 2" OR "CAARS–O:L" OR "CAARS–S:L" OR "CAARS-2 Observer" OR "Conners’ Adult ADHD Rating Scales" OR "CAARS-2 Self-Report" OR "Delis-Kaplan Executive Function System" OR "D-KEFS" OR "Dot Counting Test" OR "Grooved Pegboard Test Kaufman Test of Educational Achievement" OR "KTEA-3" OR "NEPSY-II Developmental Neuropsychological Battery" OR "Neuropsychological Assessment Battery" OR "Attention, Language, Memory, Spatial, and Executive Functions Modules" OR "NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Re-search" OR "NIH EXAMINER" OR "Personality Assessment Inventory" OR "PROMIS Sleep Assessments Pediatric Parent Proxy" OR "Repeatable Battery for the Assessment of Neuropsychological Status" OR "RBANS" OR "Rey-Osterrieth Complex" OR "Wechsler Abbreviated Scale of Intelligence" OR "WASI-2" OR "Wechsler Adult Intelligence Scale" OR "WAIS-4" OR "WAIS-IV" OR "Wechsler Individual Achievement Test" OR "WIAT-4" OR "Wechsler Intelligence Scale" OR "Wechsler Memory Scale" OR "WMS-4" OR "Wide Range Achievement Test" OR "WRAT-5" OR "Adult ADHD Rating Scale" OR "ADHD-RS" OR "Brown ADD scales" OR "Continuous Performance Tests" OR "Conners CPT" OR "QB Test" OR "TOVA" OR "Wender Utah Adult ADHD Scale" OR "diagnostic interview for Adult ADHD")

OR

("Attention Deficit Disorder with Hyperactivity" OR "attention deficit hyperactivity disorder" OR "ADHD" OR "attention deficit disorder"

FILTERS: Journal Articles, Guidelines)

Appendix B. List of Included, Background, and Excluded Publications

This appendix shows the list of included, background studies, and excluded studies with reasons for exclusion. Background papers provided more information on the topic or were retained for reference-mining. We recorded only one reason for exclusion per publications.

Included Publications

1. Abramson DA, White DJ, Rhoads T, et al. Cross-validating the Dot Counting Test Among an Adult ADHD Clinical Sample and Analyzing the Effect of ADHD Subtype and Comorbid Psychopathology. Assessment. 2023 Mar;30(2):264-73. doi: 10.1177/10731911211050895. PMID: 34643101.

2. Adamou M, Jones SL, Marks L, et al. Efficacy of Continuous Performance Testing in Adult ADHD in a Clinical Sample Using QbTest. J Atten Disord. 2022 Sep;26(11):1483-91. doi: 10.1177/10870547221079798. PMID: 35255743.

3. Aita SL, Sofko CA, Hill BD, et al. Utility of the Personality Assessment Inventory in detecting feigned Attention-Deficit/Hyperactivity Disorder (ADHD): The Feigned Adult ADHD index. Arch Clin Neuropsychol. 2018 Nov 1;33(7):832-44. doi: 10.1093/arclin/acx113. PMID: 29186287.

4. Amen DG, Hanks C, Prunella J. Preliminary evidence differentiating ADHD using brain SPECT imaging in older patients. J Psychoactive Drugs. 2008 Jun;40(2):139-46. doi: 10.1080/02791072.2008.10400623. PMID: 18720662.

5. Amen DG, Henderson TA, Newberg A. SPECT Functional Neuroimaging Distinguishes Adult Attention Deficit Hyperactivity Disorder From Healthy Controls in Big Data Imaging Cohorts. Front Psychiatry. 2021;12:725788. doi: 10.3389/fpsyt.2021.725788. PMID: 34899414. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8653781/pdf/fpsyt-12-725788.pdf

6. Andrikopoulos D, Vassiliou G, Fatouros P, et al. Machine learning-enabled detection of attention-deficit/hyperactivity disorder with multimodal physiological data: a case-control study. BMC Psychiatry. 2024;24(1). doi: 10.1186/s12888-024-05987-7. https://www.embase.com/search/results?subaction=viewrecord&id=L2030847356&from=export

7. Bakare B, Jordanova V. Psychometric Properties of a Brief Screening Measure for ADHD in Adults. Int J Psychol Res (Medellin). 2020 Jul-Dec;13(2):78-88. doi: 10.21500/20112084.4511. PMID: 33329880. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7735513/pdf/2011-2084-ijpr-13-02-78.pdf

8. Bastiaens L, Galus J. Comparison of the Adult ADHD Self Report Scale Screener for DSM-IV and DSM-5 in a Dually Diagnosed Correctional Population. Psychiatr Q. 2018 Jun;89(2):505-10. doi: 10.1007/s11126-017-9553-4. PMID: 29270886. https://link.springer.com/article/10.1007/s11126-017-9553-4

9. Becke M, Tucha L, Butzbach M, et al. Feigning Adult ADHD on a Comprehensive Neuropsychological Test Battery: An Analogue Study. Int J Environ Res Public Health. 2023 Feb 24;20(5). doi: 10.3390/ijerph20054070. PMID: 36901080. https://mdpi-res.com/d\_attachment/ijerph/ijerph-20-04070/article\_deploy/ijerph-20-04070.pdf?version=1677231890

10. Berger C, Lev A, Braw Y, et al. Detection of Feigned ADHD Using the MOXO-d-CPT. J Atten Disord. 2021 May;25(7):1032-47. doi: 10.1177/1087054719864656. PMID: 31364437.

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12. Brunkhorst-Kanaan N, Verdenhalven M, Kittel-Schneider S, et al. The Quantified Behavioral Test-A Confirmatory Test in the Diagnostic Process of Adult ADHD? Front Psychiatry. 2020;11:216. doi: 10.3389/fpsyt.2020.00216. PMID: 32265761. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7100366/pdf/fpsyt-11-00216.pdf

13. Chaim-Avancini TM, Doshi J, Zanetti MV, et al. Neurobiological support to the diagnosis of ADHD in stimulant-naïve adults: pattern recognition analyses of MRI data. Acta Psychiatr Scand. 2017 Dec;136(6):623-36. doi: 10.1111/acps.12824. PMID: 29080396. https://onlinelibrary.wiley.com/doi/10.1111/acps.12824

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Flagged for Upcoming Topics

1. A Multicentre, Randomised, Double-Blind, Placebo-Controlled, Parallel Group, Dose-Response Study To Evaluate the Safety And Efficacy Of Prolonged Release OROS Methylphenidate Hydrochloride (18, 36 and 72 mg/Day), With Open-Label Extension, In Adults With Attention Deficit/Hyperactivity Disorder. 2005. https://clinicaltrials.gov/study/NCT00246220

2. A Randomized, Double-Blind Comparison of Placebo and Atomoxetine Hydrochloride Given Once a Day in Adults With Attention-Deficit/Hyperactivity Disorder: With a Secondary Examination of Impact of Treatment on Family Functioning. 2005. https://clinicaltrials.gov/study/NCT00190775

3. A Double-Blind Comparison of Galantamine HBr and Placebo in Adults With Attention Deficit Hyperactivity Disorder. 2005. https://clinicaltrials.gov/study/NCT00181675

4. Phase IV Placebo-Controlled Study of Atomoxetine Hydrochloride in the Treatment of Adults With ADHD and Comorbid Social Anxiety Disorder. 2005. https://clinicaltrials.gov/study/NCT00190879

5. Atomoxetine Treatment of Adults With ADHD and Comorbid Alcohol Abuse: A Randomized, Placebo-Controlled Trial. 2005. https://clinicaltrials.gov/study/NCT00190957

6. A Phase II, Randomized, Double-Blind, Multi-center, Placebo-controlled, Crossover Study of SPD465 in Adults With Attention-Deficit Hyperactivity Disorder (ADHD). 2005. https://clinicaltrials.gov/study/NCT00202605

7. Eight-Week, Double-Blind, 3-Arm Parallel, Placebo-Controlled, Randomized Efficacy And Safety Trial Of Atomoxetine, Atomoxetine Plus Buspirone, And Placebo In Adults With Attention Deficit Hyperactivity Disorder. 2005. https://clinicaltrials.gov/study/NCT00174226

8. An Open International Multicentre Long-Term Follow Up Study to Evaluate Safety of Prolonged Release OROS Methlyphenidate in Adults With Attention Deficit Hyperactivity Disorder. 2006. https://clinicaltrials.gov/study/NCT00307684

9. A Randomized, Double-Blind, Placebo-Controlled, Phase 2 Dose-Ranging Study of the Safety and Efficacy of ABT-089 in Adults With Attention-Deficit/Hyperactivity Disorder (ADHD). 2006. https://clinicaltrials.gov/study/NCT00391729

10. A 9-week, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group, Dose-Finding Study to Evaluate the Efficacy and Safety of Modafinil as Treatment for Adults With Attention Deficit/Hyperactivity Disorder. 2006. https://clinicaltrials.gov/study/NCT00315276

11. Virtual Reality a Novel Screening and Treatment Aid in Attention Deficit Disorder. 2006. https://clinicaltrials.gov/study/NCT00364702

12. A Phase IIIb Study to Evaluate the Efficacy and Time Course of Treatment With ADDERALL XR and STRATTERA Compared to Placebo on Simulated Driving Safety and Performance and Cognitive Functioning in Adults With Attention Deficit Hyperactivity Disorder (ADHD). 2007. https://clinicaltrials.gov/study/NCT00557960

13. A Double-Blind Study of Atomoxetine Hydrochloride Versus Placebo for the Treatment of ADHD in Young Adults With an Assessment of Associated Functional Outcomes. 2007. https://clinicaltrials.gov/study/NCT00510276

14. A Phase IIIb Study to Evaluate the Efficacy and Time Course of Treatment With SPD465 Compared to Placebo on Simulated Driving Safety and Performance in Adults With Attention-Deficit Hyperactivity Disorder (ADHD). 2007. https://clinicaltrials.gov/study/NCT00458445

15. A Within-Subject Cross-Over Comparison Between Immediate Release and Extended Release Adderall. 2007. https://clinicaltrials.gov/study/NCT00468143

16. A Phase IIa, Randomized, Double-Blind, Placebo-Controlled, Incomplete Block, Two-period, Crossover Clinical Trial to Study the Safety and Efficacy of MK0249, 10 mg, for Adult Patients, Ages 18 to 55, With Attention Deficit Hyperactivity Disorder (ADHD). 2007. https://clinicaltrials.gov/study/NCT00475735

17. A Phase Iia, Randomized, Double Blind, Placebo Controlled, Three-treatment, Two-period Crossover Study Of The Efficacy And Safety Of Two Doses Of Pf-03654746 In Adults With Attention Deficit Hyperactivity Disorder. 2007. https://clinicaltrials.gov/study/NCT00531752

18. Quality Assurance of Administering Methylphenidate in Adults With ADHD. 2008. https://clinicaltrials.gov/study/NCT00730249

19. Placebo-Controlled Multi-Centre Double-Blind Trial for Adults With Extended-Release Methylphenidate for ADHD. 2008. https://clinicaltrials.gov/study/NCT00619840

20. Maintenance of Response After Open-Label Treatment With Atomoxetine Hydrochloride in Adult Outpatients With Attention-Deficit/Hyperactivity Disorder (ADHD): A Placebo-Controlled, Randomized Withdrawal Study. 2008. https://clinicaltrials.gov/study/NCT00700427

21. A Phase IIIb Randomized, Double-Blind, Multicenter, Placebo-Controlled, Dose Optimization, Crossover, Safety and Efficacy Workplace Environment Study of Lisdexamfetamine Dimesylate (LDX) in Adults With Attention-Deficit Hyperactivity Disorder (ADHD). 2008. https://clinicaltrials.gov/study/NCT00697515

22. A Multicentre, Randomized, Double-Blind, Placebo-Controlled, Parallel Group, Dose-Response Study to Evaluate Efficacy and Safety of Prolonged Release (PR) OROS Methylphenidate (54 and 72 mg/Day) in Adults With Attention Deficit/Hyperactivity Disorder. 2008. https://clinicaltrials.gov/study/NCT00714688

23. A Double Blind, Placebo Controlled, Randomized, Two Period 4-Arm Trial to Investigate the Dose-Related Efficacy and Safety of Org 26576 in Adults With Attention-Deficit/Hyperactivity Disorder (ADHD). 2008. https://clinicaltrials.gov/study/NCT00610441

24. A Placebo Controlled Double-Blind, Parallel Group, Individualizing Dosing Study Optimizing Treatment of Adults With Attention Deficit Hyperactivity Disorder to an Effective Response With OROS Methylphenidate. 2009. https://clinicaltrials.gov/study/NCT00937040

25. A Double-Blind Placebo-Controlled Asian Study of Atomoxetine Hydrochloride in the Treatment of Adult Patients With Attention-Deficit/Hyperactivity Disorder (ADHD). 2009. https://clinicaltrials.gov/study/NCT00962104

26. A Phase 4, Double-Blind, Multi-Center, Placebo-Controlled, Randomized Withdrawal, Safety and Efficacy Study of SPD489 in Adults Aged 18-55 With Attention-Deficit/Hyperactivity Disorder (ADHD). 2009. https://clinicaltrials.gov/study/NCT00877487

27. A Phase 2, Randomized, Double-Blind, Multi-Center, Placebo- and Active-Controlled, Crossover Study of SPD465 in Adults With Attention-Deficit Hyperactivity Disorder. 2009. https://clinicaltrials.gov/study/NCT00928148

28. A Phase I, Randomized, Double Blind, Three-Period Crossover, Estimation Study Using Lisdexamfetamine Dimesylate, Immediate Release Mixed Amphetamine Salts and Placebo to Evaluate the Utility of a Standardized Computer Battery of Tests in Adults With Attention-Deficit Hyperactivity Disorder (ADHD). 2009. https://clinicaltrials.gov/study/NCT01010750

29. A Phase IIa, Multi-center, Randomized, Double-blind, Placebo-controlled, Cross-Over Study to Assess the Efficacy, Safety ,Tolerability and Pharmacokinetics of Three Oral AZD1446 Dose Regimens and Placebo During 2 Weeks of Treatment in Adult Non-Users and Users of Nicotine Containing Products. 2009. https://clinicaltrials.gov/study/NCT01012375

30. A Randomized, Double-Blind, Placebo- and Active-Controlled, Parallel-Group, Multicenter Study of 3 Dosages of JNJ-31001074 in the Treatment of Adult Subjects With Attention-Deficit/Hyperactivity Disorder. 2009. https://clinicaltrials.gov/study/NCT00880217

31. ADHD Symptoms, Executive Functions and Quality of Life Following Three Months of Training. 2009. https://clinicaltrials.gov/study/NCT00843141

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Excluded Publications With Reasons for Exclusion

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9. An Open-label Study Evaluating the Safety and Effectiveness of OROS Methylphenidate Hydrochloride (CONCERTA) in Adults With Attention Deficit Hyperactivity Disorder. 2005. *Exclude-Comparator*

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12. Long-Term, Open Label Safety Study of Atomoxetine Hydrochloride in Patients, 6 Years and Older With Attention-Deficit/Hyperactivity Disorder. 2005. *Exclude-Comparator*

13. A Randomized, Double-Blind, Placebo-Controlled Efficacy and Safety Comparison of Fixed-Dose Ranges of Atomoxetine Hydrochloride in Child Outpatients With Attention-Deficit/Hyperactivity Disorder. 2005. *Exclude-Population*

14. Treatment of Patients With Alcoholism and Attention Deficit Disorder. 2005. *Exclude-Outcome*

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18. An Open-Label Pilot Study of Namenda (Memantine Hydrochloride) in Adult Subjects With Attention Deficit Hyperactivity Disorder (ADHD) and ADHD NOS. 2007. *Exclude-Design*

19. Psychometric Study of the Chinese Versions of the Swanson, Nolan, and Pelham, Version IV (SNAP-IV) Scale and Strengths Difficulties Questionnaire. 2007. *Exclude-Population*

20. A Multicenter Open Trial to Evaluate the Effectiveness and Quality of Life in Adults With Attention Deficit /Hyperactivity Disorder (ADHD) Treated With Long Acting Methylphenidate (CONCERTA). 2008. *Exclude-Comparator*

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Appendix C. Evidence Tables

Table C.1. Evidence table combinations as index test

| **Study ID** | **Population** | **Combination Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Chen, 202157  N = 69  n ADHD = 69  UK  Specialty care | **Target:** ADHD patients in the period between 2014 and 2017 with demographics and a number of validated self-reported screening questionnaires and clinical interviews  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults in the NHS Trust who did not meet DSM-IV diagnostic criteria for ADHD and were assessed as part of standard mental health services​  **Female:** 34.8%  **Age mean (SD):** 33.01 (9.931)  Min age: 18 Max age: 51  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  No COI | **Test description:** Combination of demographics, self-reported assessment, Conner's Adult ADHD Rating Scale (short version) with self and observer model, QbTest, and DIVA (Diagnostic Interview for AHDH in adults), 93 variables, decision tree analysis  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on structured clinical interviews using the Diagnostic Interview for ADHD in Adults (DIVA) and validated self-reported screening questionnaires collected from a National Health Service specialist mental health provider  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The highest achieved accuracy was 85.5%.  Sensitivity %  Specificity %  PPV:  NPV:  LR+:  LR-:  Accuracy 86  AUC 0.871  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Dvorsky, 201665  N = 86  n ADHD = 59  US  College | **Target:** Undergraduate students at a large public university who self-identified as having attention or concentration difficulties or a prior ADHD diagnosis, required consent for parental interviews, completed a comprehensive ADHD evaluation including structured diagnostic interviews, and met DSM-5 ADHD criteria based on both student and parent ratings  **ADHD presentation:** inattentive : 55.9,combined : 44.1  **Comorbidity:** N/A  **Other:** Undergraduate students at the same university who self-identified with attention or concentration difficulties but did not meet DSM-5 criteria for ADHD based on structured diagnostic interviews and parent ratings  **Female:** 42.4%  **Age mean (SD):** 19.71 (2.72)  Min age: 18 Max age: 27  **Age subgroup**: Adults  **Ethnicity:** Other : ADHD: 0, non-ADHD: 3.7  % Hispanic or Latino : 8.5,Other : 11.1  % Black/African American : 6.8,Other : non-ADHD: 18.5  % White : 76.3,Other : non-ADHD: 55.6  % Multiracial : 8.5,Other : 11.1  Single center  Funding unclear | **Test description:** Combination prediction model with BAARS parent and self rating of current and childhood ADHD diagnosis  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners’ Adult ADHD Diagnostic Interview for DSM-IV, which included structured diagnostic interviews separately administered to students and their parents by trained graduate-level clinicians under supervision, requiring endorsement of at least five current symptoms in two or more settings and six childhood symptoms before high school  **Diagnosed by:** Specialist (e.g., mental health) Psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Parent ratings of childhood inattention had the highest predictive validity (AUC 0.79), outperforming self-report (AUC 0.56).  Self-reports had high sensitivity (89%) but low specificity (30%), leading to a high false-positive rate.  The prediction model with both parent and student ratings of current symptoms and parent ratings of childhood symptoms accurately classified 88.9% of individuals who had a diagnosis of ADHD and 63.3% of individuals who did not have a diagnosis.  Sensitivity 89%  Specificity 63%  PPV: N/A  NPV: N/A  LR+: N/A  LR-: N/A  Accuracy N/A  AUC N/A  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Groom, 201678  N = 57  n ADHD = 33  UK  College | **Target:** Adults who were clinically diagnosed with ADHD by a psychiatrist  **ADHD presentation:** inattentive : 9.09,hyperactive : 3.03,combined : 75.76,N/A : 12.12  **Comorbidity:** N/A  **Other:** Adults diagnosed with Asperger's syndrome as part of autism spectrum disorder by a psychiatrist  **Female:** 39%  **Age mean (SD):** 31.64 (10.17)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Integration of CAARS-E (Conners Adult ADHD Rating Scale - ADHD Index), the AQ10 (Autism Quotient - 10), and the QbTest (computerized Continuous Performance Test with motion tracking) to differentiate ADHD from Autism Spectrum Disorder  Machine learning: No  Validation dataset: Unclear  **Reference standard:** Clinical diagnosis  Participants diagnosed with ADHD by a psychiatrist establishing current and long-term diagnosis using DSM-5  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** QbTotal yielded the highest AUC value 0.87 (classified as ‘good’). ROCs indicate that at equivalent sensitivity of around 80%, QbTotal demonstrates superior specificity compared with CAARS-E in differentiating ADHD and autism spectrum disorder.  CAARS-E AUC was .77 (‘fair’) in differentating ADHD and autism spectrum disorder.  QbTest added to clinical ratings may improve the differentiation of ADHD and autism spectrum disorder in adults.  Sensitivity 94%  Specificity 84%  PPV:  NPV:  LR+:  LR-:  Accuracy 90  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kingston, 201398  N = 120  n ADHD = 59  Canada  Specialty care | **Target:** Men assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **ADHD presentation:** N/A  **Comorbidity:** Other : Aggression dysregulation  **Other:** Men who were assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **Female:** 0%  **Age mean (SD):** 32.6 (10.3)  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:** Other : Aboriginal: 6.5%  % Hispanic or Latino : 2.8  % Black/African American : 2.8  % White : 78.5  Single center  Industry | **Test description:** Integration of ASRS-v1, CAARS-Self and CAARS-Observer, Brown ADD scale, and WURS in a discriminant function  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  ADHD diagnosis was determined based on DSM-IV-TR criteria following a comprehensive clinical interview and review of relevant available collateral information; interviews were conducted independently by two psychiatrists who were certified in forensic psychiatric practice; final group classification was based on consensus diagnoses and the inter-rater agreement was approximately 90%  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The integrated variables of multiple self reports and an observer report demonstrated particularly good classification accuracy, with high sensitivity (91%) and good specificity (82%).  Sensitivity 91%  Specificity 82%  PPV:  NPV:  LR+:  LR-:  Accuracy 86  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Nikolas, 2019119  N = 246  n ADHD = 109  US  Setting varies | **Target:** Adults diagnosed with ADHD based on a comprehensive clinical interview and standardized psychiatric assessments, required to have symptom onset before age 16, met full DSM-5 diagnostic criteria, provided informant reports verifying symptoms, excluded if they had neurological conditions, learning disabilities, major psychiatric disorders other than depression/anxiety, or substance abuse  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with a diagnosed unipolar mood disorder (depression) and healthy controls without ADHD or mood disorders, recruited through advertisements, email listservs, and outreach to neuropsychological clinics, with controls matched approximately by age and sex to clinical groups  **Female:** 60.6%  **Age mean (SD):** 24.8 (6.2)  Min age: 18 Max age: 40  **Age subgroup**: Adults  **Ethnicity:**  % White : 83.7,Other : Control: 80, depressed: 86.5  Multicenter  Industry | **Test description:** Combination of self/informant symptom ratings (BAARS-IV), family history, and reactiontime variability from TOVA (Test of Variables of Attention)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive clinical interview, standardized psychiatric assessment, and meeting full DSM-5 diagnostic criteria with verification of symptom onset before age 16 using self-report and informant ratings  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** While single test measures provided performed poorly in identifying ADHD participants, analyses revealed that a combined approach using self and informant symptom ratings, a positive family history of ADHD, and a reaction time variability measure correctly classified 87% of cases.  Sensitivity %  Specificity %  PPV:  NPV:  LR+:  LR-:  Accuracy 87.2  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Pettersson, 2018123  N = 108  n ADHD = 60  Sweden  Specialty care | **Target:** Adults referred for ADHD assessment, required availability of a collateral historian to provide information on childhood symptoms, excluded if treated with ADHD medications, had an IQ ≤ 70, or substance-related disorders  **ADHD presentation:** inattentive : 21.7,hyperactive : 7.1,combined : 76.7  **Comorbidity:** N/A  **Other:** Adults referred to the same specialty neuropsychological clinic for assessment, did not meet the diagnostic criteria for ADHD, included individuals with other psychiatric conditions for comparison  **Female:** 46.7%  **Age mean (SD):** 28.18 (9.09)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Model with DIVA report, QbTest cardinal variable Acticity, QbTest cardinal variable Inattention, and CpT II Commission errors, combining neuropsychological tests, DIVA clinician report, and self report ASRS Screener  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Clinical consensus decision by a multidisciplinary assessment team using clinical interviews, neuropsychological test results, self-report measures, collateral historian input, and DSM criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** All instruments showed poor discriminative ability except for the DIVA, which showed a relatively good ability to discriminate between the groups (sensitivity 90.0; specificity 72.9). A logistic regression analysis model with the DIVA and measures of inattention, impulsivity, and activity from continuous performance tests (CPTs) showed a sensitivity of 90.0 and a specificity of 83.3.  Sensitivity 90%  Specificity 83%  PPV:  NPV:  LR+:  LR-:  Accuracy 87  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Robeva, 2004132  N = 12  n ADHD = 6  US  College | **Target:** Female college students with a current ADHD diagnosis, taking ADHD medication for at least three years, not on anxiety or depression medication, without significant health conditions affecting EEG recordings, diagnosed in childhood according to Utah standards  **ADHD presentation:** combined : 100  **Comorbidity:** N/A  **Other:** Female college students with no history of ADHD or disruptive behavioral disorders, never prescribed or taken stimulant medication, not on anxiety or depression medication, without significant medical conditions affecting EEG data collection, screened to confirm the absence of ADHD symptoms  **Female:** 100%  **Age mean (SD):** 20.7 (1.5)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Other funding | **Test description:** Bayesian probability model integrated three diagnostic tools (WURS, ConsistencyIndex (EEG), Alpha Blockade Index (EEG)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a prior clinical diagnosis made during childhood following Utah criteria, confirmed through self-report screening using the Brown Attention-Deficit Disorder Scale and the ADHD Symptom Inventory, with additional verification that participants were currently prescribed and taking stimulant medication for ADHD management  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The procedure significantly improved the score separation between ADHD and non-ADHD groups. The final average probabilities for ADHD were 76% for the ADHD group and 8% for the control group. These probabilities correlated (r 0.87) with the Brown ADD scale and (r 0.84) with the ADHD-Symptom Inventory used for screening the participants.  Sensitivity 100%  Specificity 100%  PPV:  NPV:  LR+:  LR-:  Accuracy 100 average probabilities for ADHD: 76%, controls: 8% (p 0.006)  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Van Voorhees, 2011154  N = 269  n ADHD = 184  US  Specialty care | **Target:** Adults seeking evaluation for attention difficulties at an ADHD clinic diagnosed with DSM-IV  **ADHD presentation:** inattentive : 8.9,combined : 33.1  **Comorbidity:** N/A  **Other:** Adults seeking evaluation for attention difficulties at an ADHD clinic not diagnosed with ADHD  **Female:** 38.5%  **Age mean (SD):**  mean 32, median: 28  Min age: 18 Max age: 70  **Age subgroup**: Adults  **Ethnicity:** Other : Race data were only available for 77.8% of the sample  % Hispanic or Latino : 1.8  % Asian : 2.9  % White : 86.4  % Multiracial : 3.7  Single center  Public funding | **Test description:** CAARS-LV combining self-report CAARS:S and observer-report CAARS-O; T-Scores >65 for Conners’ index  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on CAARS, CAADID, and structured clinical interview for DSM-IV (SCID by a doctoral-level clinician  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Later diagnosis | **Diagnostic accuracy summary:** Self- and observer-ratings on the CAARS provide clinically relevant data about attention problems in adults, but the instrument does not effectively distinguish between ADHD and other adult psychiatric disorders. Combining self- and observer-ratings decreased the scales' sensitivity.  Sensitivity 43%  Specificity 83%  PPV:  NPV:  LR+:  LR-:  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** CAARS-S and CAARS-O (ratings from friends, parents, and spouses)  Kappa ICC  0.11-0.37  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Table C.2. Evidence table self report as index test

| **Study ID** | **Population** | **Self Report Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Aita, 201846  N = 280  n ADHD = 142  US  Specialty care | **Target:** Individuals from one of two university-affiliated psychology training clinics, diagnosed with ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Mood/Anxiety Disorder group or Clinic No Diagnosis group: Individuals from one of two university-affiliated psychology training clinics, not diagnosed with ADHD  Control group or ADHD Simulator group: Students were prospectively recruited from three southeastern universities  **Female:** 45.1% Study 1 - ADHD group: 45.1%; ADHD Simulators group: 73.9%; Mood/Anxiety Disorder group: 65.0%; Clinic No Diagnosis group: 42.3%; Healthy Controls group: 69.2%; Study 2 - ADHD group: 43.8%; ADHD Simulators group: 73.9%; Mood/Anxiety Disorder group: 65.4%; Clinic No Diagnosis group: 37.8%; Healthy Controls group: 75.5%  **Age mean (SD):** 20.29 (1.87) Study 1 - ADHD group: 21.77 (3.99); ADHD Simulators group: 19.83 (1.54); Mood/Anxiety Disorder group: 22.71 (4.58); Clinic No Diagnosis group: 22.05 (5.07); Healthy Controls group: 19.18 (1.57)  Study 2 - ADHD group: 22.33 (3.93); ADHD Simulators group: 19.83 (1.54); Mood/Anxiety Disorder group: 21.98 (4.26); Clinic No Diagnosis group: 22.80 (5.13); Healthy Controls group: 19.45 (1.35)  Min age: 18 Max age: 25  **Age subgroup**: Adults  **Ethnicity:** Other : Other Race: Study 1 - ADHD Simulators group: 4.3%; Clinic No Diagnosis group: 0.9%; Healthy Controls group: 3.8%; Study 2 - ADHD Simulators group: 4.3%; Clinic No Diagnosis group: 2.2%; Healthy Controls group: 3.8%  Other : Study 1 - ADHD group: 5.8%; ADHD Simulators group: 7.2%; Mood/Anxiety Disorder group: 1.5%; Clinic No Diagnosis group: 1.8%; Healthy Controls group: 3.8%; Study 2 - ADHD group: 9.6%; ADHD Simulators group: 7.2%; Healthy Controls group: 5.7%  Other : Study 1 - ADHD group: 10.1%; ADHD Simulators group: 10.1%; Mood/Anxiety Disorder group: 8.8%; Clinic No Diagnosis group: 10.8%; Healthy Controls group: 24.1%; Study 2 - ADHD group: 9.6%; ADHD Simulators group: 10.1%; Mood/Anxiety Disorder group: 5.8%; Clinic No Diagnosis group: 8.9%; Healthy Controls group: 9.4%  Other : Study 1 - ADHD group: 1.4%; ADHD Simulators group: 5.8%; Mood/Anxiety Disorder group: 2.2%; Clinic No Diagnosis group: 1.8%; Healthy Controls group: 3.8%; Study 2 - ADHD group: 2.7%; ADHD Simulators: 5.8%; Mood/Anxiety Disorder group: 1.9%; Clinic No Diagnosis group: 4.4%; Healthy Controls group: 1.9%  Other : Study 1 - ADHD group: 82.7%; ADHD Simulators group: 72.5%; Mood/Anxiety Disorder group: 87.6%; Clinic No Diagnosis group: 84.7%; Healthy Controls group: 64.7%; Study 2 - ADHD group: 75.3%; ADHD Simulators: 72.5%; Mood/Anxiety Disorder group: 92.3%; Clinic No Diagnosis group: 84.4%; Healthy Controls: 79.2%  Multicenter  Other funding | **Test description:** PAI (Personality Assessment Inventory), a self-report personality measure comprised of 344 items on a 4-point scale with anchor points of false and very true; items are categorized into 4 scales that assess validity of responding, 11 clinical syndrome scales, 5 treatment scales, and 2 interpersonal scales  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  All evaluations were conducted by doctoral graduate students in a clinical psychology program. Evaluations included a thorough clinical interview and all diagnoses were made under the supervision of a licensed psychologist.  **Diagnosed by:** Researcher Doctoral graduate students in a clinical psychology program, under supervision of a licensed psychologist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The new index's classification accuracy was superior to most existing PAI validity scales across groups. An item-level PAI algorithm had a sensitivity of 85% and specificity of 97% for identifying feigned ADHD.  Sensitivity 92%  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Bakare, 202050  N = 69  n ADHD = 63  UK  Specialty care | **Target:** Participants aged between 30 and 63 were recruited from a series of patients referred to adult ADHD outpatient clinics, adults with moderate or severe learning disabilities, organic brain injury or poor command of English were excluded  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** There were 8 participants who were not diagnosed with ADHD and therefore were the healthy control group  **Female:** 38.3%  **Age mean (SD):** 45 (6.95)  Min age: 30 Max age: 63  **Age subgroup**: Middle age  **Ethnicity:** N/A  Multicenter  No COI | **Test description:** WURS-brief (Wender Utah Rating Sclae); admistered together with the CAADID  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  ICD-10 diagnosis  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The WURS-brief had respectable sensitivity when compared with existing diagnostic tools  Sensitivity 89%  Specificity 11%  PPV 67  NPV 33  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** Agreement WURS-brief and DIVA rating  Kappa 0.006 ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Bastiaens, 201751  N = 140  n ADHD = 70  US  Specialty care | **Target:** Adults with a diagnosis of ADHD and substance use diagnosis  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults without a diagnosis of ADHD but a substance use diagnosis  **Female:** 35.71%  **Age mean (SD):** 33.5 (8.3)  Min age: 24 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  No COI | **Test description:** ASRS-5 (WHO Adult ADHD Self Report Scale Screener for DSM-5), dimensional scoring with 12 as threshold  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a clinical psychiatric interview using DSM-5 criteria conducted by a child and adolescent psychiatrist  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Both screeners performed equally with no significant difference between them, regardless of the scoring system used. The dimensional scoring method with a cutoff of 12/24 provided the best diagnostic accuracy, achieving sensitivity and negative predictive value above 80%.  Sensitivity 81%  Specificity 71%  PPV 74  NPV 79  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Chiasson, 201258  N = 183  n ADHD = 11  Canada  Specialty care | **Target:** A retrospective study conducted on the profiles of all newly admitted SUD patients in a multidisciplinary rehabilitation center with the ASRS-v1.1 and were later assessed by a psychiatrist specialized in ADHD  **ADHD presentation:** N/A  **Comorbidity:** SUD : all with SUD  **Other:** Family members of suspected ADHD patients were also interviewed to acquire collateral information on patient behavior patterns  **Female:** % N/A  **Age mean (SD):**  N/A  Min age: Max age:  **Age subgroup**: Age unclear  **Ethnicity:** N/A  Single center  Other funding | **Test description:** ASRS-v1.1 ADHD Self-Report Scale  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a psychiatric evaluation by a specialist using DSM-IV criteria, including collateral information from family members and consensus discussion with the clinical team.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The ASRS-v1.1 correctly identified all ADHD cases (100% sensitivity) but had a low specificity, leading to a high false positive rate, with only 26% of those screening positive diagnosed with ADHD by a psychiatrist.  Sensitivity 100%  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Unclear |
| Dakwar, 201262  Notzon, 2020120  N = 102  n ADHD = 25  US  Specialty care | **Target:** Adults seeking outpatient treatment for cocaine dependence, recruited through advertisements, diagnosed with ADHD based on the Conners Adult ADHD Diagnostic Interview for DSM-IV (CAADID), aged 18 years or older, with no exclusion criteria based on comorbid psychiatric conditions or other substance use disorders  **ADHD presentation:** inattentive : 2.9,hyperactive : 2,combined : 9.8  **Comorbidity:** SUD : adults seeking outpatient treatment for cocaine dependence  **Other:** Adults seeking outpatient treatment for cocaine dependence, without a diagnosis of ADHD, recruited from the same specialty care setting, with no exclusion based on comorbid psychiatric conditions or other substance use disorders, serving as a comparison group to differentiate ADHD diagnosis  **Female:** 17%  **Age mean (SD):**  Min age: 18 Max age: 57  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 39  % Black/African American : 33.7  % White : 27.4  Single center  Public funding | **Test description:** WURS/CAARS (Wender Utah Rating Scale / Conners Adult ADHD Rating Scale), meeting criteria for using the WURS or the CAARS; admistered together with ASRS-V1.1 (Adult ADHD Self-Report Scale-Version 1.1; brief 6-item tool developed by the WHO designed for quick ADHD screening in adults)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners Adult ADHD Diagnostic Interview for DSM-IV, a validated semistructured interview conducted by trained clinicians to assess symptoms, age of onset, pervasiveness, and impairment.  **Diagnosed by:** Specialist (e.g., mental health) clinicians with either a PhD or MA in clinical psychology  **Timing:** Concurrent | **Diagnostic accuracy summary:** The most sensitive conjunctions arose (96.0%) when WURS and CAARS were administered together, with a suggestive score on any single scale indicating the diagnosis. The CAARS emerged with the highest kappa scores and positive predictive value, but the WURS outperformed the other instruments in regard to sensitivity (87.5%).  Sensitivity 96% WURS 88%; CAARS 80%; ASRS-V1.1 61%  Specificity 65% WURS 75%; CAARS 91%; ASRS-V1.1 86%  PPV 47.06 WURS 52.5%; CAARS 74.07%; ASRS-V1.1 58.33%  NPV 98.04 WURS 95.08%; CAARS 93.06%; ASRS-V1.1 86.76%  LR+ WURS 3.55; CAARS 8.46; ASRS-V1.1 4.20  LR- 0.17 CAARS 0.22; ASRS-V1.1 0.46  Accuracy 68.99 CAARS 74.32; ASRS-V1.1 57.72  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| De Quiros, 200163  N = 48  n ADHD = 48  Multiple countries  Specialty care | **Target:** Adults from a specialty clinic, met DSM-IV criteria for ADHD with at least 6 of 9 inattentive and/or hyperactive/impulsive symptoms, had retrospectively met full DSM-IV criteria for ADHD in childhood, had no other psychiatric disorder that could explain ADHD-like symptoms, had never been diagnosed with ADHD or received stimulant therapy, and were not taking psychoactive medications  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Age-matched adults without ADHD symptoms, recruited as controls, had no history of attention or behavior problems, were not taking psychoactive medications, and were evaluated in the same specialty care setting  **Female:** 47.9%  **Age mean (SD):** 34 (11)  Min age: 23 Max age: 45  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** APQ (Adult Problem Questionnaire), a 43-item self-rating scale that assesses distractibility, impulsivity, and behavioral control using a cutoff score of 2.5 on three key items; admistered together with the CHI (Conners Hyperactivity Index)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria by a behavioral neurologist through clinical interviews with the patient and, when feasible, their spouse or parents, with retrospective confirmation of childhood ADHD symptoms.  **Diagnosed by:** Specialist (e.g., mental health) Behavioral neurologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Discriminant analysis revealed the APQ correctly classified 83% of ADHD and 90% of controls correctly.  Sensitivity 83% CHI: 81  Specificity 90% CHI: 90  PPV 91 CHI: 91  NPV 82 CHI: 80  LR+ 8.33 CHI: 8.13  LR- 0.19 CHI: 0.21  Accuracy 86 CHI: 85  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Dunlop, 201864  N = 95  n ADHD = 5  US  Specialty care | **Target:** Adults diagnosed with Major Depressive Disorder based on DSM-IV criteria, scoring ≥15 on the Hamilton Depression Rating Scale, off psychiatric medications (except sedative/hypnotic) for one month prior, with ADHD diagnosis confirmed by structured interview and psychiatrist assessment  **ADHD presentation:** inattentive : 40,combined : 60  **Comorbidity:** Depression : Major Depressive Disorder (MDD) as the primary diagnosis  **Other:** The healthy control group consisted of adults without a DSM-IV mental illness diagnosis in the past year, no history of MDD or dysthymia, no psychotropic medication use, scoring ≤7 on the Hamilton Depression Rating Scale, recruited through the same specialty psychiatric care setting  **Female:** 72.5% healthy control: 70.9  **Age mean (SD):** 49.5 (8.1) Healthy control: 44.0 (11.5)  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 32.5  % White : 47.5  % Multiracial : 20  Single center  Public funding | **Test description:** ASRS-v1.1 (Adult ADHD Self-Report Scale v1.1) a self-administered questionnaire based on the 18 DSM-IV ADHD symptom criteria; Part A contains six questions used as the primary screening tool, with a threshold score of ≥4 indicating a positive ADHD screen; Part B contains 12 additional questions providing further insight into symptom severity but not used for diagnostic purposes  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the ADHD module of the Mini International Neuropsychiatric Interview (MINI), requiring symptoms to meet DSM-IV criteria, including onset before age 7 and functional impairment, confirmed through a structured clinician interview and assessment by a study psychiatrist  **Diagnosed by:** Specialist (e.g., mental health) psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** The ASRS-v1.1 demonstrated fair performance in identifying full-syndrome DSM-IV ADHD in adults with MDD, with sensitivity of 60%, specificity of 69%, PPV of 21.4%, NPV of 92.3%, and total classification accuracy of 67.5%.  Sensitivity 60% (CI 14.7, 94.7)  Specificity 68.6% (CI 50.7, 83.2)  PPV 21.4 (CI 10.3, 39.4)  NPV 92.3 (CI 80, 97.3)  LR+ 1.91  LR- 0.58  Accuracy 67.5 (CI 50.9, 81.4)  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator),Comorbidity (e.g. anxiety, depression)  A high false-positive rate was observed in participants with Major Depressive Disorder, attributed to overlapping symptoms such as inattention and anxiety, which are common in both conditions. Participants with a positive ADHD screen demonstrated greater functional impairments and higher levels of anxiety compared to those without ADHD, suggesting that functional impairments are more pronounced in those with comorbid conditions. The high false-positive rate was attributed to symptom overlap, particularly with inattention and anxiety in depressive disorders.  MDD participants with ADHD symptomatology reported significantly higher levels of anxiety (Hamilton Anxiety Rating Scale) and rumination compared to those without ADHD, demonstrating the impact of comorbid conditions on symptom scores. |
| Dvorsky, 201665  N = 86  n ADHD = 59  US  College | **Target:** Undergraduate students at a large public university who self-identified as having attention or concentration difficulties or a prior ADHD diagnosis, required consent for parental interviews, completed a comprehensive ADHD evaluation including structured diagnostic interviews, and met DSM-5 ADHD criteria based on both student and parent ratings  **ADHD presentation:** inattentive : 55.9,combined : 44.1  **Comorbidity:** N/A  **Other:** Undergraduate students at the same university who self-identified with attention or concentration difficulties but did not meet DSM-5 criteria for ADHD based on structured diagnostic interviews and parent ratings  **Female:** 42.4%  **Age mean (SD):** 19.71 (2.72)  Min age: 18 Max age: 27  **Age subgroup**: Adults  **Ethnicity:** Other : ADHD: 0, non-ADHD: 3.7  % Hispanic or Latino : 8.5,Other : 11.1  % Black/African American : 6.8,Other : non-ADHD: 18.5  % White : 76.3,Other : non-ADHD: 55.6  % Multiracial : 8.5,Other : 11.1  Single center  Funding unclear | **Test description:** BAARS-IV (Barkley Adult ADHD Rating Scale-IV) self-reported assessment of ADHD symptoms, cut off > 3 symptoms presence  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners’ Adult ADHD Diagnostic Interview for DSM-IV, which included structured diagnostic interviews separately administered to students and their parents by trained graduate-level clinicians under supervision, requiring endorsement of at least five current symptoms in two or more settings and six childhood symptoms before high school  **Diagnosed by:** Specialist (e.g., mental health) Psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Parent ratings of childhood inattention had the highest predictive validity (AUC 0.79), outperforming self-report (AUC 0.56).  Self-reports had high sensitivity (89%) but low specificity (30%), leading to a high false-positive rate.  The prediction model with both parent and student ratings of current symptoms and parent ratings of childhood symptoms accurately classified 88.9% of individuals who had a diagnosis of ADHD and 63.3% of individuals who did not have a diagnosis.  Sensitivity 89%  Specificity 30%  PPV 68  NPV 60  LR+  LR-  Accuracy 61  AUC Total scores on student ratings of current symptoms = inattention: 0.56 (0.41, 0.71), hyperactivity: 0.51 ( 0.37, 0.64), impulsivity: 0.51 (0.37, 0.65)  **Concordance:** N/A  **Rater agreement:** BAARS-IV self report vs BAARS-IV parent ratings  Kappa ICC 0.43 current hyperactivity: 0.31, current impulsivity: 0.32, retrospective children inattention: 0.42, retrospective childhood hyperactivity/impulsivity: 0.37  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Erhardt, 199970  N = 51  n ADHD = 80  US  College | **Target:** Participants were individuals aged 18–60 years who self-reported ADHD symptoms based on DSM-IV criteria, were recruited through university clinics, and had no other primary psychiatric disorders.  **ADHD presentation:** inattentive : 39,hyperactive : 17,combined : 44  **Comorbidity:** N/A  **Other:** Non-ADHD participants included neurotypical individuals without reported ADHD symptoms, matched for age and gender, and recruited from the same university setting for comparison.  **Female:** 29%  **Age mean (SD):** 29.7 (7.8)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** CAARS:S (Conners' Adult ADHD Rating Scale Self Report), a standardized questionnaire evaluating ADHD symptoms based on DSM-IV criteria, completed by participants to assess inattentive, hyperactive, and combined presentations with cutoff scores applied for diagnostic evaluation  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through a structured clinical interview conducted by trained clinicians.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Sensitivity and specificity were high, with an overall diagnostic efficiency rate of 85%.  Sensitivity 82%  Specificity 87.2%  PPV 86.49  NPV 82.93  LR+ 6.31  LR- 0.21  Accuracy 84.62  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** Subsample completed the CAARS questionnaire on two separate occasions one month apart  0.89  **Internal consistency:**  Cronbach’s alpha  0.86 (self-concept and impulsivity subscale in different subgroups) to 0.92 (impulsivity, hyperactivity, self-concept subscales in different subgroups)  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD presentation  Sensitivity and specificity were consistent across ADHD presentationtypes (inattentive, hyperactive, and combined), with no significant differences observed between self-reported and clinically diagnosed participants. Misdiagnosis rates were slightly high |
| Faraone, 201071  N = 370  n ADHD = 206  US  Specialty care | **Target:** Adults recruited through psychiatric clinics and advertisements , met DSM-IV criteria for childhood-onset ADHD or had late-onset ADHD (met all criteria except age-at-onset), excluded if they had deafness, blindness, psychosis, inadequate English proficiency, or IQ <80. 127 individuals who met full DSM-IV criteria for childhood-onset ADHD. 79 individuals who met all criteria except the age-at-onset criterion  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD adults recruited through advertisements, did not meet DSM-IV criteria for ADHD, included subthreshold ADHD participants and neurotypical controls, the setting was community-based rather than clinical  **Female:** 13%  **Age mean (SD):** 34 (N/A)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:**  % White : 84  Multicenter  Public funding | **Test description:** CBS (Current Behavior Scale), a 99-item questionnaire assessing ADHD-related behaviors with responses ranging from never to very often; Barkley's 9-item algorithm (derived from CBS and DSM-IV symptoms) is a self-report based on difficulties with attention, impulsivity, and organization  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria using the Structured Clinical Interview for DSM-IV Axis I Disorders and modules from the Schedule for Affective Disorders and Schizophrenia for School-Age Children—Epidemiologic Version, administered by trained interviewers and reviewed by a diagnostic committee of board-certified child and adolescent psychiatrists or licensed psychologists (kappa 0.88 for ADHD)  **Diagnosed by:** Specialist (e.g., mental health) Licensed psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Barkley's 9-item algorithm showed substantial diagnostic efficiency as a predictor of current DSM-IV diagnoses in adults. The best nine items and the best 18 items were not better than Barkley's 9-item algorithm.  Sensitivity 92% calculated from AUC 0.8606)  Specificity 99% calculated from AUC 0.8606)  PPV  NPV  LR+  LR-  Accuracy  AUC 0.8606 9 -item CBS algorithm: 0.8224, 18-item CBS algorithm: 0.8152  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Grogan, 201877  N = 126  n ADHD = 38  Ireland  College | **Target:** Adults with clinical diagnosis of ADHD and ADHD with anxiety recruited from ADHD specialist clinic and support group websites. 22 with ADHD only, 16 with ADHD and anxiety.  **ADHD presentation:** inattentive : 42.3,combined : 30.8  **Comorbidity:** Anxiety  **Other:** Adults with clinical diagnosis of anxiety alone recruited from specialist clinic and support group websites, control group included adults recruited from a university sample  **Female:** 36%  **Age mean (SD):** 30.64 (7.56)  Min age: 18 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** CAARS (Conners Adult ADHD Rating Scale long version), a 66 item questionnaire, contains 8 subscales regarding inattentive, hyperactive and impulsive issues, and is completed through an online questionnaire form for ADHD evaluation with responses rated on a 4 point scale, cut-off criteria is T scores of 70STAI (State Trait Anxiety Inventory) is also an online questionnaire with 40-items and 2 subscales: state (current anxiety symptoms) and trait (general anxiety symptoms)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Participants diagnosed with ADHD by a multidisciplinary team which included a consultant psychiatrist and clinical psychologist  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Most of CAARS subscales demonstrated low sensitivity and specificity in diagnosing and differentiating between ADHD and/or anxiety  Sensitivity 53% For CAARS ADHD index  Specificity 87.5% Total sample of CAARS ADHD index  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha 0.982  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  ADHD group and ADHD + anxiety group had statistically significant higher scores on CAARS subscale of inattention issues (p 0.001) compared to anxiety group alone, however no significant differences amongst the ADHD groups were seen. |
| Groom, 201678  N = 57  n ADHD = 33  UK  College | **Target:** Adults who were clinically diagnosed with ADHD by a psychiatrist  **ADHD presentation:** inattentive : 9.09,hyperactive : 3.03,combined : 75.76,N/A : 12.12  **Comorbidity:** N/A  **Other:** Adults diagnosed with Asperger's syndrome as part of autism spectrum disorder by a psychiatrist  **Female:** 39%  **Age mean (SD):** 31.64 (10.17)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** CAARS-E (Conners Adult ADHD Rating Scale-subscale E)  Machine learning: No  Validation dataset: Unclear  **Reference standard:** Clinical diagnosis  Participants diagnosed with ADHD by a psychiatrist establishing current and long-term diagnosis using DSM-5  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** QbTotal yielded the highest AUC value 0.87 (classified as ‘good’). ROCs indicate that at equivalent sensitivity of around 80%, QbTotal demonstrates superior specificity compared with CAARS-E in differentiating ADHD and autism spectrum disorder.  CAARS-E AUC was .77 (‘fair’) in differentating ADHD and autism spectrum disorder.  QbTest added to clinical ratings may improve the differentiation of ADHD and autism spectrum disorder in adults.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC 0.77 fair  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harrison, 201986  N = 201  n ADHD = 249  Canada  College | **Target:** University and college students who were diagnosed by clinical psychologists, passed symptom validity testing, and had CAARS scores below eight, they provided evidence to corroborate lifetime impairment, had selfreported deficits in keeping with observed and documented behavioral problems, and provided evidence from reliable collateral informants to confirm that their self-reported impairments were both present and severe  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Students with attention issues who did not meet ADHD criteria but passed the Word Memory Test, and symptom validity testing  **Female:** 37.8%  **Age mean (SD):** 21.1 (4.6)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** CAARS:S ADHD Index (Conners' Adult ADHD Rating Scale Self Report), corresponds to DSM-IV symptoms  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical psychologists  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The overall discriminant validity of the CAARS was 69%, and it had an unacceptably high false positive and false negative rate. At lower prevalence rates, a high score on the CAARS has only a 22% chance of accurately identifying individuals with ADHD.  Sensitivity 14%  Specificity 92%  PPV 47  NPV 68  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Houston, 201187  N = 343  n ADHD = 65  US  Primary care | **Target:** Adults at least 18 years old, nonpsychotic, presenting to primary care  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults from primary care who did not meet ADHD diagnostic criteria  **Female:** 60%  **Age mean (SD):** 50 (N/A)  Min age: 18 Max age:  **Age subgroup**: Age unclear  **Ethnicity:** N/A  Multicenter  Industry | **Test description:** PDI-4 (Provisional Diagnostic Instrument-4), a 17-item screening tool designed to assess generalized anxiety disorder, major depressive episode, past/present mania, and adult ADHD; rating of symptom frequency, with a scoring system requiring at least three of four symptom responses within a diagnostic category, and reported functional impairment for a provisional diagnosis  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the SCID (Structured Clinical Interview for DSM-IV) and the ACDS (Adult ADHD Clinician Diagnostic Scale)  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** A comparison of limited symptom-based versus full DSM-IV criteria-based diagnosis showed minimal differences in relative diagnostic accuracy. Sensitivities and specificitieswere 82% and 73% for ADHD.  Sensitivity 82% (70, 90) GAD: 83 (63, 95), MDE: 80 (70, 88), Mania: 83 (63, 95)  Specificity 73% (68, 79) GAD: 75 (70, 80), MDE: 80 (74, 84), Mania: 82 (77, 86)  PPV 42 (33, 51) GAD: 20 (13, 30), MDE: 58 (49, 67), Mania: 26 (17, 38)  NPV 94 (91, 97) GAD: 98 (96, 100), MDE: 92 (87, 95), Mania: 98 (96, 100)  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kessler, 200592  N = 154  n ADHD =  US  Community | **Target:** Adults from the US National Comorbidity Survey Replication were stratified into four groups based on self-reported childhood ADHD symptoms and persistence into adulthood, assessed using DSM-IV criteria, including those meeting full childhood ADHD criteria and reporting current symptoms; 154 respondents were included in the clinical calibration sample, but the exact number diagnosed with ADHD was not explicitly stated  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults from the general population who denied childhood ADHD symptoms or reported subthreshold symptoms without current persistence were drawn from a nationally representative community sample  **Female:** % N/A  **Age mean (SD):**  N/A  Min age: 18 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Public funding | **Test description:** ASRS (Adult ADHD Self-Report Scale), 18 DSM-IV Criterion A symptom questions assessing inattentive and hyperactive-impulsive symptoms over the past 6 months using a 5-point Likert scale (Never, Rarely, Sometimes, Often, Very Often), including a 6-item short-form screener derived using logistic regression for optimal predictive accuracy  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a semi-structured clinical interview using the ADHD Rating Scale and DSM-IV criteria  **Diagnosed by:** Specialist (e.g., mental health) PhD clinical psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** The Adult ADHD Self-Report Scale (ASRS) Full 18-Item Scale distinguished ADHD from non-ADHD participants with 56.3% sensitivity, 98.3% specificity, 96.2% accuracy, and an AUC of 0.77.  The ASRS 6-Item Screener outperformed the full version with 68.7% sensitivity, 99.5% specificity, 97.9% accuracy, and an AUC of 0.84.  Sensitivity 56% 6-item screener 69%  Specificity 98% 6-item screener 99.5%  PPV  NPV  LR+  LR-  Accuracy 96.2 6-item screener 97.9 accuracy; 18-item scale kappa 0.58  AUC 0.77 6-item screener AUC 0.84  **Concordance:**  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** N/A |
| Kessler, 200793  N = 20011  n ADHD = 18  US  Primary care | **Target:** Adults enrolled in a managed care plan in California and Georgia, excluding those receiving treatment for ADHD, screening for DSM-IV ADHD criteria using the ASRS Screener​  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** The study included both ADHD and non-ADHD participants, using a structured ASRS Screener followed by a clinical interview for validation.  **Female:** % N/A  **Age mean (SD):**  N/A  Min age: 18 Max age: N/A  **Age subgroup**: Age unclear  **Ethnicity:** N/A  Multicenter  Industry | **Test description:** ASRS (Adult ADHD Self-Report Scale Screener) is a six-question self-report screening tool evaluated both a dichotomous scoring approach (0–3 vs. 4–6) and a continuous scoring approach (0–24)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Adult ADHD Clinician Diagnostic Scale (ACDS v1.2).  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The diagnostic accuracy of the ASRS Screener in distinguishing adults with ADHD from those without ADHD in a managed care population, finding that the dichotomous scoring approach (cutoff 4–6) had a sensitivity of 39.1%, specificity of 88.3%, and AUC of 0.64, while the continuous scoring approach (cutoff 14+) improved sensitivity to 64.9%, specificity to 94.0%, and AUC to 0.79.  Sensitivity % Dichotomous: 39.1, Continuous: 64.9  Specificity % Dichotomous: 88.3, Continuous: 94.0  PPV Dichotomous: 23.5, Continuous: 49.9  NPV Dichotomous: 94, Continuous: 96.7  LR+  LR-  Accuracy Dichotomous: 84.1, Continuous: 91.5  AUC Dichotomous: 0.64, Continuous: 0.79  **Concordance:** The ASRS Screener was validated against clinical diagnoses made by mental health specialists using the Adult ADHD Clinician Diagnostic Scale (ACDS v1.2)  **Rater agreement:** Agreement between self-reported ASRS scores and clinician-diagnosed ADHD using the ACDS v1.2 in a managed care population​  Kappa ICC  **Test-retest:** Test-retest reliability was assessed using Pearson correlations at three time points: T1-T2 (0.63), T2-T3 (0.67), and T1-T3 (0.47), with retests conducted between 6 months to 1 year apart​  T1-T2: 0.63, T2-T3: 0.67, T1-T3: 0.47  The expected T1-T3 correlation (0.42) was close to the observed correlation (0.47)  **Internal consistency:**  Cronbach’s alpha  T1: 0.63, T2: 0.72, T3: 0.70  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** Less than 2 minutes for completion and scoring​ . | **Subgroup analysis:** N/A |
| Kessler, 201094  N = 345  n ADHD = 90  US  Community | **Target:** ADHD respondents meeting DSM-IV/ACDS criteria for ADHD. 55 met full criteria for both childhood and adult ADHD, and 35 met full adult criteria.  **ADHD presentation:** inattentive : 60.8,inattentive\_other : More predictive of adult persistence,hyperactive : 12.1,hyperactive\_other : Lower persistence compared to inattentive,combined : 34.9,combined\_other : Most common among those who had both subtypes in childhood  **Comorbidity:** N/A  **Other:** Adults without ADHD  **Female:** % N/A  **Age mean (SD):**  ADHD-Combined group: 34.34 (8.78), ADHD-Inattentive group​ 36.08 (11.60)  Min age: 18 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Industry | **Test description:** ASRS (Adult ADHD Self-Report Scale), a structured questionnaire designed to assess DSM-IVADHD symptoms in adults, includes inattention and hyperactivity-impulsivity symptom items, with responses based on frequency ratings over the past six months  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria using ACDS  **Diagnosed by:** Specialist (e.g., mental health) PhD-level clinical interviewers trained by board-certified psychiatrists specializing in adult ADHD research  **Timing:** Concurrent | **Diagnostic accuracy summary:** Almost half (45.7%) of individuals with childhood ADHD continued to meet full DSM-IV criteria for adult ADHD, with inattention persisting more strongly than hyperactivity-impulsivity. Executive functioning deficits were the most specific and consistent predictors of DSM-IV adult ADHD.  Sensitivity 70%  Specificity 93%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.93  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Age,Age of diagnosis,ADHD presentation,Comorbidity (e.g. anxiety, depression)  Executive functioning impairments were more predictive of ADHD persistence in older adults, while hyperactivity-impulsivity symptoms were more prevalent in younger adults, suggesting age-related shifts in symptom expression and diagnostic criteria applica  Sensitivity and specificity of ADHD diagnoses were higher in younger adults (18–30 years) compared to older adults (31–44 years), likely due to better recall of childhood symptoms and reduced cognitive decline in memory-based reporting.  The inattention symptoms were more predictive of ADHD persistence into adulthood than hyperactivity-impulsivity symptoms, with 94.9% of persistent ADHD cases meeting inattention criteria, compared to only 34.6% meeting hyperactivity-impulsivity criteria.  Logistic regression predicting 6-month prevalence of any DSM-IV/CIDI mood disorder, anxiety disorder, substance disorder, and behavioral disorder (other than ADHD) from each ACDS item in the four-item scales controlling total ACDS scores. The total ACDS s |
| Kingston, 201398  N = 120  n ADHD = 59  Canada  Specialty care | **Target:** Men assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **ADHD presentation:** N/A  **Comorbidity:** Other : Aggression dysregulation  **Other:** Men who were assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **Female:** 0%  **Age mean (SD):** 32.6 (10.3)  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:** Other : Aboriginal: 6.5%  % Hispanic or Latino : 2.8  % Black/African American : 2.8  % White : 78.5  Single center  Industry | **Test description:** ASRS-v1.1-A (Adult ADHD Self-Report Symptom Checklist Part A), a scale of adult attention-deficit/hyperactivity disorder based on nosological criteria and pertain to frequency, rather than severity, of ADHD symptoms; Part A comprises 6 screening questions and is considered to be the most predictive of symptoms consistent with ADHD; adminstered together with ASRS-v1.1 Part B, Brown ADD (Attention Deficit Disorder) Scale, CAARS-Self ADHD Index (Connors Adult ADHD Rating Scale, Long Version, Self-Report), and WURS (Wender Utah Rating Scale)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  ADHD diagnosis was determined based on DSM-IV-TR criteria following a comprehensive clinical interview and review of relevant available collateral information; interviews were conducted independently by two psychiatrists who were certified in forensic psychiatric practice; final group classification was based on consensus diagnoses and the inter-rater agreement was approximately 90%  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The integrated variables of multiple self reports and an observer report demonstrated particularly good classification accuracy, with high sensitivity (91%) and good specificity (82%).  Sensitivity 76% (CI 63, 86) ASRS-v1.1 Part B 66%, Brown ADD Scale 84%, CAARS-Self ADHD Index 63%. WURS 82%  Specificity 84% (CI 71, 92) ASRS-v1.1 Part B 93%, Brown ADD Scale 73%, CAARS-Self ADHD Index 91%, WURS 69%  PPV 83 (CI 70, 92) ASRS-v1.1 Part B 91%, Brown ADD Scale 76%, CAARS-Self ADHD Index 88%, WURS 73%  NPV 77 (CI 64, 86) ASRS-v1.1 Part B 72%, Brown ADD Scale 0.82, CAARS-Self ADHD Index 70%, WURS 79%  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** rater agreement between self-report measures (ASRS-v1.1, CAARS-Self, WURS, and Brown ADD Scale) and observer-rated measures (CAARS-Observer)  Kappa ICC r 0.51  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kumar, 2011100  N = 110  n ADHD = 6  US  Specialty care | **Target:** Adults recruited from psychiatric inpatient unit of a general hospital with a chart diagnosis of ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with different mental disorders recruited from psychiatric inpatient unit of a general hospital  **Female:** 50%  **Age mean (SD):** 36.6 (11.1)  Min age: 25 Max age: 49  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 8  % Black/African American : 16  % White : 64  % Multiracial : 12,Other : other ethnic backgrounds  Single center  Funding unclear | **Test description:** CAARS-S:SV (Conners' Adult ADHD Rating Scales: Screening Version), 30-item self-report tool that screens for ADHD symptoms in adults, using a 4-point rating scale to assess the frequency of symptoms based on DSM-IV criteria, cut off point wasT score>70  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Chart diagnosis, diagnosed with ADHD by board certified psychiatrists after inpatient admission through DSM-IV-TR  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The CAARS-S–S: SV indicated adequate disrimination.  The MINI ADHD module was most effective for identifying inpatients without ADHD.  Sensitivity 83% (CI 36, 100)  Specificity 69% (CI 59, 78)  PPV 14 (CI 5, 29)  NPV 99 (CI 93, 100)  LR+  LR-  Accuracy 70 (CI 61, 78)  AUC 0.75 (CI 0.6, 0.91)  **Concordance:** N/A  **Rater agreement:** Correlation self report CAARS-S:SV and MINI  Kappa ICC r 0.58  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Age,Sex  ADHD diagnosis based on CAARS-S or MINI were not correlated with age.  ADHD diagnosis based on CAARS-S or MINI were not correlated with sex. |
| Kwan, 2024101  N = 550  n ADHD = 102  Canada  College | **Target:** Community college or university students referred for assessments and diagnosed with ADHD through a comprehensive evaluation that included self-and-observer ratings, historical record reviews, and symptom validity tests  **ADHD presentation:** inattentive : 66.7,hyperactive : 1,combined : 30.4  **Comorbidity:** N/A : currently reported academic difficulties  **Other:** Students from the same educational settings referred for assessments but did not meet ADHD criteria, diagnosed based on a multi-method, multi-informant approach  **Female:** 48%  **Age mean (SD):**  mean 21.5  Min age: 17 Max age: 40  **Age subgroup**: Adults  **Ethnicity:** Other : 3% Middle Eastern; 7% other  % Black/African American : 6  % Asian : 12  % White : 72  Single center  Other funding | **Test description:** CAARS-S:L (Conners’ Adult ADHD Rating Scales–Self-Report: Long Version), a 66-itemquestionnaire to measure symptoms and behaviors associated with ADHD in adults. It uses a 4-point Likert scale (0 = not at all/never, 3 = very much/very frequently) and includes subscales such as Inattention/Memory Problems, Hyperactivity/Restlessness, Impulsivity/Emotional Lability, and Self-Concept Problems. Additional scales align with DSM-IV criteria for Inattentive Symptoms, Hyperactive-Impulsive Symptoms, and Total ADHD Symptoms; tool is designed for screening but not for definitive diagnosis  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a multi-method, multi-informant assessment procedure including historical records, semi-structured clinical interviews using DSM criteria, self-and observer ratings of symptoms, and performance validity tests.  **Diagnosed by:** Specialist (e.g., mental health) Clinical psychologists or supervised graduate students trained in ADHD assessment  **Timing:** Concurrent | **Diagnostic accuracy summary:** Cutoffs of <54 (ADHD Symptoms Total subscale) and <63 (Inattentive Symptoms subscale) were also identified, both with a sensitivity of 0.95 or higher. The analysis found the ADHD Index to be a poor predictor of a negative ADHD diagnosis.  Sensitivity 100%  Specificity 10%  PPV 20  NPV 100  LR+ 1.11  LR- 0  Accuracy 27  AUC 0.767 (CI 0.721, 0.813)  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD presentation,Comorbidity (e.g. anxiety, depression)  Sensitivity for the inattentive subtype was 100% at a cutoff score of <54 on the Inattentive Symptoms subscale, with specificity at 25%. For the combined subtype, sensitivity and specificity data were not specifically stratified. Misdiagnosis was more pre  The comorbidities, particularly learning disabilities and anxiety, contributed to challenges in specificity, as these conditions often overlap with ADHD symptoms, increasing the likelihood of false positives. Sensitivity remained unaffected, maintaining h |
| Lancaster, 2018102  N = 166  n ADHD = 55  US  Other setting | **Target:** Adult clients who requested ADHD or learning disorder assessment at a university outpatient center, completed the Personality Assessment Inventory (PAI), and provided consent for their data to be used for research purposes; participants with valid PAI profiles and complete intelligence tests were included, with ADHD diagnoses made based on semistructured interviews and Conners' Adult ADHD Rating Scales  **ADHD presentation:** inattentive : 42.27,hyperactive\_other : 3.64,combined : 49.09  **Comorbidity:** N/A  **Other:** Non-ADHD participants were adult clients seeking assessment at a university outpatient center who completed the Personality Assessment Inventory (PAI) and intelligence testing, with no ADHD diagnosis determined based on semistructured interviews and Conners' Adult ADHD Rating Scales; they included individuals with various presenting concerns or no significant clinical conditions.  **Female:** 61.45%  **Age mean (SD):** 24.39 (8.32)  Min age: 18 Max age: 63  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 11.45  % White : 83.13  Single center  Funding unclear | **Test description:** PAI (Personality Assessment Inventory), includes 344 items rated on a four-point scale, measuring various psychological domains such as anxiety, depression, and impulsivity, with specific subscales examined for their association with ADHD symptoms  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on semistructured interviews, Conners' Adult ADHD Rating Scales (Self-Report and Observer Report when applicable), and strict adherence to DSM criteria.  **Diagnosed by:** Specialist (e.g., mental health) mental health clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** Adding the PAI scales to the criterion variables significantly improved the model's fit, with an overall classification accuracy of 75%.  Sensitivity 55%  Specificity 86%  PPV 65.22  NPV 88.79  LR+ 3.93  LR- 0.523  Accuracy 75  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator),Comorbidity (e.g. anxiety, depression)  Comorbidities such as anxiety and depression were associated with elevated scores on specific PAI subscales (ANX-C, DEP), which may overlap with ADHD symptoms and potentially contribute to misclassification. The findings highlight the importance of considering comorbid conditions during assessment to minimize misdiagnosis and improve diagnostic accuracy.  20% of participants with ADHD had comorbid conditions, including anxiety (7%), depression (5%), and other disorders. Still, these comorbidities did not significantly affect the sensitivity (55%) or specificity (86%) of the PAI scales. |
| Lewandowski, 2008105  N = 534  n ADHD = 38  US  College | **Target:** College students who provided documentation to the university Office of Disability Services verifying a professional ADHD diagnosis, evidence of past and current impairment, patterns of symptoms across the lifespan, and substantial limitations in learning  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants were college students recruited from introductory psychology courses representing a neurotypical sample without reported ADHD diagnoses, spanning various academic years and demographic backgrounds  **Female:** 39.47%  **Age mean (SD):**  mean 19.2  Min age: 18 Max age: 49  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 4  % Black/African American : 6.5  % Asian : 6  % White : 81  % Multiracial : 2.5  Single center  Funding unclear | **Test description:** ADHD-items (18 items reflecting ADHD symptom from a DSM-IV Checklist for ADHDs, binary response option (rarely/never vs. often/always) and additional items assessing academic and test-taking concerns  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on professional evaluation, evidence of past and current impairment, patterns of symptoms across the lifespan, and documentation of substantial limitation in learning submitted to the university Office of Disability Services  **Diagnosed by:** Specialist (e.g., mental health) mental health clinician  **Timing:** Concurrent | **Diagnostic accuracy summary:** College students with ADHD reported significantly more ADHD symptoms and academic concerns than their peers without ADHD, but none of the 18 ADHD symptoms or six academic concerns were sensitive and specific to ADHD. Sensitivity (84%) and specificity (70%) of the self-report tool were calculated based on clinical diagnosis as the reference standard, indicating that self-reports were moderately effective at identifying individuals with ADHD but less accurate at ruling out false positives. Functional impairment (academic challenges) was also higher in the ADHD group, although similar complaints were noted among non-ADHD participants, indicating poor specificity for these academic concerns.  Sensitivity 84%  Specificity 70%  PPV 17.7  NPV 98.3  LR+ 2.8  LR- 0.23  Accuracy 71  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Approximately 15 minutes. | **Subgroup analysis:** N/A |
| Liu, 2023106  N = 955  n ADHD = 432  Canada  Specialty care | **Target:** Adults attending a tertiary mental health center who consented to participate in a retrospective study and completed the EarlyDetect questionnaire; ADHD diagnosis was confirmed by certified psychiatrists based on DSM-5 criteria  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults attending a tertiary mental health center for various mental health concerns, including major depressive disorder, generalized anxiety disorder, bipolar disorder, and alcohol use disorder, and were assessed by certified psychiatrists using DSM-5 criteria to confirm the absence of ADHD  **Female:** 56.4%  **Age mean (SD):** 31.31 (10.66)  Min age: 17 Max age: 76  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** EarlyDetect Questionnaire, comprehensive digital tool incorporating multiple clinical screening instruments, including ASRS-v1.1 Part A (Adult ADHD Self-Report Scale) to assess ADHD symptoms based on DSM criteria and the Sheehan Disability Scale to evaluate functional impairments; assesses mental health history, ADHD-related symptoms, and functional impairments, which were then used as features for machine learning-based ADHD screening  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria through face-to-face assessment by certified psychiatrists blinded to the results of the EarlyDetect screening questionnaire.  **Diagnosed by:** Specialist (e.g., mental health) Mental health clinician  **Timing:** Concurrent | **Diagnostic accuracy summary:** The ADHD classification model using composite scoring achieved a balanced accuracy of 0.788, a 2.1% increase over standalone ADHD screening.  The classification model, including ADHD with comorbidity, was also successful (balanced accuracy = 0.712).  Sensitivity 82%  Specificity 75.3%  PPV 73.3  NPV 83.7  LR+ 3.33  LR- 0.24  Accuracy 78.8  AUC 0.86  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  The participants with ADHD and comorbid conditions (e.g., major depressive disorder, bipolar disorder, generalized anxiety disorder, alcohol use disorder) exhibited differences in classification accuracy. The model achieved a balanced accuracy of 0.712 in |
| Luty, 2009108  N = 107  n ADHD = 37  UK  Community | **Target:** Adults attending NHS community drug and alcohol services in South East England are able to provide informed consent and complete self-report questionnaires, excluding those unable to complete them due to illiteracy or acute agitation  **ADHD presentation:** N/A  **Comorbidity:** SUD : all teated for opiate dependence and alcohol use disorders  **Other:** Adults attending NHS community drug and alcohol services in South East England without a confirmed diagnosis of ADHD, including individuals with substance use disorders or other mental health conditions, recruited from the same community care settings as the ADHD group  **Female:** 37%  **Age mean (SD):** 37.8 (11.4)  Min age: 18 Max age: 58  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  No COI | **Test description:** CAARS-S:L (Connors Adult ADHDRating Scale Self-report Long version), the WHO Adult ADHD Self-report Screener, and the Wender Utah Adult ADHD Scale, which assess ADHD symptoms in adults, with validation against DSM-IV diagnostic interviews with both the patient and a collateral informant  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through an interview with the patient and a collateral informant conducted by a trained psychiatrist.  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist with qualifications such as Member of the Royal College of Psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** CAARS-S:L had the highest diagnostic accuracy with a cutoff of 91 of 198, yielding 97% sensitivity and 83% specificity.  WHO-ASRS confirmed the optimal cutoff of 12 of 13, achieving 89% sensitivity and 83% specificity.  WURS, though designed for childhood ADHD assessment, demonstrated 88% sensitivity and 70% specificity for diagnosing adult ADHD.  Sensitivity 97% ASRS: 89; WURS: 88  Specificity 83% ASRS: 83; WURS: 70  PPV 78.49 ASRS: 76.99; WURS: 65.22  NPV 97.74 ASRS: 92.19; WURS: 90.12  LR+ 5.71 ASRS: 5.24; WURS: 2.93  LR- 0.036 ASRS: 0.13; WURS: 0.17  Accuracy 88.46 ASRS: 85.34; WURS: 77.02  AUC  **Concordance:** N/A  **Rater agreement:** Agreement between patient’s self-report and the collateral informant's report  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Marchant, 2015109  N = 242  n ADHD = 37  US  Setting varies | **Target:** Adults meeting DSM-IV or Utah Criteria for ADHD, with at least moderate impairment on the Clinical Global Impressions-Severity scale, excluding those with major depressive disorder, panic disorder, bipolar disorder, schizophrenia, psychosis, or recent psychiatric hospitalization  **ADHD presentation:** inattentive : 40  **Comorbidity:** N/A : Emotional Dysregulation Presentation, Inattentive Presentation  **Other:** Couples recruited from community settings without a personal or family history of ADHD, recent Axis I disorders, or psychiatric hospitalization, while anxiety or depression trials involved participants with no ADHD diagnosis as confirmed through retrospective chart review and self-report scales; in addition, participants in anxiety and depression trials with some mental health concerns, even if they do not have a specific diagnosis of ADHD; the normative sample was selected with criteria to exclude ADHD, psychiatric disorders, or recent hospitalization  **Female:** 29%  **Age mean (SD):** 33.7 (11.7)  Min age: 18 Max age: 63  **Age subgroup**: Adults  **Ethnicity:**  % White : 87  Multicenter  Industry | **Test description:** SR-WRAADDS (Self-Report Wender-Reimherr Adult ADHD Scale), a self-administered tool assessing 7 ADHD domains (attention difficulties, hyperactivity/restlessness, temper, affective lability, emotional over-reactivity, disorganization, impulsivity) based on the Utah Criteria for ADHD, cutoff score of ≥15  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical evaluation using the Wender-Reimherr Adult ADHD Scale and DSM-IV or Utah Criteria by trained mental health clinicians with moderate or greater impairment on the Clinical Global Impressions-Severity scale  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The Self-Report Wender-Reimherr Adult Attention Deficit Disorder Scale (SR-WRAADDS) distinguished adults with ADHD from normal controls with 97% sensitivity and 89% specificity. When used to screen for ADHD in individuals with depression or anxiety, the SR-WRAADDS had 87% sensitivity and 49% specificity. The SR-WRAADDS successfully differentiated ADHD inattentive presentation from ADHD emotional dysregulation presentation with 72% agreement compared to the clinician-rated WRAADDS.  Sensitivity 97% screening for ADHD depression or anxiety: 87  Specificity 89% screening for ADHD depression or anxiety: 49  PPV 91.8  NPV 95.9  LR+  LR-  Accuracy 60% of anxiety/depression trial participants for whom evidence of ADHD was lacking had SR-WRAADDS scores above this threshold.  AUC  **Concordance:** N/A  **Rater agreement:** Self reported SR-WRAADDS and investigator-rated WRAADDS  Kappa ICC r 0.51 (p 0.001)  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha 0.78  split-half reliability r 0.92  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| McCann, 2004111  N = 82  n ADHD = 38  US  Specialty care | **Target:** Adults presenting to a university-affiliated ADHD specialty clinic based on suspected ADHD, diagnosed with ADHD through a structured clinical interview incorporating DSM-IV criteria, corroborating documents, and family interviews  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults presenting to the same ADHD specialty clinic for evaluation but diagnosed with non-ADHD conditions through structured clinical interviews, including major depressive disorder, dysthymia, bipolar disorder, anxiety disorders, and other psychiatric conditions  **Female:** 44.7%  **Age mean (SD):** 37.5 (10.1)  Min age: 18 Max age: 59  **Age subgroup**: Adults  **Ethnicity:**  % White : 96.3  Single center  Funding unclear | **Test description:** ADSA (Attention-Deficit Scales for Adults), a 54-item scale with multiple subscales, focusing on Attention-Focus/Concentration and Behavior-Disorganized Activity, using a cutoff corresponding to a T-score of 70; admistered together with the ARS (Adult Rating Scale), 25-item scale based on DSM-III-R criteria measuring inattention, hyperactivity, and impulsivity, scored on a 4-point Likert scale (0 to 3), with a cutoff of 31  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a semistructured clinical interview incorporating DSM-IV criteria, corroborating documents such as school records and performance evaluations, and interviews with significant others  **Diagnosed by:** Specialist (e.g., mental health) Senior psychologist and board-certified psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** ADSA, ARS, and Symptom Inventory for ADHD were sensitive to the presence of ADHD in adults (correctly identifying 78-92% of patients with ADHD). A high proportion of individuals with non-ADHD diagnosis screened positive (incorrectly identifying between 36 – 67% of non-ADHD patients.  Sensitivity 81% Individuals with ADHD scoring at or above the ARS cutoff was 91.9%  Specificity 46% 67.4% of individuals who do not have ADHD obtain an ARS score suggesting that they do  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  Cronbach's alpha in the ADSA subscales ranged from 0.70 to 0.82; ARS Cronbach's alpha was 0.89  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression) |
| Mehringer, 2002112  N = 101  n ADHD = 51  US  Specialty care | **Target:** Adults aged approximately 18-50 years with a history of smoking or cocaine dependence, enriched for ADHD cases by recruiting from smoking and substance use populations, assessed for ADHD diagnosis based on DSM-IV criteria requiring evidence of symptoms in both childhood and adulthood, with no other psychiatric disorders explaining the symptomatology  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults without ADHD, including smokers and cocaine-dependent individuals recruited from specialized research settings, assessed for ADHD diagnosis but not meeting the DSM-IV criteria for childhood or adult ADHD.  **Female:** 26%  **Age mean (SD):** 33.7 (9.7)  Min age: 18 Max age: 50  **Age subgroup**: Adults  **Ethnicity:**  % White : 73  Single center  Public funding | **Test description:** AHA (Assessment of Hyperactivity and Attention), an 18-item self-report pencil-and-paperquestionnaire based on DSM-IV criteria, assessing both childhood and adult ADHD symptoms, with a cutoff score of 4 for adult symptoms and 6 for childhood symptoms  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a semi-structured clinical interview similar to the Structured Clinical Interview for DSM-IV (SCID), requiring at least 6 inattentive or hyperactive/impulsive symptoms in both childhood and adulthood, with no other psychiatric disorders explaining the symptoms  **Diagnosed by:** Specialist (e.g., mental health) psychologists & psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** AHA results had sensitivity of 0.80, specificity of 0.60, PPV of 0.67, NPV of 0.75, kappa of 50 , AUC of 0.79 with odds ratio of 6.15.  Sensitivity 80%  Specificity 60%  PPV 67  NPV 75  LR+  LR-  Accuracy  AUC 0.79 0.70, 0.88  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Palmer, 2023122  N = 71  n ADHD = 40  UK  Community | **Target:** Autistic young adults recruited from a population-based cohort (SNAP) with parent-informed ADHD research diagnoses based on DSM criteria, including those with varying intellectual functioning. 40 total number of individuals with ADHD based on the parent-reported YAPA diagnostic interviews  **ADHD presentation:** inattentive : 30,hyperactive : 37.5,combined : 32.5  **Comorbidity:** Autism : Autism subgroup includes young autistic adults with varying intellectual functioning  **Other:** Autistic young adults identified through the same cohort and screened as non-ADHD cases  **Female:** 10.1%  **Age mean (SD):** 23.1 (0.77)  Min age: 21.33 Max age: 25.08  **Age subgroup**: Young  **Ethnicity:**  % White : 94.1  Single center  Public funding | **Test description:** CAARS-S (Conners Adult ADHD Rating Scales Self Report) ADHD Index assessed ADHD symptoms with a cutoff of ≥56; adminstered together with the SDQ (Strengths and Difficulties Questionnaire), cutoff of ≥9  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the parent-informed Young Adult Psychiatric Assessment using DSM criteria and conducted by a trained researcher or clinician to ascertain symptom frequency, duration, intensity, and impairment  **Diagnosed by:** Researcher  **Timing:** Concurrent | **Diagnostic accuracy summary:** Although the measures performed at or close to adequate levels (AUC was 0.66 to 0.79 for the parent report and 0.70 to 0.65 for the self-report), no single measure simultaneously met adequate thresholds for sensitivity and specificity in young adults with autism.  Sensitivity 57% (CI 23, 81) SDQ>9: 28%  Specificity 81% (CI 63, 92) SDQ>9: 100%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.70 (CI 0.51, 0.90) SDQ AUC 0.65 (CI 0.44-0.87)  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Pettersson, 2018123  N = 108  n ADHD = 60  Sweden  Specialty care | **Target:** Adults referred for ADHD assessment, required availability of a collateral historian to provide information on childhood symptoms, excluded if treated with ADHD medications, had an IQ ≤ 70, or substance-related disorders  **ADHD presentation:** inattentive : 21.7,hyperactive : 7.1,combined : 76.7  **Comorbidity:** N/A  **Other:** Adults referred to the same specialty neuropsychological clinic for assessment, did not meet the diagnostic criteria for ADHD, included individuals with other psychiatric conditions for comparison  **Female:** 46.7%  **Age mean (SD):** 28.18 (9.09)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** ASRS Screener (Adult ADHD Slef-Report Scale Screener)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Clinical consensus decision by a multidisciplinary assessment team using clinical interviews, neuropsychological test results, self-report measures, collateral historian input, and DSM criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** All instruments showed poor discriminative ability except for the DIVA, which showed a relatively good ability to discriminate between the groups (sensitivity 90.0; specificity 72.9). A logistic regression analysis model with the DIVA and measures of inattention, impulsivity, and activity from continuous performance tests (CPTs) showed a sensitivity of 90.0 and a specificity of 83.3.  Sensitivity 92%  Specificity 27%  PPV 61  NPV 72  LR+  LR-  Accuracy 63  AUC 0.759  **Concordance:**  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** N/A |
| Reimherr, 2021130  Gift, 202176  N = 485  n ADHD = 137  US  Specialty care | **Target:** Adults with a primary diagnosis of ADHD who met criteria for both adult and childhood ADHD, assessed through intake questionnaires and interviews, with patients experiencing comorbidity or incomplete data excluded  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with primary diagnoses of major depressive disorder or generalized anxiety disorder, and a community control group consisting of neurotypical adults, all recruited from specialty care settings and reviewed through intake processes in clinical trials  **Female:** 43%  **Age mean (SD):** 32.5 (8.7)  Min age: 18 Max age: 59  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  No COI | **Test description:** WURS (Wender Utah Rating Scale), including the WURS-25 and WURS-45 versions, is used to assess symptoms of ADHD and differentiate it from other conditions, with factor scores calculated from item averages and evaluated for diagnostic accuracy using ROC curves and logistic regression  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on intake questionnaires, interviews with a clinic psychiatrist, and review by several clinicians in accordance with diagnostic criteria  **Diagnosed by:** Specialist (e.g., mental health) Clinic psychiatrist  **Timing:** Concurrent | **Diagnostic accuracy summary:** WURS-25 (Total Score) distinguished adults with ADHD from those with MDD/GAD with 62% sensitivity and 86% specificity.  WURS-25 (Factor Scores) improved diagnostic accuracy in distinguishing ADHD from MDD/GAD with 74% sensitivity and 88% specificity.  WURS-45 effectively differentiated ADHD from MDD/GAD with 80% sensitivity and 90% specificity, maintaining strong diagnostic separation with reduced redundancy.  WURS-61 (Full Version) had the highest accuracy in distinguishing ADHD from MDD/GAD, with 84% sensitivity and 94% specificity.  The WURS-25 produced good separation of ADHD subjects from normal controls with ROC (AUC 0.974) and logistic regression (Sensitivity 91%, Specificity 92%). Conversely, the full WURS better separated ADHD subjects from psychiatric controls with both ROC (AUC 0.995) and logistic regression (Sensitivity 84%, Specificity 94%). Use of the full WURS with its five factors proved more successful at distinguishing ADHD from MDD and GAD than did the WURS-25.76  Sensitivity 74% WURS-25 total: 62; WURS-45: 80; WURS-61: 84; For MDD/GAD vs ADHD (WURS-25): 62%; For Non-Clinical Control vs ADHD (WURS-25): 91%  Specificity 88% WURS-25 total: 86; WURS-45: 90; WURS-61: 94; For MDD/GAD vs ADHD (WURS-25): 86%; For Non-Clinical Control vs ADHD (WURS-25): 92%  PPV 79 WURS-25 total: 73; WURS-45: 83; WURS-61: 88; For MDD/GAD vs ADHD (WURS-25): 73%; For Non-Clinical Control vs ADHD (WURS-25): 93%  NPV 85 WURS-25 total: 79; WURS-45: 88; WURS-61: 91; For MDD/GAD vs ADHD (WURS-25): 79%; For Non-Clinical Control vs ADHD (WURS-25): 90%  LR+ For the MDD/GAD vs ADHD (WURS-25): 4.43; For the Non-Clinical Control vs ADHD (WURS-25): 11.38  LR- For the MDD/GAD vs ADHD (WURS-25): 0.44; For the Non-Clinical Control vs ADHD (WURS-25): 0.10  Accuracy For MDD/GAD vs ADHD (WURS-25): 77; For Non-Clinical Control vs ADHD (WURS-25): 91.5  AUC 0.924 WURS-25 total: 0.838; WURS-45: 0.942; For MDD/GAD vs ADHD (WURS-25): AUC = 0.838; For Non-Clinical Control vs ADHD (WURS-25): AUC 0.974  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Reyes, 2019131  N = 379  n ADHD = 29  US  Specialty care | **Target:** Adults diagnosed with alcohol dependence recruited from inpatient and outpatient addiction treatment facilities, excluding those with psychotic disorders, unstable psychiatric or medical conditions, and those not meeting DSM-IV-TR criteria for alcohol dependence or presenting with contraindications to study medication  **ADHD presentation:** N/A  **Comorbidity:** SUD : all alcohol dependence  **Other:** Adults with alcohol dependence who did not meet criteria for ADHD, recruited from addiction treatment settings, including both inpatient and outpatient care, with similar exclusion criteria to ensure comparability  **Female:** 34.6%  **Age mean (SD):** 41.9 (11.7)  Min age: 18 Max age: 80  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 2.4  % Black/African American : 1.6  % American Indian or Alaska Native : 0.3  % Asian : 0.5  % White : 95.2  Single center  Public funding | **Test description:** ASRS-v1.1 (Adult ADHD Self-Report Scale, Version 1.1), a six-item self-administeredscreening tool with a cutoff score of ≥4 to identify symptoms consistent with ADHD diagnosis, focusing on symptoms experienced within the past six months  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Psychiatric Research Interview for Substance and Mental Disorders (PRISM), a semi-structured interview designed to differentiate primary psychiatric disorders from substance-induced effects using DSM criteria.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The positive predictive value (PPV) of the ASRS-v1.1 was 18.1% (95% CI = [12.4, 25.7]), and the negative predictive value (NPV) was 97.6% (95% CI = [94.9, 98.9]). The ASRS-v1.1 demonstrated a sensitivity of 79.3% (95% CI = [61.6, 90.2]) and a specificity of 70.3% (95% CI = [65.3, 74.8]).  Sensitivity 79% 61.6, 90.2  Specificity 70.3% 65.3, 74.8  PPV 18.1 12.4, 25.7  NPV 97.6 94.9, 98.9  LR+  LR-  Accuracy  AUC 0.75 0.67, 0.83  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Robeva, 2004132  N = 12  n ADHD = 6  US  College | **Target:** Female college students with a current ADHD diagnosis, taking ADHD medication for at least three years, not on anxiety or depression medication, without significant health conditions affecting EEG recordings, diagnosed in childhood according to Utah standards  **ADHD presentation:** combined : 100  **Comorbidity:** N/A  **Other:** Female college students with no history of ADHD or disruptive behavioral disorders, never prescribed or taken stimulant medication, not on anxiety or depression medication, without significant medical conditions affecting EEG data collection, screened to confirm the absence of ADHD symptoms  **Female:** 100%  **Age mean (SD):** 20.7 (1.5)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Other funding | **Test description:** WURS (Wender Utah Rating Scale), a 61-item retrospective questionnaire witha cutoff score of 30 on the short form with higher cutoff values  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a prior clinical diagnosis made during childhood following Utah criteria, confirmed through self-report screening using the Brown Attention-Deficit Disorder Scale and the ADHD Symptom Inventory, with additional verification that participants were currently prescribed and taking stimulant medication for ADHD management  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The procedure significantly improved the score separation between ADHD and non-ADHD groups. The final average probabilities for ADHD were 76% for the ADHD group and 8% for the control group. These probabilities correlated (r 0.87) with the Brown ADD scale and (r 0.84) with the ADHD-Symptom Inventory used for screening the participants.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy classification less than 85%; <0.5 probabilities with ADHD 0.42, control 0.54 (p 0.02)  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Roy-Byrne, 1997135  N = 143  n ADHD = 46  US  Specialty care | **Target:** Adults presented for ADHD evaluation at a university-based specialty clinic, self-reported inattentiveness, disorganization, distractibility, or procrastination, hyperactivity-impulsivity complaints were variable, must have been able to pay a $385 fee and wait 1-2 months for an appointment. 46 out of 143 (32%) with ADHD  **ADHD presentation:** N/A  **Comorbidity:** Other : Major mood disorder  **Other:** Adults seeking ADHD evaluation at the same specialty clinic who either did not meet ADHD criteria or had ambiguous ADHD features due to a lack of childhood history or confounding psychiatric/substance abuse comorbidity  **Female:** 31.5%  **Age mean (SD):** 33.1 (9.7)  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:**  % White : 95  Single center  Funding unclear | **Test description:** WURS (Wender Utah Rating Scale) evaluating childhood symptoms; a cutoff score of 46  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria using a structured psychiatric interview  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** WURS distinguished ADHD from non-ADHD participants but had high false positives in psychiatric patients (40-60% of patients without ADHD also had high scores on the WURS). CPT showed group differences, but no diagnostic accuracy data were reported. WRAT-R identified lower reading scores in ADHD patients, suggesting learning disability associations but was not used for ADHD diagnosis.  Sensitivity 72%  Specificity % 61% specificity in clear non-ADHD sample and 39% in unclear sample  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** Comprehensive exam that included self report: $385 in 1997  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  More ADHD patients had learning disabilities (37%) than Possible ADHD (15.7%) and Non-ADHD (13%). Lifetime major mood disorder was highly prevalent across all groups (>50%), but current substance use disorder was significantly more common in the Possible |
| Singh, 2015141  N = 113  n ADHD = 43  UK  Specialty care | **Target:** Adults recruited from an inpatient psychiatric assessment facility, excluding those unable to give written informed consent due to acute mental illness, incapacity, or poor language skills, or those detained under the Mental Health Act. 17 with the inattentive type, 10 with the hyperactive-impulse type, 16 with the combined type  **ADHD presentation:** inattentive : 14.2,hyperactive : 8.4,combined : 36.1  **Comorbidity:** N/A  **Other:** Adults from an inpatient psychiatric assessment facility, primarily with diagnoses of depression, anxiety disorders, personality disorders, or other psychiatric conditions, excluding those with acute mental illness, incapacity, or poor language skills  **Female:** 42%  **Age mean (SD):** 34 (11.4)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:**  % White : 91  Single center  No COI | **Test description:** IPDE-SQ (International Personality Disorder Examination screening questionnaire), 59-item designed to assess personality traits across multiple domains (interpersonal relations, impulsivity, and mood regulation, 11-item subscale was derived from the IPDE-SQ to identify adult ADHD, cutoff score of 5 on the 11-item subscale  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the DSM-IV clinical interview conducted by a mental health clinician, assessing all 18 core criteria for ADHD subtypes and their associated impairment across multiple life domains  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Concurrent | **Diagnostic accuracy summary:** An 11-item subscale from the IPDE-SQ shows potential as a screening instrument for ADHD in an adult psychiatric population.  Sensitivity 84%  Specificity 82%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.873 0.805–0.942  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD presentation,Comorbidity (e.g. anxiety, depression),Any additional description/clarification of subgroup reported on this form : The study analyzed ADHD presentation (inattentive, hyperactive-impulsive, and combined) and comorbid conditions such as p  Diagnostic accuracy did not significantly vary across ADHD presentations/subtypes (inattentive, hyperactive-impulsive, and combined). However, the study noted that combined type ADHD was the most frequently identified subtype, which could influence overal  The study noted a high prevalence of comorbid conditions, including depression (51%), anxiety disorders (28%), and personality disorders (23%), among participants and the authors did highlight the potential for symptom overlap between ADHD and personality |
| Skirrow, 2013142  N = 88  n ADHD = 41  UK  Specialty care | **Target:** Male adults meeting DSM-IV criteria for ADHD, recruited from a National Adult ADHD Clinic with no current or past Axis I or II comorbid psychiatric disorders (except for recurrent or current major depressive disorder), no history of substance abuse or frequent substance use, no neurological conditions, no IQ below 70, and no recent exposure to psychoactive medication (minimum washout period of 1 month for stimulants and 6 months for other psychoactive medication)  **ADHD presentation:** inattentive : 19.5,combined : 80.5  **Comorbidity:** N/A  **Other:** Male adults recruited from hospital volunteer databases, local community advertisements, and university settings, screened to ensure they did not meet ADHD criteria using the Barkley Adult ADHD Rating Scale, with no current or past psychiatric conditions, neurological conditions, substance abuse history, or frequent substance use  **Female:** 0%  **Age mean (SD):** 28.5 (9.5)  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** ALS-SF (Affective Lability Scale-Short Form) to measure emotional lability, which is often associated with ADHD  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a structured clinical interview using DSM-IV criteria conducted by a consultant adult psychiatrist specializing in ADHD, incorporating the CAADID (Conners Adult ADHD Diagnostic Interview for DSM-IV), confirming symptom onset and chronicity before age 7 and meeting criteria for at least six symptoms of hyperactivity-impulsivity and/or inattention in adulthood  **Diagnosed by:** Specialist (e.g., mental health) Consultant adult psychiatrist specializing  **Timing:** Concurrent | **Diagnostic accuracy summary:** For ALS-SF (AUC 91), a mean score of 1.86 corresponded to a sensitivity of 85 and a specificity of 81. Similar results were found for CNS-LS (AUC 93), with a mean score of 1.06, corresponding to a sensitivity of 88 and a specificity of 83.  Sensitivity 85% CNS-LS 88  Specificity 85% CNS-LS 83  PPV  NPV  LR+  LR-  Accuracy  AUC 91 88-98 CNS-LS AUC 93, CI 85-97  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Solanto, 2004145  N = 93  n ADHD = 70  US  Specialty care | **Target:** Adults diagnosed with ADHD by clinical evaluation based on DSM-IV criteria, excluding individuals with neurological disorders, intellectual disabilities, or severe substance use disorders, and requiring stable medication use or no psychotropic medications during the assessment timeframe. 44 had the combined subtype (ADHD-CB) and 26 had predominantly inattentive subtype (ADHD-IA).  **ADHD presentation:** inattentive : 25.24,combined : 47.42  **Comorbidity:** N/A  **Other:** Adults recruited from the same specialty care setting, with diagnoses of other psychiatric conditions such as anxiety, depression, or adjustment disorders, but who did not meet the diagnostic criteria for ADHD  **Female:** % male: ADHD combined (24); ADHD Inattentive (18); Other Psychiatric (16)  **Age mean (SD):**  ADHD combined 34.34 (8.78); ADHD Inattentive 36.08(11.60); Other psychiatric 44.39(10.35)  Min age: 25 Max age: 60  **Age subgroup**: Adults  **Ethnicity:**  Other : ADHD combined (2.2); ADHD Inattentive (0); other psychiatric (0)  Other : ADHD combined (2.2); ADHD Inattentive (0); other psychiatric (4.3)  Other : ADHD combined (11.1); ADHD Inattentive (3.8); other psychiatric (4.3)  Other : ADHD combined (84.1); ADHD Inattentive (96.2); other psychiatric (91.3)  Single center  Funding unclear | **Test description:** BADDS (Brown Attention-Deficit Disorder Scale), assesses executive and adaptive functioning across five clusters (Activation, Attention, Effort, Affect, and Memory), cutoff 50; adminstered together with CAARS (Conners Adult ADHD Rating Scale) , cutoff ≥65 for inattention, hyperactivity-impulsivity, and total ADHD scores  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through a comprehensive clinical interview conducted by experienced psychologists, supplemented with developmental history, school records, standardized test reports  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** For the Brown scales, sensitivity to a diagnosis of ADHD was 92% and specificity in identifying adults in the Other Psychiatric group was 33%, yielding an overall correct classification rate of 74%. For the CPT scores, sensitivity to a diagnosis of ADHD-Inattentive type was 47% and specificity was 86%, yielding an overall correct classification rate of 70%. The results indicate a need for closer examination of executive and adaptive functioning in adults with ADHD compared with those with internalizing disorders to identify features that could assist in differential diagnosis.  Sensitivity 92%  Specificity 33%  PPV 76  NPV 67  LR+  LR-  Accuracy 74  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha 0.93  Cluster-specific coefficient alphas ranged from 0.79 to 0.92 for the Brown ADD Scale  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator),Age  Sensitivity and specificity for self-report measures were high when comparing ADHD-diagnosed participants to the general population but were less effective when distinguishing ADHD from other psychiatric conditions, with overlapping scores noted for anxiety and depression.  Age was inversely correlated with scores on the Brown ADD Scale for attention and effort, suggesting that older participants exhibited fewer ADHD-related symptoms, potentially reflecting developmental improvements in executive functioning. |
| Suhr, 2008148  N = 85  n ADHD = 15  US  Primary care | **Target:** Adults who showed evidence of childhood ADHD symptoms from at least two sources (self-report, parent report, school records, prior medical/psychological records), exhibited clinically significant current ADHD symptoms confirmed by self-report and either collateral report or behavioral observation, and passed the Word Memory Test (WMT) assessing credible performance  **ADHD presentation:** inattentive : 47,combined : 53  **Comorbidity:** N/A  **Other:** Adults with psychological diagnoses other than ADHD who reported no evidence of childhood ADHD-related impairment, had psychological conditions (commonly major depressive disorder), and were evaluated in a university-based psychology specialty clinic.  **Female:** 40%  **Age mean (SD):** 25.4(9.8)  Min age: 18 Max age: 56  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 5  % White : 94  % Multiracial : 1  Single center  Funding unclear | **Test description:** WURS (Wender Utah Rating Scale) using a cutoff score of 46 and CAARS (Conners' Adult ADHD Rating Scale) particularly subscale F for hyperactive/impulsive symptoms were used to assess ADHD symptoms through self-report in a specialty clinic setting​  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  DSM-IV  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Self-report measures (WURS and CAARS) could not reliably distinguish ADHD from psychological controls, with substantial overlap in symptom endorsement between groups.  Neuropsychological tests did not reliably distinguish ADHD from psychological controls, except for the Stroop Interference score where ADHD participants performed worse.  Feigning ADHD was effectively identified by the Word Memory Test (WMT), with a 31% failure rate among referrals, and WMT failure associated with worse neuropsychological performance and higher symptom self-report across groups.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** WMT failure was associated with increased symptom reporting and worse neuropsychological performance, suggesting noncredible performance may distort both self-report and objective cognitive testing results.  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Ustun, 2017152  N = 637  n ADHD = 268  US  Setting varies | **Target:** Adults with ADHD (DSM-5); Sample 1: Household sample from the National Comorbidity Survey Replication, a national face-to-face survey; Sample 2: Managed care sample based on a telephone survey of subscribers to a large managed health care plan; Sample 3: Clinical sample included patients who were either obtaining a free evaluation through the Adult ADHD Program at NYU Langone based on mass media recruitment and referrals. 44 from NCS-R, 51 from managed care, 173 NYU clinic.  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with no current ADHD symptoms; Sample 1: Household sample from the National Comorbidity Survey Replication (NCS-R), a national face-to-face survey; Sample 2: Managed care sample based on a telephone survey of subscribers to a large managed health care plan; Sample 3: Recruited from primary care waiting rooms near the NYU Langone campus  **Female:** % N/A  **Age mean (SD):**  ADHD group: 33.1 (11.4) years  Min age: 18 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Other funding | **Test description:** ASRS (Adult ADHD Self-Report Scale) screening scale developed to generate 1 fully structured question for each DSM-IV Criterion A1-A2 symptom of inattention and hyperactivity-impulsivity plus 11 non–DSM-IV symptoms of deficits in higher-level executive function believed to be relevant to adult ADHD similar to the Utah Criteria for adult ADHD, each question asked how often the symptom occurred over the past 6 months with responses of never, rarely, sometimes, often, and very often  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Clinical diagnoses of DSM-5 adult ADHD were made based on semistructured interviews using version 1.2 of the adult ADHD Clinical Diagnostic Scale.  **Diagnosed by:** Researcher The ACDS was administered in the NCS-R by 4 experi- enced PhD-level clinical interviewers who received 40 hours of training from 2 board certified psychiatrists specializing in adult ADHD research (L.A.A. and T.J.S.). Each interviewer had to complete 5 pr  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The new ADHD screening scale is short, easily scored, detects the vast majority of general population cases at a threshold that also has high specificity and PPV.  Sensitivity 91% Pooled National Comorbidity Survey Replication and managed care development samples: 91.4%; NYU Langone validation sample: 91.9%  Specificity 96% Pooled National Comorbidity Survey Replication and managed care development samples: 96.0%; NYU Langone validation sample: 74.0%  PPV 67.3 Pooled National Comorbidity Survey Replication and managed care development samples: 67.3; NYU Langone validation sample: 82.8%  NPV  LR+  LR-  Accuracy  AUC Pooled National Comorbidity Survey Replication and managed care development samples: 0.94; NYU Langone validation sample: 0.83  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| van de Glind, 2013153  N = 1138  n ADHD = 148  Multiple countries  Specialty care | **Target:** Adults with ADHD recruited from an international ADHD in SUD prevalence study, seeking treatment for SUD during the study period, excluding those with inadequate language skills, severe physical or psychiatric issues, or who declined informed consent  **ADHD presentation:** N/A  **Comorbidity:** SUD : all treatment seeking  **Other:** Adults without ADHD recruited from an international ADHD in SUD prevalence study, seeking treatment for SUD during the study period, excluding those with inadequate language skills, severe physical or psychiatric issues, or who declined informed consent  **Female:** 26%  **Age mean (SD):** 35.7 (10.2)​  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Industry | **Test description:** ASRS (Adult ADHD Self-Report-Scale), a 6 item validated self-report screening tool designed for optimal alignment with clinical classifications, with scores ranging from 0 to 24 based on the sum of the first six item, cut off score 14 or more  Machine learning: No  Validation dataset: N/A  **Reference standard:** Other  Diagnosis of ADHD based on CAADID (Conners’ ADHD Adult Diagnostic Interview for DSM-IV)  **Diagnosed by:** Unclear/NR Principal investigator of study trained site co-ordinators and local addiction treatment professionals to use CAADID as reference standard in this study  **Timing:** Later diagnosis | **Diagnostic accuracy summary:** Sensitivity was 84% and specificity 66%.  Sensitivity 84% CI 76, 88)(  Specificity 66% (CI 63, 69)  PPV 26 (CI 22, 30)  NPV 97 (CI 96, 98)  LR+ 2.44  LR- 0.19  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** Agreement between the Adult ADHD Self-Report Scale (ASRS) at baseline (t1)and after 1–2 weeks (t2) in the same individuals  55% scored negative on the ASRS both at t1 and t2 and 29% scored positive at both time points; 8% scored positive at t1 but negative at t2 and 8% scored negative at t1 and positive at t2; findings indicate a stable result in 84% and a change of results in  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  Specificity was significantly higher in patients with alcohol use disorders at 0.76 compared to 0.56 in patients with drug use disorders, while sensitivity remained similar across both groups (0.80 and 0.85). |
| Van Voorhees, 2011154  N = 269  n ADHD = 184  US  Specialty care | **Target:** Adults seeking evaluation for attention difficulties at an ADHD clinic diagnosed with DSM-IV  **ADHD presentation:** inattentive : 8.9,combined : 33.1  **Comorbidity:** N/A  **Other:** Adults seeking evaluation for attention difficulties at an ADHD clinic not diagnosed with ADHD  **Female:** 38.5%  **Age mean (SD):**  mean 32, median: 28  Min age: 18 Max age: 70  **Age subgroup**: Adults  **Ethnicity:** Other : Race data were only available for 77.8% of the sample  % Hispanic or Latino : 1.8  % Asian : 2.9  % White : 86.4  % Multiracial : 3.7  Single center  Public funding | **Test description:** CAARS:S (Conners’ Adult ADHD Rating Scales, Self Rating, Long Version), 66-items rated on a 4-point scale (0 to 3)  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on CAARS, CAADID, and structured clinical interview for DSM-IV (SCID by a doctoral-level clinician  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Later diagnosis | **Diagnostic accuracy summary:** Self- and observer-ratings on the CAARS provide clinically relevant data about attention problems in adults, but the instrument does not effectively distinguish between ADHD and other adult psychiatric disorders. Combining self- and observer-ratings decreased the scales' sensitivity.  Sensitivity 65%  Specificity 61%  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** Self-reports (CAARS-S) and observer reports (CAARS-O including ratings from friends, parents, and spouses)  Kappa ICC Ranged from r 0.24 (“distractible”) through r 0.46 (“on the go/driven by a motor”)  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Vizgaitis, 2023155  N = 122  n ADHD = 27  US  Other setting | **Target:** Archival data from adults (>18years) seeking ADHD assessment, including those who consented to research participation, and completed a comprehensive ADHD assessment battery including the CAARS-S:L  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Not ADHD, similar to ADHD group  **Female:** 44.4%  **Age mean (SD):** 23 (7.81)  Min age: 18 Max age: 67  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 3.3  % Black/African American : 1.6  % Asian : 11.5  % White : 75.4  % Multiracial : 8.2  Multicenter  No COI | **Test description:** CAARS-S:L (Conners’ Adult ADHD Rating Scale—Self-Report: Long Version), a 66-itemself-report tool rated on a 4-point scale, assessing ADHD symptoms across four primary and four composite subscales  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnoses made utilizing multiple self-report scales and interview assessments and confirmed by doctorate-level psychology trainees and a licensed psychologist  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Later diagnosis | **Diagnostic accuracy summary:** The CAARS-S:L may be useful for screening purposes in some cases but should not be the main method used for diagnostic purposes.  Sensitivity 56%  Specificity 62.1%  PPV 29.4  NPV 83.1  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Sex  Stratified by gender, the outcome measures for the ADHD index were for males: sensitivity 53.3%, specificity 72.7%, PPV 40%, NPV 82.1%; and for females: sensitivity 58.2%, specificity 52%, PPV 22.6%, NPV 83.9%. |
| Williamson, 2014159  N = 76  n ADHD = 44  US  College | **Target:** Adults with a history of ADHD diagnosis confirmed by a mental health practitioner based on more than self-reported symptoms, to have received their diagnosis before age 18, and to have abstained from stimulant medication for 12 hours prior to the study. 22 with ADHD only (ADHD-O). 22 with ADHD and comorbid psychological disorder  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical individuals without a history of diagnosed or suspected ADHD, learning disorders, neurological disorders, or psychological disorders, recruited from an introductory psychology participant pool or a university disability resource center, with a subset instructed to feign ADHD  **Female:** 36.36%  **Age mean (SD):** 19.05 (1.29)  Min age: 18 Max age: 23  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** WAIS-IV PSI (Wechsler Adult Intelligence Scale-IV Processing Speed) lower than 97, administered together with the Woodcock-Johnson III Test of Achievement, and the CTIP (Computerized Test of Information Processing) assessed cognitive abilities such as processing speed, reading fluency, and attention control under controlled conditions  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on evaluation by a mental health practitioner using clinical interviews, self-report symptom scales, and cognitive or neuropsychological testing, with diagnosis required to be established before age 18  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Sensitivity of the WAIS-IV PSI was 65% for feigning ADHD, specificity for detecting ADHD decreased from 73% to 59% in a subgroup of participants with comorbidity. Performance validity tests such as the Test of Memory Malingering (TOMM), the Letter Memory Test (LMT), and the Nonverbal Medical Symptom Validity Test (NV-MSVT) were effective in differentiating both ADHD groups from normal participants feigning ADHD.  Sensitivity 72%  Specificity 72% in comorbid participants 59%  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Young, 2016164  N = 392  n ADHD = 96  UK  Other setting | **Target:** All-male sample recruited from a UK prison through flyers and letters, interviewed through DIVA-2 (structured interview for ADHD)  **ADHD presentation:** inattentive : 14.4,hyperactive : 13.1,combined : 18  **Comorbidity:** N/A  **Other:** All-male sample without ADHD, recruited from a UK prison through flyers and letters  **Female:** 0%  **Age mean (SD):** 30.3 (N/A)  Min age: 28 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** BAARS-IV ( Barkley Adult ADHD Rating Scale) is a self-rating scale and assesses18 current and childhood ADHD symptoms, onset age, and impairment domains cutoff value > or = to 3  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on Diagnostic Interview for ADHD in Adults (DIVA-2) interview by mental health professional  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The brief screening tool for ADHD demonstrated improved diagnostic accuracy among UK prison inmates, with a sensitivity of 0.82, specificity of 0.84, and overall accuracy of 0.84. This tool outperformed the original BAARS-IV scale, offering a more efficient and reliable method for identifying ADHD in correctional settings.  Sensitivity 84% Based on BAARS-IV brief screening tool  Specificity 82.2% Based on BAARS-IV brief screening tool  PPV  NPV  LR+  LR-  Accuracy 83.6 Based on BAARS-IV brief screening tool  AUC 0.89  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Young, 2023163  N = 897  n ADHD = 30  US  Specialty care | **Target:** Adults seeking outpatient psychiatric care with suspected ADHD, aged 18-71, screened for ADHD using the ASSET-BS, Brown EF/A, and CAARS scales, inclusion required elevated T-scores across these measures and no validity flags on CAARS assessments  **ADHD presentation:** combined : 74.26  **Comorbidity:** N/A  **Other:** Adults seeking outpatient psychiatric care for a wide range of DSM-5 psychiatric conditions, including generalized anxiety disorder, major depressive disorder, social phobia, and bipolar disorders, assessed in a specialty care setting  **Female:** % Study 1: 83.9; Study 2: 52; Study 3: 64  **Age mean (SD):**  Study 1: 32.02 (12.22); Study 2: 39.13 (12.54); Study 3: 30.26 (11.38)  Min age: 18 Max age: 71  **Age subgroup**: Adults  **Ethnicity:** Other : Study 3: 1.5  Other : study 2: 15  Other : Study 1: 5.8; Study 2: 9.5; Study 3: 3  Other : Study 2: 1.2  Other : Study 1: 4.5; Study 2: 3.9; Study 3: 3.7  Other info : Study 2: 0.3  Other : Study 1: 83.9; Study 2: 65.8; Study 3; 91  Other : Study 2: 2.9  Single center  Funding unclear | **Test description:** ASSET-BS (ADHD Symptom and Side Effect Tracking - Baseline Scale), a 10-itemself-report screening tool designed to measure the impact of ADHD symptoms on daily functioning using a 6-point Likert scale  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on elevated T-scores across the Brown Executive Function/Attention Scales, Conners’ Adult ADHD Rating Scales, and clinician referral for ADHD evaluation, with no validity flags triggered on the CAARS assessments  **Diagnosed by:** Specialist (e.g., mental health) Clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** The scale demonstrated effectiveness in screening for ADHD in a psychiatric outpatient population.  Sensitivity 80% ASSET BS Factor at 4.04: 96.7  Specificity 80.2% ASSET BS Factor at 4.04: 65.9  PPV 57.14 ASSET BS Factor at 4.04: 47.54  NPV 92.6 ASSET BS Factor at 4.04: 98.39  LR+  LR- 0.13 - 0.49  Accuracy  AUC 0.895 0.835 - 0.954  **Concordance:** N/A  **Rater agreement:** self-reported ASSET-BS scores with CAARS Observer-Report scores  Kappa ICC r 0.55  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha 0.899  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Sex  Sensitivity and specificity of the ASSET-BS did not significantly vary between sexes. |

Table C.3. Evidence table peer report as index test

| **Study ID** | **Population** | **Peer Report Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Dvorsky, 201665  N = 86  n ADHD = 59  US  College | **Target:** Undergraduate students at a large public university who self-identified as having attention or concentration difficulties or a prior ADHD diagnosis, required consent for parental interviews, completed a comprehensive ADHD evaluation including structured diagnostic interviews, and met DSM-5 ADHD criteria based on both student and parent ratings  **ADHD presentation:** inattentive : 55.9,combined : 44.1  **Comorbidity:** N/A  **Other:** Undergraduate students at the same university who self-identified with attention or concentration difficulties but did not meet DSM-5 criteria for ADHD based on structured diagnostic interviews and parent ratings  **Female:** 42.4%  **Age mean (SD):** 19.71 (2.72)  Min age: 18 Max age: 27  **Age subgroup**: Adults  **Ethnicity:** Other : ADHD: 0, non-ADHD: 3.7  % Hispanic or Latino : 8.5,Other : 11.1  % Black/African American : 6.8,Other : non-ADHD: 18.5  % White : 76.3,Other : non-ADHD: 55.6  % Multiracial : 8.5,Other : 11.1  Single center  Funding unclear | **Test description:** BAARS-IV (Barkley Adult ADHD Rating Scale-IV) parent report  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners’ Adult ADHD Diagnostic Interview for DSM-IV, which included structured diagnostic interviews separately administered to students and their parents by trained graduate-level clinicians under supervision, requiring endorsement of at least five current symptoms in two or more settings and six childhood symptoms before high school  **Diagnosed by:** Specialist (e.g., mental health) Psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Parent ratings of childhood inattention had the highest predictive validity (AUC 0.79), outperforming self-report (AUC 0.56).  Self-reports had high sensitivity (89%) but low specificity (30%), leading to a high false-positive rate.  The prediction model with both parent and student ratings of current symptoms and parent ratings of childhood symptoms accurately classified 88.9% of individuals who had a diagnosis of ADHD and 63.3% of individuals who did not have a diagnosis.  Sensitivity 60%  Specificity 77%  PPV 80  NPV 50  LR+  LR-  Accuracy 63  AUC Total scores parent ratings of current symptoms = inattention: 0.68 (0.56, 0.81), hyperactivity: 0.50 (0.31, 0.61), impulsivity: 0.51 (0.37, 0.65); parent ratings of childhood symptoms = inattention: 0.78 (0.66, 0.89), hyperactivity/impulsivity: 0.54 (0.41, 0.67)  **Concordance:** N/A  **Rater agreement:** Parent ratings were compared against student self-reports for both current and childhood ADHD symptoms using Pearson correlations, intraclass correlations (ICCs), and mean differences.  Kappa ICC Current inattention ICC 0.43, current hyperactivity ICC 0.31, current impulsivity ICC 0.32, retrospective children inattention ICC 0.42, retrospective childhood hyperactivity/impulsivity ICC 0.37  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Unintended consequences:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kingston, 201398  N = 120  n ADHD = 59  Canada  Specialty care | **Target:** Men assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **ADHD presentation:** N/A  **Comorbidity:** Other : Aggression dysregulation  **Other:** Men who were assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **Female:** 0%  **Age mean (SD):** 32.6 (10.3)  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:** Other : Aboriginal: 6.5%  % Hispanic or Latino : 2.8  % Black/African American : 2.8  % White : 78.5  Single center  Industry | **Test description:** CAARS-O ADHD Index (Observer), observer report, a 66-item measure that contains 9 empirically-derived scales related to adult ADHD symptoms  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  ADHD diagnosis was determined based on DSM-IV-TR criteria following a comprehensive clinical interview and review of relevant available collateral information; interviews were conducted independently by two psychiatrists who were certified in forensic psychiatric practice; final group classification was based on consensus diagnoses and the inter-rater agreement was approximately 90%  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The integrated variables of multiple self reports and an observer report demonstrated particularly good classification accuracy, with high sensitivity (91%) and good specificity (82%).  Sensitivity 76% (CI 0.61, 0.86)  Specificity 75% (CI 0.57, 0.87)  PPV 80 (CI 0.66, 0.90)  NPV 69 (CI 0.52, 0.82)  LR+  LR-  Accuracy  AUC  **Concordance:**  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Unintended consequences:** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** N/A |
| Palmer, 2023122  N = 71  n ADHD = 40  UK  Community | **Target:** Autistic young adults recruited from a population-based cohort (SNAP) with parent-informed ADHD research diagnoses based on DSM criteria, including those with varying intellectual functioning. 40 total number of individuals with ADHD based on the parent-reported YAPA diagnostic interviews  **ADHD presentation:** inattentive : 30,hyperactive : 37.5,combined : 32.5  **Comorbidity:** Autism : Autism subgroup includes young autistic adults with varying intellectual functioning  **Other:** Autistic young adults identified through the same cohort and screened as non-ADHD cases  **Female:** 10.1%  **Age mean (SD):** 23.1 (0.77)  Min age: 21.33 Max age: 25.08  **Age subgroup**: Young  **Ethnicity:**  % White : 94.1  Single center  Public funding | **Test description:** CAARS-P (Conners Adult ADHD Rating Scales Peer Report) parent report, ADHD Index cutoff >56; administered together with ABC (Aberrant Behavior Checklist) Hyperactivity/Non-compliance subscale (a cutoff of ≥3), parent-report to measure hyperactive and non-compliant behaviors in individuals with developmental disabilities  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the parent-informed Young Adult Psychiatric Assessment using DSM criteria and conducted by a trained researcher or clinician to ascertain symptom frequency, duration, intensity, and impairment  **Diagnosed by:** Researcher  **Timing:** Concurrent | **Diagnostic accuracy summary:** Although the measures performed at or close to adequate levels (AUC was 0.66 to 0.79 for the parent report and 0.70 to 0.65 for the self-report), no single measure simultaneously met adequate thresholds for sensitivity and specificity in young adults with autism.  Sensitivity 94% (CI 85, 100) ABC scale: 91%  Specificity 57% (CI 34, 80) ABC scale: 42%  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Unintended consequences:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Table C.4. Evidence table neuropsychological tests as index test

| **Study ID** | **Population** | **Neuropsychological Tests as Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Adamou, 202245  N = 69  n ADHD = 38  UK  Specialty care | **Target:** Adults over the age of 18 years with good comprehension of the English language, and IQ within normal range (>70), diagnosed with ADHD. 20 without comorbidity, 18 with comorbidity  **ADHD presentation:** inattentive\_other : ADHD group, N=45, M(SD) scores for DIVA - symptoms of attention-deficit: 8.6 (0.6),hyperactive\_other : ADHD group, N=45, M(SD) scores for DIVA - symptoms of hyperactivity-impulsivity: 7.6 (1.8)  **Comorbidity:** N/A  **Other:** Adults over the age of 18 years with a good comprehension of the English language, and IQ within normal range (>70), not diagnosed with ADHD after full assessment in the study  **Female:** 34.8%  **Age mean (SD):** 33 (9.9)  Min age: 23 Max age: 42  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** QbTest, a continuous performance test measuring inattention, impulsivity, and hyperactivity combined with activity levels which are measured by an infrared motion tracking camera; consists of unconditional identical pair paradigm to avoid floor to ceiling effects; participants are asked to sit 1m from a monitor which the infrared motion tracking camera is attached to, and to hold a handheld responder; participants are instructed (by standardized instruction on the screen, and verbally) that there will be time for a 5-minute practice before they begin, and that accuracy and speed is the objective; consists of 600 stimuli presented on the monitor, each stimulus is present for 200ms, followed by an interval of 2000ms; stimulus consists of red or blue circles and squares; participants are instructed to only press the responder when the stimuli they see matches the previous stimuli in color or shape; attention is measured by number of correctly identified targets, reaction time, and variability of reaction time. Impulsivity is measured by incorrect responses, and hyperactivity is measured using the motion- tracking system using the infrared camera (captures movement by tracking a reflective headband); camera captures movement throughout the whole of the task at a frequency of 50 samples a second and with spatial resolution of 1/27 mm per infrared camera unit  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with DIVA interview by a doctor with expertise in ADHD and General Psychiatry  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** N/A | **Diagnostic accuracy summary:** The QbTest+ demonstrated 70% sensitivity and 43% specificity, failing to effectively differentiate between those diagnosed with ADHD and those without a diagnosis after full clinical assessment.  Sensitivity 70%  Specificity 43%  PPV 60  NPV 54  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes on average. | **Subgroup analysis:** N/A |
| Biederman, 201754  N = 60  n ADHD = 34  US  Specialty care | **Target:** Adults aged 18 to 55 years with a DSM-IV diagnosis of ADHD, onset of symptoms in childhood, persistence into adulthood, unmedicated for at least 1 week before the study, and no active symptoms of depression or anxiety  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Healthy adults aged 18 to 55 years without ADHD or other psychiatric disorders, recruited as controls to differentiate ADHD from neurotypical individuals in a specialty care setting  **Female:** 23.33%  **Age mean (SD):** 30.06 (10.76)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:**  % White : 82  Single center  Industry | **Test description:** Go/NoGo task errors, participants were seated in a dimly lit room at a distance of 70 cm from a 17-inch CRT screen; Go stimuli were white letters appearing in equal proportions, the NoGo stimulus was a white x symbol, stimuli were presented on the center of a black background computer screen for 150 ms and were located between 2 vertical white lines, 10 trial practice block, analyzed reaction time, error rates (commission and misses)  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through clinical evaluation and ADHD module of the K-SAD-E conducted by clinicians with expertise in ADHD diagnosis and treatment  **Diagnosed by:** Specialist (e.g., mental health) clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** EEG Brain Network Activation analysis demonstrated high diagnostic accuracy in distinguishing adults with ADHD from neurotypical controls, with an AUC of 0.92, sensitivity of 0.86, and specificity of 0.95 in the Go condition, and an AUC of 0.84, sensitivity of 0.76, and specificity of 0.91 in the NoGo condition.  Neuropsychological tests alone showed no high discriminability for any of the indicators.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC 0.67 hit RT AUC 0.52; commission RT AUC 0.43; percent misses AUC 0.61; percent commission AUC 0.64  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 12 minutes across all tests. | **Subgroup analysis:** N/A |
| Brunkhorst-Kanaan, 202055  N = 114  n ADHD = 94  Germany  Specialty care | **Target:** ADHD group composed of 94 (82.5%) patients who met the criteria for an ADHD diagnosis.  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD-Group where adult ADHD was ruled out during the diagnostic process, consists of 20 patients (17.5%)  **Female:** 42.6%  **Age mean (SD):** 34.7 (11.05)  Min age: 23 Max age: 48  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** QbTest  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Diagnostic Interview for Adult ADHD (DIVA 2.0), which assessed current and childhood ADHD symptoms, impairment in multiple domains of functioning, and additional childhood symptom information from the Wender Utah Rating Scale (WURS-K), with final diagnosis confirmed through clinical judgment​  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The QbTest demonstrated limited clinical utility in differentiating adult ADHD from other psychiatric conditions, with hyperactivity being the only parameter showing some discriminative ability (AUC 0.65). Despite a sensitivity of 68% and specificity of 48%, its low accuracy suggests it is not a reliable standalone diagnostic tool in real-world outpatient settings.  Sensitivity 68%  Specificity 48%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.65  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes | **Subgroup analysis:** Age,Sex,Comorbidity (e.g. anxiety, depression)  Age represented as independent variable in a multiple regression did not significantly influence parameters measured by the QbTest.  Sex represented as independent variable in a multiple regression did not significantly influence parameters measured by the QbTest.  Psychiatric disorders represented as independent variable in a multiple regression did not significantly influence parameters measured by the QbTest. The QbTest had poor sensitivity (68%) and specificity (48%) for ADHD diagnosis, with outcomes largely unaffected by participant comorbidities. |
| Cohen, 200759  N = 58  n ADHD = 28  US  Setting varies | **Target:** Adults aged 19 to 25, recruited through psychology classes, the university disabilities office, and local medical offices; ADHD diagnosis confirmed via self-report, scores on the Conners’ Adult ADHD Rating Scale exceeded 1.5 standard deviations above the mean on the DSM-IV Inattentive or Hyperactive-Impulsive Symptoms Scales, excluded if on psychoactive medication other than ADHD medication  **ADHD presentation:** inattentive : 54,hyperactive : 4,combined : 43  **Comorbidity:** N/A  **Other:** Neurotypical adults with no history of ADHD diagnosis, scores within one standard deviation on the Conners’ Adult ADHD Rating Scale, recruited from the same university setting, excluded if on psychoactive medication  **Female:** 68%  **Age mean (SD):** 20.46 (1.71)  Min age: 19 Max age: 25  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** Model combined Flicker task commission errors and C-CPT reaction time standard error;Flicker task measures change blindness and focused attention by requiring participants to detect changes between alternating images separated by a blank screen; metrics include the number of cycles needed to detect changes, variability, and accuracy; administered together with the C-CPT (Conners’ Continuous Performance Test) assessing sustained attention, impulsivity, and response inhibition through a computerized Go/NoGo task in which participants respond to all letters except "X " to measure reaction time, omission and commission errors and variability in response  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on self-reported diagnosis, supported by scores exceeding 1.5 standard deviations above the mean on the DSM-IV Inattentive or Hyperactive-Impulsive Symptoms Scales using the Conners’ Adult ADHD Rating Scale, confirmed through demographic screening and clinician evaluation.  **Diagnosed by:** Specialist (e.g., mental health) clinician  **Timing:** Concurrent | **Diagnostic accuracy summary:** Integration showed a sensitivity of 75% and specificity of 80%.  Flicker task did not demonstrate better discriminative utility than the C-CPT, although it supported the robust nature of change blindness.  The CCPT exhibited only modest utility for discriminating performance in adults with and without ADHD, with weak sensitivity and moderate specificity.  Sensitivity 75% Flicker Task: 57; C-CPT: 71  Specificity 80% Flicker Task: 87; C-CPT: 77  PPV 78 Flicker Task: 80; C-CPT: 74  NPV 77 Flicker Task: 68; C-CPT: 74  LR+ 3.75 Flicker Task: 4.38; C-CPT: 3.09  LR- 0.3125 Flicker Task: 0.49; C-CPT: 0.38  Accuracy 77.6 Flicker Task: 72; C-CPT: 74  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 10-15 minutes, depending on participant performance | **Subgroup analysis:** N/A |
| Edebol, 201266  Edebol, 201367  N = 341  n ADHD = 55  Sweden  Specialty care | **Target:** Adults diagnosed with ADHD based on DSM-IV criteria, requiring symptoms to be present since childhood, assessed at neuropsychiatric clinics using clinical interviews, psychological testing, and QbTest-Plus, excluding those with clinically unstable psychiatric conditions  **ADHD presentation:** inattentive : 3.8,combined : 88.7,N/A : 7.5  **Comorbidity:** N/A  **Other:** Neurotypical adults without psychiatric diagnoses recruited from universities, workplaces, and music organizations  **Female:** 54.55%  **Age mean (SD):** 33.35 (8.84)​  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  No COI | **Test description:** QbTest-Plus plus motion tracking, objectively measures hyperactivity by tracking head movements during a 20-minute continuous performance test, records movement distance, frequency, and variability, providing a quantitative measure of motor activity that helps differentiate ADHD from non-ADHD participants  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through clinical interviews, psychological testing, self-report scales, and corroborative information from relatives conducted by mental health clinicians  **Diagnosed by:** Specialist (e.g., mental health) mental health clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** The QbTest-Plus, combining a Continuous Performance Test and Motion Tracking System, distinguished ADHD from non-ADHD normative participants with 87% sensitivity and 85% specificity. The Prediction of ADHD variable, developed from QbTest-Plus data, identified ADHD with 86% sensitivity and 83% specificity.  Sensitivity 86%  Specificity 83%  PPV 57.32  NPV 95.43  LR+ 5.06  LR- 0.17  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  Misdiagnosis was more common in individuals with overlapping symptoms of borderline personality disorder and bipolar disorder, reducing specificity to 36% in these subgroups. The QbTest-Plus was effective in differentiating ADHD from normative participants, with functional impairment and standardized symptom scores aligning well with clinical diagnoses in specialty care settings​. |
| Elbaum, 202068  N = 85  n ADHD = 43  Israel  College | **Target:** Undergraduate adult ADHD students with normal or corrected to normal vision without any learning disabilities and/or other neuropsychiatric issues  **ADHD presentation:** hyperactive : 4.4,N/A : Assessed attention = 94.4% impulsivity= 4.82%  **Comorbidity:** N/A  **Other:** Healthy control undergraduate students with normal or corrected to normal vision without any potential ADHD indicators  **Female:** 60.5%  **Age mean (SD):** 23.84 (2.28)  Min age: 21 Max age: 26  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Industry | **Test description:** MOXO-dCPT (continuous performance test) uses varying visual and auditory distractors to simulate real-world challenges and assess performance, and it's integrated with the EyeLink 1000 eye tracker, monitoring eye movements with calibration performed for each participant before the task  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 by licensed clinician  **Diagnosed by:** Other care provider (e.g., primary care physician) Licensed/trained clinician  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The findings indicate the utility of eye tracker-integrated CPTs and their enhanced diagnostic precision.  Sensitivity 69%  Specificity 69%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.78  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 18.7 minutes | **Subgroup analysis:** N/A |
| Emser, 201869  N = 136  n ADHD = 68  Germany  Specialty care | **Target:** Participants with ADHD were clinically referred, met DSM-IV criteria for ADHD (combined, inattentive, or hyperactive/impulsive subtype), had IQ ≥ 80, and were free from other medical conditions causing inattention, hyperactivity, or impulsivity such as hyperthyroidism or brain disorders  **ADHD presentation:** inattentive : 10.5,hyperactive : 2.6,combined : 81.6  **Comorbidity:** N/A  **Other:** Non-ADHD participants were age- and gender-matched controls recruited from local universities and advertisements, had no established or suspected ADHD diagnosis or family history of ADHD, and were neurotypical without significant medical or psychiatric conditions. 38 adults with ADHD. 30 children with ADHD​  **Female:** 34.2% children with ADHD: 30  **Age mean (SD):** 35.1 (11.7)  Min age: Max age: 63  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  No COI | **Test description:** Model with objective measures from QbTest+ and TAP task (variables used in over85% of predictions: overall omission errors made at the subtest sustained attention in the TAP; QbTest+: omission errors, error rate, normalized reaction time variance, normalized reaction time variance without outliers, and the ability of the patient to distinguish between target and non-target); assessment included QbTest variables, motion tracker, and Qb+ (Quantified BehaviorTest), a continuous performance task combined with motion tracking that evaluates sustained attention, impulsivity, and hyperactivity to capture reaction time, omission/commission errors, and physical activity (distance traveled, area covered, micro-movements); and TAP (Test Battery of Attention), a neuropsychological battery for assessing selective attention, divided attention, and sustained attention, subtests include Go/NoGo Task assesses response inhibition and selective attention, Divided Attention Task evaluates the ability to process visual and auditory stimuli simultaneously, Sustained Attention Task measures attentiveness over a prolonged period  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interviews conducted by experienced clinicians using DSM-IV criteria, including the Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL) for children and the Wender Reimherr Interview (WRI) for adults  **Diagnosed by:** Specialist (e.g., mental health) clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** The diagnostic accuracy using only objective data showed 79% accuracy. Predicting an ADHD diagnosis using both subjective and objective measures exceeded the accuracy of objective measures for adults (89.5%) with the subjective variables proving to be the most relevant.  Sensitivity 82%  Specificity 76%  PPV  NPV  LR+  LR-  Accuracy 79  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes | **Subgroup analysis:** N/A |
| Galloway-Long, 202275  N = 133  n ADHD = 353  US  College | **Target:** Adults met full DSM criteria for ADHD based on the Conners’ Adult ADHD Diagnostic Interview, recruited from counties, required cross-situational severity and impairment based on standardized behavior rating scales, stimulant medication use was discontinued 24–48 hours prior, exclusions included sensorimotor disabilities, neurological disorders, autism, psychosis, non-stimulant ADHD medication use, and low estimated IQ. Preschool sample: 75. School-aged sample: 216. Adult sample: 62  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults never diagnosed with or treated for ADHD, recruited from the same counties, reported fewer than two inattentive or hyperactive/impulsive symptoms and fewer than three total ADHD symptoms, exclusions matched those for the ADHD group including neurological disorders and low estimated IQ  **Female:** % pre-school: 30.67, school-aged: 33.80, adult: 56.45  **Age mean (SD):** 21.13 (1.80)  Min age: Max age: 25  **Age subgroup**: Young  **Ethnicity:** N/A  Multicenter  Public funding | **Test description:** Go/NoGo task, percentage of failed inhibits on Go/NoGo Task; reaction time variabilitymeasures were used to assess inhibitory control and attention in ADHD; Go/NoGo task involved responding to frequent Go stimuli while withholding responses to infrequent NoGo stimuli and assessing response inhibition; reaction time variability, including standard deviation of reaction time ex-Gaussian parameters analyzed to determine cognitive processing differences between ADHD and non-ADHD participants  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Diagnostic Interview Schedule for Children version IV for children or the Conners’ Adult ADHD Diagnostic Interview for adults, required cross-situational severity and impairment based on standardized behavior rating scales, including parent and teacher reports for children and self-report for adults, stimulant medication use was discontinued 24–48 hours prior, exclusions included neurological disorders, autism, psychosis, and low estimated IQ  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Go-no-go percentage of failed inhibits successfully discriminated between adults with and without ADHD.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC 0.73  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Approximately 15 minutes. | **Subgroup analysis:** N/A |
| Groom, 201678  N = 57  n ADHD = 33  UK  College | **Target:** Adults who were clinically diagnosed with ADHD by a psychiatrist  **ADHD presentation:** inattentive : 9.09,hyperactive : 3.03,combined : 75.76,N/A : 12.12  **Comorbidity:** N/A  **Other:** Adults diagnosed with Asperger's syndrome as part of autism spectrum disorder by a psychiatrist  **Female:** 39%  **Age mean (SD):** 31.64 (10.17)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** QbTest is a computerized continuous performance test with infra-red motion tracking system, designed to assess attention, impulsivity, and activity levels; participants respond to stimuli on a screen while their movements are tracked, and scores are calculated based on attention accuracy, reaction time, and movement data, standardized against a normative sample  Machine learning: No  Validation dataset: Unclear  **Reference standard:** Clinical diagnosis  Participants diagnosed with ADHD by a psychiatrist establishing current and long-term diagnosis using DSM-5  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** QbTotal yielded the highest AUC value 0.87 (classified as ‘good’). ROCs indicate that at equivalent sensitivity of around 80%, QbTotal demonstrates superior specificity compared with CAARS-E in differentiating ADHD and autism spectrum disorder.  CAARS-E AUC was .77 (‘fair’) in differentating ADHD and autism spectrum disorder.  QbTest added to clinical ratings may improve the differentiation of ADHD and autism spectrum disorder in adults.  Sensitivity 84%  Specificity 80%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.87 good  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Approximately 20 minutes. | **Subgroup analysis:** N/A |
| Katz, 199890  N = 78  n ADHD = 58  US  Specialty care | **Target:** Diagnosed with ADHD based on DSM-III-R criteria following a structured clinical interview, no history of major neurological disorder, no evidence of intellectual disability, no comorbid major psychiatric illness, not currently taking psychoactive medication  **ADHD presentation:** N/A  **Comorbidity:** Depression  **Other:** Adults with a primary diagnosis of depression based on DSM-III-R criteria and structured clinical interview, and healthy controls with no history of psychiatric or neurological disorder  **Female:** 21.9%  **Age mean (SD):** 29.06(11.96)  Min age: 18 Max age: 42  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** Measures of attention, executive functioning, and memory; Stroop Color-Word Test, Trail Making Test, Wisconsin Card Sorting Test, and WAIS-R subtests  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  DSM-IV criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Neuropsychological tests correctly classified 82.1% of adults as having ADHD or depression based on performance in attention, executive functioning, and memory tasks.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy 82.1  AUC  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC N/A  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Khan, 202295  N = 317  n ADHD = 226  US  Specialty care | **Target:** Adults referred for outpatient neuropsychological evaluation for suspected or confirmed ADHD, reported English as their primary language, underwent a standardized diagnostic protocol including record review, clinical interview, and neuropsychological testing, and were evaluated for ADHD using DSM-5 criteria  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included adults referred for neuropsychological evaluation who failed performance validity tests, with evaluations conducted in a specialty care setting focused on diagnostic clarification for conditions other than ADHD  **Female:** 62.46%  **Age mean (SD):** 27.7 (6.67)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** Other : 5  % Black/African American : 24  % Asian : 10  % White : 46  Single center  Funding unclear | **Test description:** SCWT WR raw (Stroop Color and Word Test word reading trial), SCWT assesses cognitive flexibility and processing speed through 3 trials: word reading, color naming, and color-word interference, cut of 75 or less  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria by a board-certified clinical neuropsychologist  **Diagnosed by:** Specialist (e.g., mental health) Clinical neuropsychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The embedded validity indicators from the Stroop Color and Word Test were effective in determining validity status. Word Reading and Color Naming trials demonstrated acceptable classification accuracy (AUCs 0.750–0.794), with optimal cut scores of WR raw ≤75 (54% sensitivity, 89-90% specificity), WR T score ≤28 (54% sensitivity, 87-88% specificity), CN raw ≤57 (42% sensitivity, 90% specificity), and CN T score ≤30 (40% sensitivity, 90% specificity).  Sensitivity 54% range for subscores 37 to 54%  Specificity 89% range for subscores 82 to 90%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.775 range 0.75 to 0.79  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kingston, 201398  N = 120  n ADHD = 59  Canada  Specialty care | **Target:** Men assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **ADHD presentation:** N/A  **Comorbidity:** Other : Aggression dysregulation  **Other:** Men who were assessed at an outpatient forensic psychiatric clinic; individuals are typically referred to this program when they are engaging in aggression or other difficulties associated with anger dysregulation (e.g., relationship breakdown)  **Female:** 0%  **Age mean (SD):** 32.6 (10.3)  Min age: 18 Max age: 64  **Age subgroup**: Adults  **Ethnicity:** Other : Aboriginal: 6.5%  % Hispanic or Latino : 2.8  % Black/African American : 2.8  % White : 78.5  Single center  Industry | **Test description:** IVA+Plus-FSRCQ (Integrated Visual and Auditory Continuous Performance Test Full Scale Response Control Quotient), a computerized continuous performance test utilizing visual and auditory stimuli to assess response control; constant and sustained attention is required, as participants respond or inhibit their response to 500 counterbalanced trials; and FSRCQ (Full Scale Attention Quotient), measures impulsivity and commission errors, normative quotient scores have a mean of 100 and a standard deviation of 15  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  ADHD diagnosis was determined based on DSM-IV-TR criteria following a comprehensive clinical interview and review of relevant available collateral information; interviews were conducted independently by two psychiatrists who were certified in forensic psychiatric practice; final group classification was based on consensus diagnoses and the inter-rater agreement was approximately 90%  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The integrated variables of multiple self reports and an observer report demonstrated particularly good classification accuracy, with high sensitivity (91%) and good specificity (82%).  Sensitivity 30% (CI 17, 45) IVA+Plus-FSAQ 39% (29, 54)  Specificity 74% (CI 58, 86) IVA+Plus-FSAQ 69% (53, 82)  PPV 54 CI (33, 74) IVA+Plus-FSAQ 57% (38, 74)  NPV 50 (CI 37, 63) IVA+Plus-FSAQ 52% (38, 65)  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kovner, 199899  N = 29  n ADHD = 19  US  Specialty care | **Target:** Adults diagnosed with ADHD based on DSM-IV criteria, without known medical or neurological conditions that could account for ADHD symptoms, not on psychoactive medication, and evaluated independently by a psychiatrist, neurologist, and neuropsychologist using historical, questionnaire, and interview data  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with no ADHD diagnosis but with other non-psychotic psychiatric disorders (depression, generalized anxiety, narcissistic personality disorder) or pre-diagnosed learning disabilities, recruited from a specialty clinic setting and assessed similarly to the ADHD group using independent psychiatric, neurological, and neuropsychological evaluations  **Female:** 26.32%  **Age mean (SD):** 33.1 (11.3)  Min age: 18 Max age: 57  **Age subgroup**: Adults  **Ethnicity:**  % White : 100  Single center  Funding unclear | **Test description:** Model with DGBR and HSST4MNR (Digits Backwards from Digit Span subtest of WAIS-R and mean reaction time from the 4h set of the Shifting Sets Test, based on Digit Span Subtest of the WAIS-R measured working memory and inhibitory control; Shifting Sets Test assessed cognitive flexibility, response inhibition, and reaction time; Continuous Performance Tests (Connors CPT and repeated stimuli CPT) evaluated sustained attention and impulse control; Recognition Memory Tests (Warrington Recognition Memory Test) gauged memory recall and incidental learning; Boston Naming Test evaluated language processing and naming ability; (WRAT-R (Wide Range Achievement Test-Revised ) measured academic skills like reading, spelling, and arithmetic  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria following evaluation by a psychiatrist, neurologist, and neuropsychologist, incorporating clinical interviews, rating scales, historical records, and neuropsychological testing.  **Diagnosed by:** Specialist (e.g., mental health) psychiatrist, neurologist, neuropsychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Three measures significantly (p < 0.01) distinguished the groups: Digits Backwards from the WAIS-R and two reaction time measures from a computerized task modeled after Luria's Competing Motor Programs. ROC curve analyses indicated that, in combination, these measures had greater than 90% accuracy for classifying ADHD and non-ADHD patients.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC probability of classifying someone with ADHD and someone without ADHD was between 90.5 and 93.3%  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 2.5 hours | **Subgroup analysis:** N/A |
| Lev, 2022104  N = 66  n ADHD = 33  Israel  College | **Target:** Adults with a previous ADHD diagnosis by a licensed clinician confirmed using the Structured Clinical Interview for DSM-5, undergraduate students with normal or corrected-to-normal vision, no significant neuropsychiatric comorbidities, and no learning disabilities  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical adults matched by age and education to the ADHD group, undergraduate students with normal or corrected-to-normal vision, no reported attentional impairments and a total score below 37 on the Adult ADHD Self-Report Scale (ASRS)  **Female:** 67%  **Age mean (SD):** 23.3 (2.13)  Min age: 20 Max age: 26  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** MOXO-dCPT with eye tracking measures included gaze duration at different areas of interest and task area of interest visit count  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by a licensed clinician using the Structured Clinical Interview for DSM-5 criteria and confirmation of prior diagnosis.  **Diagnosed by:** Specialist (e.g., mental health) Clinician  **Timing:** Concurrent | **Diagnostic accuracy summary:** Integrating an eye tracker with CPTs is a feasible way of enhancing diagnostic precision and shows initial promise for clarifying the cognitive profile of ADHD patients.  Sensitivity 76%  Specificity 82%  PPV  NPV  LR+  LR-  Accuracy  AUC 0,826  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 18.7 minutes | **Subgroup analysis:** N/A |
| Lovejoy, 1999107  N = 52  n ADHD = 26  US  Specialty care | **Target:** Adults diagnosed with ADHD based on DSM-IV criteria through clinical interview by a board-certified psychiatrist specializing in ADHD, currently taking stimulant medication (methylphenidate or dextroamphetamine) and reporting these medications as "very helpful" for addressing ADHD symptoms, with no comorbid psychiatric disorders, substance abuse history, or neurological disease, and with an estimated IQ of 85 or higher based on WAIS-R  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants were recruited from clinic waiting rooms in medical practice settings and through referrals, endorsed three or fewer ADHD symptoms on a DSM-IV checklist, had no history of taking stimulant medications for attentional difficulties, and met the same criteria as ADHD participants for IQ (≥85), absence of psychiatric or neurological conditions, and absence of learning disabilities.  **Female:** 50%  **Age mean (SD):**  median 41 (N/A)  Min age: 21 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** SNST (Stroop Neuropsychological Screening Test) evaluates cognitive inhibition and impulsivity; cutoff score 20th-21st percentile for ages 18-49 and 11th percentile for age 50+; Trail Making Test (Parts A and B) assesses attention, cognitive flexibility, and working memory; clinical cutoff 1 standard deviation below the normative mean; California Verbal Learning Test (CVLT) measures verbal memory and organization; cutoff 2 standard deviations below the normative mean for Short-Delay Free Recall; Controlled Oral Word Association Test (COWA) evaluates verbal fluency and executive functioning, clinical cutoff below 16th percentile; WAIS-R Freedom From Distractibility Factor (Digit Span and Arithmetic) assesses attention-concentration and working memory, cutoff 1 standard deviation below the normative mean  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a clinical interview by a board-certified psychiatrist specializing in ADHD using DSM-IV criteria and confirmation through participant self-report of sufficient symptoms for inattentive, hyperactive-impulsive, or combined subtype.  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Individual neuropsychological tests showed high positive predictive power (PPP) (83–100%), but negative predictive power (NPP) was lower.  When considering the entire test battery, classification accuracy improved significantly  Sensitivity % COWA: 58, CVLT: 38, SNST: 23, Trails A: 19, Trails B 96, WAIS:38  Specificity % COWA: 92, CVLT: 92, SNST: 1.0, Trails A: 1.0, Trails B 96, WAIS:1.0  PPV COWA: 88, CVLT: 83, SNST: 1.0, Trails A: 1.0, Trails B 86, WAIS:1.0  NPV COWA: 69, CVLT: 60, SNST: 57, Trails A: 55, Trails B 56, WAIS:62  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Mostert, 2015114  N = 265  n ADHD = 133  Netherlands  Specialty care | **Target:** Adults diagnosed with persistent ADHD present since childhood by a psychiatrist according to DSM-IV criteria, aged 18–60 years, with no psychosis, alcohol or substance addiction in the last six months, current major depression, IQ <70, neurological disorders, or sensorimotor disabilities, and no non-Caucasian ethnicity  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical adults recruited as healthy controls from the community and university settings, with no history of psychiatric or neurological disorders and no first-degree relatives with such disorders, matched for age, gender, and estimated IQ  **Female:** 57.9%  **Age mean (SD):**  mean 36  Min age: 18 Max age: 59  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Model with Digit span (forward), Flanker (total SD of RT), SAdots (SD series errors and response bias), Delay discounting (k100) and Time estimation (absolute median deviation from 1000ms) based on a battery of tasks assessing executive functioning (working memory, attention, inhibition), delay discounting, time estimation, and reaction time variability; tasks included measures like the WAIS-III Digit Span, Flanker Task, SART (Sustained Attention to Response Task), and a delay discounting task chosen to align with ADHD-related cognitive pathways; variability in errors, reaction times, and impulsivity parameters analyzed  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a structured Diagnostic Interview for ADHD in Adults (DIVA) and prior clinical diagnosis by a psychiatrist according to DSM-IV criteri  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Concurrent | **Diagnostic accuracy summary:** A combined predictive model incorporating 6 neuropsychological measures achieved 82.1% specificity and 64.9% sensitivity in diagnosing ADHD.  Sensitivity 65%  Specificity 82%  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Prior to MRI: 1.5 hours; Post-MRI: 1 hour | **Subgroup analysis:** N/A |
| Nielsen, 2011118  N = 60  n ADHD = 30  Denmark  Specialty care | **Target:** Adults aged 18–43 referred to a regional outpatient psychiatric center for ADHD evaluation, diagnosed with ADHD based on DSM-IV-TR and ICD-10 criteria, with no prior ADHD medication use, including individuals with substance abuse, personality disorders, or other co-morbidities  **ADHD presentation:** combined : 70  **Comorbidity:** N/A  **Other:** Neurotypical adults aged 18–43 recruited from the urban community, matched by age and sex with the ADHD group, with no history of neuropsychiatric disorders or recent changes in daily habits  **Female:** 53.3%  **Age mean (SD):** 28.3 (6.6)  Min age: 18 Max age: 43  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** AQT (A Quick Test of Cognitive Speed) evaluates single- and dual-dimension naming speed (color, form, and color-form combination) and processing efficiency (overhead), cutoffs of ≥60 seconds for dual-dimension naming and ≥6 seconds for processing efficiency  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV-TR and ICD-10 criteria using a psychiatric interview and behavioral rating scales  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** When using fail criteria for dual-dimension naming (60s) and overhead (processing efficiency) (6s) together, the sensitivity was 93% and specificity 100%.  Sensitivity 93%  Specificity 100%  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Nikolas, 2019119  N = 246  n ADHD = 109  US  Setting varies | **Target:** Adults diagnosed with ADHD based on a comprehensive clinical interview and standardized psychiatric assessments, required to have symptom onset before age 16, met full DSM-5 diagnostic criteria, provided informant reports verifying symptoms, excluded if they had neurological conditions, learning disabilities, major psychiatric disorders other than depression/anxiety, or substance abuse  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with a diagnosed unipolar mood disorder (depression) and healthy controls without ADHD or mood disorders, recruited through advertisements, email listservs, and outreach to neuropsychological clinics, with controls matched approximately by age and sex to clinical groups  **Female:** 60.6%  **Age mean (SD):** 24.8 (6.2)  Min age: 18 Max age: 40  **Age subgroup**: Adults  **Ethnicity:**  % White : 83.7,Other : Control: 80, depressed: 86.5  Multicenter  Industry | **Test description:** TOVA ommission errors, cutoff <95  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive clinical interview, standardized psychiatric assessment, and meeting full DSM-5 diagnostic criteria with verification of symptom onset before age 16 using self-report and informant ratings  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** While single test measures provided performed poorly in identifying ADHD participants, analyses revealed that a combined approach using self and informant symptom ratings, a positive family history of ADHD, and a reaction time variability measure correctly classified 87% of cases.  Sensitivity 50%  Specificity 85%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.66 Youden 0.35; AUC ranged from 0.43 for Numbers and letter efficiency to 0.55 for TOVA reaction time variability and TOVA omission errors.  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Pettersson, 2018123  N = 108  n ADHD = 60  Sweden  Specialty care | **Target:** Adults referred for ADHD assessment, required availability of a collateral historian to provide information on childhood symptoms, excluded if treated with ADHD medications, had an IQ ≤ 70, or substance-related disorders  **ADHD presentation:** inattentive : 21.7,hyperactive : 7.1,combined : 76.7  **Comorbidity:** N/A  **Other:** Adults referred to the same specialty neuropsychological clinic for assessment, did not meet the diagnostic criteria for ADHD, included individuals with other psychiatric conditions for comparison  **Female:** 46.7%  **Age mean (SD):** 28.18 (9.09)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Model with CPT II Commission errors, QbTest cardinal variable Inattention, and QbTest cardinal variable Activity  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Clinical consensus decision by a multidisciplinary assessment team using clinical interviews, neuropsychological test results, self-report measures, collateral historian input, and DSM criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** All instruments showed poor discriminative ability except for the DIVA, which showed a relatively good ability to discriminate between the groups (sensitivity 90.0; specificity 72.9). A logistic regression analysis model with the DIVA and measures of inattention, impulsivity, and activity from continuous performance tests (CPTs) showed a sensitivity of 90.0 and a specificity of 83.3.  Sensitivity 80% QBTest Act 77%; QBTest Ina 58%; QBTest Omi 73%, QBTest RT Var 43%; PASAT tot 33%; CPT II Com 33%, CPT II Var 27%  Specificity 67% QBTest Act 44%; QBTest Ina 67%; QBTest Omi 56%, QBTest RT Var 75%; PASAT tot 77%; CPT II Com 92%, CPT II Var 85%  PPV QBTest Act 63%; QBTest Ina 69%; QBTest Omi 68%, QBTest RT Var 68%; PASAT tot 65%; CPT II Com 83%, CPT II Var 70%  NPV QBTest Act 60%; QBTest Ina 56%; QBTest Omi 63%, QBTest RT Var 51%; PASAT tot 48%; CPT II Com 52%, CPT II Var 48%  LR+  LR-  Accuracy QBTest Act 62%; QBTest Ina 62%; QBTest Omi 66%, QBTest RT Var 57%; PASAT tot 53%; CPT II Com 59%, CPT II Var 53%  AUC 74.1 QBTest Act 66%; QBTest Ina 67%; QBTest Omi 73%, QBTest RT Var 67%; PASAT tot 66%; CPT II Com 74%, CPT II Var 71%  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes | **Subgroup analysis:** N/A |
| Rogers, 2021134  N = 147  n ADHD = 73  US  College | **Target:** Adults with a prior clinical diagnosis of ADHD, assessed using comprehensive psychological evaluations, with common comorbidities including major depressive disorder, learning disorders, and anxiety disorders  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Undergraduate students enrolled in psychology courses, with no history of ADHD or ADHD medication use, instructed to simulate ADHD symptoms for the purpose of the study  **Female:** 54.8%  **Age mean (SD):** 25.59 (4.17)  Min age: 18 Max age: 34  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 23.8  % Black/African American : 10.2  % Asian : 4.8  % White : 51  % Multiracial : 6.1  Single center  No COI | **Test description:** DS FE-90 (Digit Span) assessed with Matrix Reasoning WAIS-IV (Wechsler Adult Intelligence Scale–4h Edition), WAIS assesses cognitive functioning through subtests such as Digit Span, Matrix Reasoning, Visual Puzzles, and Coding, targeting attention, working memory, and processing speed  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on comprehensive psychological assessments conducted by clinicians, including clinical interviews and standardized testing to confirm the diagnosis.  **Diagnosed by:** Specialist (e.g., mental health) Clinician mental specialist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Very large effect sizes (Cohen’s ds from 1.66 to 1.90) differentiated between genuine and feigned ADHD. Two strategies (significantly below-chance performance and floor effect) showed strong promise if cross-validated for other feigning presentations.  Sensitivity 73%  Specificity 83%  PPV  NPV  LR+  LR-  Accuracy 81  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Schreiber, 1999137  N = 36  n ADHD = 18  US  Specialty care | **Target:** Adults diagnosed with ADHD by independent evaluations from a neuropsychologist and psychiatrist, fulfilling DSM-IV criteria, without comorbid psychiatric disorders or learning disabilities predominantly of the inattentive type, with assessments conducted before any medication trial.  **ADHD presentation:** inattentive : 89,combined : 2  **Comorbidity:** N/A  **Other:** The non-ADHD participants were neurotypical adults without a history of neurological, psychiatric, developmental, or learning disorders, matched to the ADHD group on gender, age, and education level, and recruited from university, community center, and clinical settings  **Female:** 50%  **Age mean (SD):** 30.3 (10.4)  Min age: 18 Max age: 52  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** BQSS (Boston Qualitative Scoring System) for the Rey-Osterrieth Complex Figure to assess executive functioning deficits, performance was compared on configurable accuracy, planning, neatness, and perseveration measures  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on independent evaluations by a neuropsychologist and psychiatrist using DSM-IV criteria, supported by clinical interviews, Barkley's ADHD-IV Self-Report of Current Behavior, third-party confirmation of childhood symptoms, and neuropsychological assessments focusing on attention, executive functioning, and learning  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The BQSS may be a useful tool contributing to the neuropsychological evaluation of adults with ADHD, sensitivity was 75% and specificity 81%.  Sensitivity 75% ROCF 36 point score: 68  Specificity 81% ROCF 36 point score: 71  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC The six summary scores had good to excellent reliability.  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Shepler, 2024140  N = 140  n ADHD = 61  US  Specialty care | **Target:** Adults referred for evaluation at two private psychology practices, diagnosed with ADHD or ADHD comorbid with psychiatric disorders based on DSM-5 criteria, comprehensive clinical interviews, rating scales, and standardized test performance. 17 with ADHD only and 44 with ADHD and at least one other psychiatric disorder  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults referred to the same private psychology practices, diagnosed with psychiatric disorders other than ADHD, including mood, anxiety, or learning disorders, using similar diagnostic criteria and assessments  **Female:** 41.18%  **Age mean (SD):** 35.31 (14.18)  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** Other : 1.4 Albanian and Jamaican  % Hispanic or Latino : 0.7  % Black/African American : 3.6  % Asian : 0.7  % White : 85  % Multiracial : 0.7  Multicenter  Other funding | **Test description:** Model combining WMI, PSI and 5 CTMT trail scores; CTMT (Comprehensive Trail Making Test) to assess executive functioning, including tasks related to set-shifting, visual search, and attentional control, alongside the WMI (WAIS-IV Working Memory Index) and PSI (Processing Speed Index) to evaluate cognitive performance​  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria, comprehensive clinical interviews, review of patient and informant rating scales, and performance on standardized neuropsychological tests.  **Diagnosed by:** Specialist (e.g., mental health) Clinicians & clinical psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Logistic regression analyses indicated that WMI and CTMT trail 5 scores were individually useful indicators in identifying the presence of ADHD. The best model showed a sensitivity of 67% and a specificity of 79%.  Sensitivity 67%  Specificity 79%  PPV 75  NPV 72  LR+ 3.19  LR- 0.42  Accuracy 73  AUC WMI: 0.708; PSI: 0.632; CTMT: 0.701  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Soederstroem, 2014144  N = 61  n ADHD = 41  Sweden  Specialty care | **Target:** Adults referred for neuropsychological assessment at a specialty clinic, aged 18 years or older, with suspected ADHD based on clinical evaluation and presenting with ADHD symptoms, excluding those on ADHD-specific medications during the assessment timeframe  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults referred to a specialty care neuropsychological clinic for psychiatric evaluation, including those with comorbid conditions such as mood disorders, anxiety disorders, and substance dependence but who did not meet the diagnostic criteria for ADHD  **Female:** 56.1% 60%  **Age mean (SD):** 32.46 (8.99)  Min age: 18 Max age: 54  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Model with QbTest Plus QbInattention and QbActivity, assessed with QbTest Plus, a computerized neuropsychological test designed to assess ADHD symptoms  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interviews, self-report scales, cognitive screening, and a general psychiatric assessment evaluating Axis I and II disorders  **Diagnosed by:** Specialist (e.g., mental health) Mental health specialist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The discriminant validity of self-rating scales and the more objective measure of ADHD symptoms are poor and should be integrated generally with other sources of data. The combination function yielded an overall correct classification of 72.1% and the cross-validated classification showed the same result; the classification correctly identified 87.8% of the patients diagnosed with ADHD and 40.0% of the patients not diagnosed with ADHD.  Sensitivity 88%  Specificity 40%  PPV  NPV  LR+  LR-  Accuracy 72  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 20 minutes | **Subgroup analysis:** N/A |
| Solanto, 2004145  N = 93  n ADHD = 70  US  Specialty care | **Target:** Adults diagnosed with ADHD by clinical evaluation based on DSM-IV criteria, excluding individuals with neurological disorders, intellectual disabilities, or severe substance use disorders, and requiring stable medication use or no psychotropic medications during the assessment timeframe. 44 had the combined subtype (ADHD-CB) and 26 had predominantly inattentive subtype (ADHD-IA).  **ADHD presentation:** inattentive : 25.24,combined : 47.42  **Comorbidity:** N/A  **Other:** Adults recruited from the same specialty care setting, with diagnoses of other psychiatric conditions such as anxiety, depression, or adjustment disorders, but who did not meet the diagnostic criteria for ADHD  **Female:** % male: ADHD combined (24); ADHD Inattentive (18); Other Psychiatric (16)  **Age mean (SD):**  ADHD combined 34.34 (8.78); ADHD Inattentive 36.08(11.60); Other psychiatric 44.39(10.35)  Min age: 25 Max age: 60  **Age subgroup**: Adults  **Ethnicity:**  Other : ADHD combined (2.2); ADHD Inattentive (0); other psychiatric (0)  Other : ADHD combined (2.2); ADHD Inattentive (0); other psychiatric (4.3)  Other : ADHD combined (11.1); ADHD Inattentive (3.8); other psychiatric (4.3)  Other : ADHD combined (84.1); ADHD Inattentive (96.2); other psychiatric (91.3)  Single center  Funding unclear | **Test description:** C-CPT (Conners Continuous Performance Test), a 14-minute computerized task where participants respond to non-target stimuli  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through a comprehensive clinical interview conducted by experienced psychologists, supplemented with developmental history, school records, standardized test reports  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** For the Brown scales, sensitivity to a diagnosis of ADHD was 92% and specificity in identifying adults in the Other Psychiatric group was 33%, yielding an overall correct classification rate of 74%. For the CPT scores, sensitivity to a diagnosis of ADHD-Inattentive type was 47% and specificity was 86%, yielding an overall correct classification rate of 70%. The results indicate a need for closer examination of executive and adaptive functioning in adults with ADHD compared with those with internalizing disorders to identify features that could assist in differential diagnosis.  Sensitivity 47%  Specificity 86%  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 15 minutes | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator),Age  Sensitivity and specificity for self-report measures were high when comparing ADHD-diagnosed participants to the general population but were less effective when distinguishing ADHD from other psychiatric conditions, with overlapping scores noted for anxie  Age was inversely correlated with scores on the Brown ADD Scale for attention and effort, suggesting that older participants exhibited fewer ADHD-related symptoms, potentially reflecting developmental improvements in executive functioning. |
| Sollman, 2010146  N = 73  n ADHD = 29  US  College | **Target:** College students with a verifiable diagnosis of ADHD confirmed through neuropsychological or psychological evaluation, including corroborative interviews with parents or teachers, medication washout for 12 hours before testing, excluding those with comorbid learning disabilities, psychiatric or neurological conditions, or substance abuse  **ADHD presentation:** inattentive : 20,hyperactive : 5,combined : 75  **Comorbidity:** N/A  **Other:** College students recruited from the same university setting, divided into two groups: a normal honest-responding group with no history of ADHD or related disorders, and a feigning group instructed to simulate ADHD based on provided materials; participants were screened to exclude those with learning disabilities, psychiatric or neurological conditions, or substance abuse  **Female:** 44.8%  **Age mean (SD):** 19.40 (1.21)  Min age: 18 Max age: 21  **Age subgroup**: Young  **Ethnicity:**  % Black/African American : 6.90  % Asian : 0  % White : 86.20  % Multiracial : 6.90  Single center  Funding unclear | **Test description:** C-CPT (Conner's Continuous Performance Test-II) detectability index  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive clinical evaluation including neuropsychological testing, symptom self-report measures, corroborative interviews with parents or teachers, and confirmation of developmental origin of symptoms  **Diagnosed by:** Specialist (e.g., mental health) Mental health clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** The detectability index in Connor's CPT-II had a sensitivity of 17% to detect ADHD and a specificity of 90% for feigning ADHD. Failing 1 or more, 2 or more, 3 or more, 4 or more cognitive feigning test indices lowered the sensitivity from 63 to 50, 47, and 35%, while the specificity increased from 82, to 93, 100%, and 100%. Indicates limited sensitivity in distinguishing ADHD from controls and susceptible to manipulation by feigning participants; results point to a need for a thorough evaluation of history, cognitive and emotional functioning, and the consideration of exaggerated symptomatology in the diagnosis of ADHD.  Sensitivity 17%  Specificity 90%  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Suhr, 2008148  N = 85  n ADHD = 15  US  Primary care | **Target:** Adults who showed evidence of childhood ADHD symptoms from at least two sources (self-report, parent report, school records, prior medical/psychological records), exhibited clinically significant current ADHD symptoms confirmed by self-report and either collateral report or behavioral observation, and passed the Word Memory Test (WMT) assessing credible performance  **ADHD presentation:** inattentive : 47,combined : 53  **Comorbidity:** N/A  **Other:** Adults with psychological diagnoses other than ADHD who reported no evidence of childhood ADHD-related impairment, had psychological conditions (commonly major depressive disorder), and were evaluated in a university-based psychology specialty clinic.  **Female:** 40%  **Age mean (SD):** 25.4(9.8)  Min age: 18 Max age: 56  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 5  % White : 94  % Multiracial : 1  Single center  Funding unclear | **Test description:** A battery of neuropsychological tests, including AVLT (Auditory Verbal Learning Test) learning and recall scores, WAIS-III Processing Speed Index and Working Memory Index, TMT (Trail Making Test) Parts A and B, verbal fluency, and Stroop Color and Word Test (interference score) was used to assess cognitive functioning related to ADHD in adults referred for specialty evaluation  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  DSM-IV  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Self-report measures (WURS and CAARS) could not reliably distinguish ADHD from psychological controls, with substantial overlap in symptom endorsement between groups.  Neuropsychological tests did not reliably distinguish ADHD from psychological controls, except for the Stroop Interference score where ADHD participants performed worse.  Feigning ADHD was effectively identified by the Word Memory Test (WMT), with a 31% failure rate among referrals, and WMT failure associated with worse neuropsychological performance and higher symptom self-report across groups.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** WMT failure was associated with increased symptom reporting and worse neuropsychological performance, suggesting noncredible performance may distort both self-report and objective cognitive testing results.  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Unal, 2019151  N = 44  n ADHD = 14  Ireland  Other setting | **Target:** Aged between 18 and 65 years of age with minimum of 5 years of education and literate in English, diagnosed with ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Healthy volunteers recruited from the staff working in the hospital and from medical students aged between 18 and 65 years of age with minimum of 5 years of education and literate in English  **Female:** 50%  **Age mean (SD):**  ADHD group: 47.29 (9.03) years; Control group: 41.57 (11.42) years  Min age: 18 Max age: 65  **Age subgroup**: Middle age  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Stroop Test accuracy; assessed with Stroop Color-Word, Stroop Plus Test to measure selective attention, Perceptual Selectivity Test  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by using the Connor's Adult ADHD Diagnostic Interview for DSM-IV (CAADID)  **Diagnosed by:** Unclear/NR  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Adults with ADHD have a longer response time and perform less accurately than controls. The data suggest that there is a use for objective visual attention tests in the diagnosis of adult ADHD.  Sensitivity % Sensitivity is not available  Specificity % Specificity is not available  PPV  NPV  LR+  LR-  Accuracy  AUC 0.814 CI 0.679, 0.949) Stroop Test (response time): 0.810; Stroop Plus Test (accuracy): 0.723; Stroop Plus Test (response time): 0.724; Perceptual Selectivity Test (accuracy): 0.707; Perceptual Selectivity Test (response time): 0.783  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Total run time was 10 minutes. | **Subgroup analysis:** N/A |
| Wiig, 2012158  N = 134  n ADHD = 64  Denmark  Specialty care | **Target:** Adults referred to a regional outpatient psychiatric clinic for evaluation of possible ADHD, diagnosed with ADHD based on ICD-10 and DSM-IV criteria, including those with impaired academic achievement, difficulties with employment, and comorbidities such as substance abuse or mild personality disorders  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults referred to a regional outpatient psychiatric clinic, diagnosed with mild psychiatric disorders such as personality disorders, addiction, affective disorders, or obsessive-compulsive disorder based on ICD-10 criteria; this group excluded individuals with ADHD, autism spectrum disorder, organic brain disorders, or bipolar disorder  **Female:** 43.8%  **Age mean (SD):** 31.14 (9.7)  Min age: 17 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** AQT (A Quick Test of Cognitive Speed) involving tasks of single-dimension naming (color and form) and dual-dimension naming (color-form combinations) to measure processing speed and efficiency, with specific fail criteria applied for diagnosing ADHD  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on ICD-10 and DSM-IV criteria through structured psychiatric interviews conducted by a mental health clinician at a regional outpatient clinic.  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Results support AQT as a possible complement to psychiatric intake procedures to differentiate adults with ADHD from those with mild psychiatric disorders.  Sensitivity 89%  Specificity %  PPV  NPV  LR+  LR-  Accuracy  AUC  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha The study mentions that AQT tests are highly reliable with test-retest reliability coefficients ranging from 0.91 to 0.95  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Woods, 2002160  N = 52  n ADHD = 26  US  Specialty care | **Target:** ADHD participants were recruited through their psychiatrists, met DSM-IV criteria, and were evaluated after a 12-hour medication break, and were excluded if they had other Axis I diagnoses, use of non-stimulant psychoactive medications, intellectual scores <85, substance abuse, neurological issues, learning disabilities, or ineffective response to stimulant medication  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Control group participants were included if they were matched to ADHD participants based on age and gender, with no more than three ADHD symptoms, no current or prior ADHD diagnosis, intellectual scores ≥85, and no history of substance abuse, no neurological disease, or head injury, or prior diagnosis or special education for a learning disability  **Female:** 50%  **Age mean (SD):** 38.38 (9.27)  Min age: 21 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** DII (Discrepancy Impairment Index) assesses cognitive impairment by comparing test performance to an individual’s estimated IQ; 6 scores: COWA total, CVLT Short-Delay Free Recall, Color-Word from SNST, TMT A time, TMT B time, average age-adjusted WAIS-R FD index, highlighting cognitive deficits beyond IQ, cutoff >2 measures impaired  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosis based on DSM-IV criteria by board certified psychiatrist  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** These results support the consideration of discrepancies between intellectual ability and frontal/executive functioning in the assessment of adult ADHD.  Sensitivity % 38 -100  Specificity % 23 - 100  PPV 57 - 100  NPV 44 - 100  LR+  LR-  Accuracy  AUC 0.8373  Concordance: N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Table C.5. Evidence table neuroimaging as index test

| **Study ID** | **Population** | **Clinician Tools Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Amen, 200847  N = 47  n ADHD = 27  US  Specialty care | **Target:** Patients diagnosed with ADHD based on structured interviews, DSM-IV criteria, and psychiatrist-confirmed diagnosis, no current major depressive disorder diagnosis, provided informed consent for use of clinical and imaging data  **ADHD presentation:** inattentive : 85,combined : 15  **Comorbidity:** N/A  **Other:** Healthy, right-handed, age-matched adults without psychiatric, psychological, neurological conditions, or substance abuse history, recruited through University of California Irvine psychology department and web postings, screened using MMPI, SCID, and Mental Skills Test  **Female:** 33%  **Age mean (SD):** 57.1 (5.1)  Min age: 50 Max age:  **Age subgroup**: Middle age  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** SPECT (Single Photon Emission Computed Tomography) imaging of regional cerebral blood flow at rest and during a concentration task (Connors Continuous Performance Test), visually rated by trained clinicians using a semi-quantitative scale to assess perfusion deficits in 14 cortical and 7 subcortical regions based on the Mai Atlas of the Human Brain  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  DSM-IV criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Brain SPECT imaging distinguished older adults with ADHD from healthy controls based on significantly lower prefrontal cortical perfusion during concentration tasks, with a sensitivity of 0.81 and specificity of 0.70 for left prefrontal orbit activity.  Sensitivity % Left POC: 0.81; Right POC: 0.74;L/R PFP: 0.74; Right Parietal Lobe: 0.70; Left PFL:0.56; Right PFL: 0.41; L/R Cerebella: 0.37; Right Occipital: 0.37  Specificity % Left POC: 0.70; Right POC: 0.75;L/R PFP: 0.75; Right Parietal Lobe: 0.65; Left PFL:0.85; Right PFL: 0.90; L/R Cerebella: 0.95; Right Occipital: 0.95  PPV Left POC: 0.79; Right POC: 0.80;L/R PFP: 0.80; Right Parietal Lobe: 0.73; Left PFL:0.83; Right PFL: 0.85; L/R Cerebella: 0.91; Right Occipital: 0.91  NPV Left POC: 0.74; Right POC: 0.68;L/R PFP: 0.68; Right Parietal Lobe: 0.62; Left PFL:0.59; Right PFL: 0.53; L/R Cerebella: 0.53; Right Occipital: 0.53  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa  ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Amen, 202148  N = 1135  n ADHD = 1006  US  Specialty care | **Target:** Participants from a multidisciplinary group of psychiatric clinics that incorporate single-photon emission computed tomography (SPECT) neuroimaging into diagnostic assessment and treatment, met the DSM-IV criteria for ADHD and no other diagnoses  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Participants did not meet criteria for any psychiatric condition and had not history of traumatic or toxic brain injury; recruited using local advertisements in newspapers and local colleges; met clinical criteria for a healthy brain subject based on authors' criteria that included the absence of current medical illnesses, brain trauma, family history of psychiatric illness, drug/alcohol abuse and no current or past evidence of behavioral or psychiatric issues as measured by a detailed clinical history, Minnesota Multiphase Personality Inventory and Structured Clinical Interview for Diagnosis for DSM-IV  **Female:** 34% ADHD group: 34% female; control group: % female not reported  **Age mean (SD):** 37.7 (15.5)  Min age: 22 Max age: 72  **Age subgroup**: Adults  **Ethnicity:** Other : ADHD group: 33% non-caucasian; Control group: race information not reported  Multicenter  Industry | **Test description:** Brain perfusion SPECT (single-photon emission computed tomography), photon emission was captured using a high-resolution Picker Prism 3000 triple-headed gamma camera with fan beam collimator with data collected in 128 × 128 matrices, yielding 120 images per scan separated by 3 degrees spanning 360 degrees; a low pass filter applied with a high cutoff and Chang attenuation correction; patients sat upright in a quiet, dimly lit room with open eyes, and the bolus was injected after 10 min, patients sat for an additional 10 minutes after  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Clinical diagnosis based on DSM-IV by specialists at the Amen Clinics, Incorporated branches  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** SPECT Functional Neuroimaging distinguishes adult ADHD patients without comorbidities from healthy controls with 100% sensitivity and specificity in post-hoc ROI analysis.  Visual reads of SPECT scans showed 100% sensitivity and >97% specificity in distinguishing adult ADHD from healthy controls.  Sensitivity 100%  Specificity 97%  PPV  NPV  LR+  LR-  Accuracy  AUC 97.6  **Concordance:** N/A  **Rater agreement:** Rater agreement in visual interpretations of SPECT scans by multiple nuclear medicine physicians and radiologists by analyzing regional cerebral blood flow (rCBF) in 14 cortical and 7 subcortical regions  Kappa 0.79  ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Chaim-Avancini, 201756  N = 116  n ADHD = 67  Brazil  Specialty care | **Target:** Stimulant-naive men with ADHD  **ADHD presentation:** inattentive : 53.7,combined : 46.2  **Comorbidity:** N/A  **Other:** 66 healthy controls (44 men)  **Female:** 22.39% non-ADHD: 33.33  **Age mean (SD):** 27 (6.0)  Min age: 18 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Structural MRI and diffusion tensor imaging, 1.5T Espree system  Machine learning: Yes  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Structured Clinical Interview for DSM-IV and ADHD-related items from an adapted version of the Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS-E), requiring at least 6 inattention or hyperactivity/impulsivity symptoms persisting from childhood into adulthood with impairment in multiple domains  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The combination of T1-weighted MRI and DTI features achieved an AUC of 0.71 and diagnostic accuracy of 65.4% (P 0.005) in a mixed-gender ADHD group.  Sensitivity 65% 53, 78 Male only: 73 (62, 86)  Specificity 86% Male only: 86 (77, 97)  PPV 68.6 Male only: 79.1  NPV 63.1 Male only: 71.1  LR+  LR-  Accuracy 65.4 Male only: 73.8  AUC 0.71 Male only: 0.74  **Concordance:** N/A  **Rater agreement:** N/A  Kappa  ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Sex  In a male-only ADHD subgroup, the combination of T1-weighted MRI and DTI features improved classification accuracy to 74% (P 0.0001), with an AUC of 0.74. Classification performance was higher in the male-only subgroup compared to the mixed-gender subgroup, suggesting that male ADHD patients may have more significant neuroanatomical deviations from controls​. However, the authors cautioned that they could not conduct female-only analyses due to the limited sample size, and the observed differences might reflect the use of a more homogeneous sample rather than actual sex-based differences in diagnostic performance​. |
| Schneider, 2014136  N = 427  n ADHD = 170  Canada  Specialty care | **Target:** Participants with a clinical DSM-IV diagnosis of ADHD identified through community-based psychiatric clinics and offices, presenting with complex or refractory cases requiring further diagnostic clarification, ranging in age from teenage to geriatric. 39.8% of 427 patients had a clinical DSM-IV diagnosis of ADHD.  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Individuals with various psychiatric and neuropsychiatric disorders other than ADHD, identified through the same community-based psychiatric clinics and offices, representing a mix of general and specialty care settings  **Female:** 51%  **Age mean (SD):** 40.9 (15.7)  Min age: 14 Max age: 82  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** 3D thresholded SPECT (Single Photon Emission Computed Tomography), which discards areas below 55% of maximum activity to evaluate regional cerebral blood flow; Tc99m radiotracers following baseline or concentration protocols, and a nuclear medicine physician interpreted them without formal blinding  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical DSM-IV criteria evaluated by community-based psychiatrists using clinical interviews and patient history  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** 3D thresholded SPECT provides a stronger signal for ADHD detection in clinical settings and may outperform conventional SPECT in sensitivity while maintaining reasonable specificity.  Sensitivity 54% (CI 46, 61) Conventional SPECT: 4%  Specificity 76% (CI 71, 81) Conventional SPECT: 97%  PPV  NPV  LR+  LR-  Accuracy 67 computed  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa  ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Approximately 15-20 minutes. | **Subgroup analysis:** N/A |
| Wang, 2013157  N = 46  n ADHD = 23  China  College | **Target:** Adults (>18 years) with combined lifetime ADHD  **ADHD presentation:** inattentive : 73.9,hyperactive : 56.5  **Comorbidity:** N/A  **Other:** Adults (>18years) without ADHD, gender and age matched to ADHD group  **Female:** 21.7%  **Age mean (SD):** 31.54 (9.75) VC: 32.04 (9.23)  Min age: 18 Max age: 35  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Resting-state fMRI and structural MRI images were collected while subjects relaxed, with voxel-wise ReHO (regional homogeneity) used to extract signals as model inputs to differentiate patterns amongst ADHD group and control group  Machine learning: Yes  Validation dataset: Unclear  **Reference standard:** Other  Unclear how reference standard test was completed and unclear if conducted by appropriate clinician  **Diagnosed by:** Unclear/NR  **Timing:** N/A | **Diagnostic accuracy summary:** ADHD brain regions were more activated than normal controls during resting state. Linear support vector classifier can provide useful discriminative information of altered ReHo patterns for ADHD; and feature selection can improve the performances of classification.  Sensitivity 87%  Specificity 74%  PPV  NPV  LR+  LR-  Accuracy 80  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa  ICC Correlation coefficient map amongst the ADHD-RS scores and the most discriminative ReHo features, Inattentive scores showed positive correlation with ReHo, while hyperactive/impulsive results demonstrated negative correlation with ReHo  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Yao, 2018161  N = 251  n ADHD = 112  China  Other setting | **Target:** Participants with ADHD recruited from clinics, required to be drug-naïve for stimulants and psychotropic drugs, have an IQ score greater than 80, and be right-handed. 112 ADHD, 77 healthy controls  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants were age-matched healthy controls recruited from local universities, with no history of psychiatric or neurological disorders, and were selected to match the ADHD participants in demographics and handedness  **Female:** 25.3%  **Age mean (SD):** 25.93 (4.86)  Min age: Max age: 34  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Public funding | **Test description:** Resting state-fMRI (functional MRI) to analyze functional connectivity patterns across 246 brain regions, identifying potential biomarkers for ADHD diagnosis; a novel feature selection method, FS\_RIEL, was applied to reduce dimensionality and improve classification accuracy  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical evaluation conducted by mental health clinicians at Peking University Sixth Hospital following established diagnostic criteria.  **Diagnosed by:** Specialist (e.g., mental health) Mental health clinician  **Timing:** Concurrent | **Diagnostic accuracy summary:** The method achieved 80% accuracy in distinguishing ADHD from healthy controls.  Sensitivity 91%  Specificity 65%  PPV  NPV  LR+  LR-  Accuracy 80  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa  ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Table C.6. Evidence table EEG as index test

| **Study ID** | **Population** | **EEG as Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Baghdassarian, 201889  N = 108  n ADHD = 24  Sweden  Specialty care | **Target:** Adults, unmedicated for at least 24 hours prior to testing, meeting DSM-IV criteria through multidisciplinary assessment, with a history of ADHD symptoms from before age 7, excluding those with psychosis, schizophrenia, schizoaffective disorder, bipolar disorder, autism spectrum disorders, brain damage, epilepsy, ongoing substance misuse, or neurological disorders  **ADHD presentation:** inattentive : 37.5,combined : 58.3  **Comorbidity:** N/A  **Other:** Adults recruited from healthy controls (primarily students and hospital personnel, screened to rule out ADHD, psychosis, or prodromal syndromes) and patients with schizophrenia diagnosed using DSM-IV criteria; healthy controls were neurotypical with no significant mental or neurological conditions, while schizophrenia patients were stably medicated, had a duration of illness of at least one year, recruited from a psychosis hospital unit  **Female:** 50%  **Age mean (SD):** 29.5 (8.1)  Min age: 18 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Auditory Brainstem Response profiling tests using disease-specific traits derived from auditory waveform characteristics to differentiate ADHD from other conditions and healthy controls. The cutoff for a positive diagnosis was a disease index ≥50%  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through multidisciplinary assessments conducted at a neuropsychiatric outpatient clinic using structured clinical interviews and consensus best estimate diagnosis methods  **Diagnosed by:** Specialist (e.g., mental health) psychiatrists and neuropsychiatric experts  **Timing:** Concurrent | **Diagnostic accuracy summary:** Profiling identified adult ADHD versus controls with a sensitivity of 87.5% and a specificity of 91.4%. 1/26 schizophrenia patients was a false positive for ADHD.  Sensitivity 88%  Specificity 91%  PPV 80.8  NPV 94.6  LR+ 10.2  LR- 0.14  Accuracy 90.2 DOR 72.8  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** About 40 minutes. | **Subgroup analysis:** Sex  The sensitivity for the ABR profiling test was lower in females (83.3%) compared to males (91.6%) for ADHD diagnosis. |
| Biederman, 201754  N = 60  n ADHD = 34  US  Specialty care | **Target:** Adults aged 18 to 55 years with a DSM-IV diagnosis of ADHD, onset of symptoms in childhood, persistence into adulthood, unmedicated for at least 1 week before the study, and no active symptoms of depression or anxiety  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Healthy adults aged 18 to 55 years without ADHD or other psychiatric disorders, recruited as controls to differentiate ADHD from neurotypical individuals in a specialty care setting  **Female:** 23.33%  **Age mean (SD):** 30.06 (10.76)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:**  % White : 82  Single center  Industry | **Test description:** Event-related potential data to analyze brain activity patterns during Go/NoGo task, Go condition  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria through clinical evaluation and ADHD module of the K-SAD-E conducted by clinicians with expertise in ADHD diagnosis and treatment  **Diagnosed by:** Specialist (e.g., mental health) clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** EEG Brain Network Activation analysis demonstrated high diagnostic accuracy in distinguishing adults with ADHD from neurotypical controls, with an AUC of 0.92, sensitivity of 0.86, and specificity of 0.95 in the Go condition, and an AUC of 0.84, sensitivity of 0.76, and specificity of 0.91 in the NoGo condition.  Neuropsychological tests alone showed no high discriminability for any of the indicators.  Sensitivity 86% NoGo condition 76%; cross-validation data: NoGo 68%, Go 62%  Specificity 95% NoGo condition 91%; cross-validation data: NoGo 80%, Go 69%  PPV 0.93 NoGo condition 0.90%; cross-validation data: NoGo 0.77, Go 0.69  NPV 0.85 NoGo condition 0.80%; cross-validation data: NoGo 0.72, Go 0.65  LR+  LR-  Accuracy  AUC 0.92 NoGo condition AUC 0.84  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** 12 minutes across all tests. | **Subgroup analysis:** N/A |
| Hadas, 202180  N = 108  n ADHD = 56  Israel  College | **Target:** Adults with confirmed diagnosis of ADHD without other co-morbidites, with no use of psychoactive medications 1 week prior to study  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Fit and healthy adults recruited from university advertisement boards or online newsletter  **Female:** 33%  **Age mean (SD):** 26 (0.3)  Min age: 17 Max age: 30  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** EEG (Electroencephalography) was recorded during transcranial magnetic stimulation (TMS) targeting the right prefrontal cortex and during the Stop Signal Task.  Stop Signal Task assesses the response inhibition and cognitive control by responding to visual cues and pressing corresponding buttons, the test serves as a paradigm to elicit neural activity for EEG recordings.  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosis of ADHD confirmed with psychiatrist through clinical  interview  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Significant reductions in transcranial magnetic stimulation-evoked potentials (TEPs) and event-related potentials (ERPs) in individuals with ADHD compared to healthy controls, as well as significant correlations between ADHD severity and TEP.  Sensitivity 88%  Specificity 54%  PPV  NPV  LR+  LR-  Accuracy 72  AUC 0.73  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Kaur, 202091  N = 97  n ADHD = 47  India  College | **Target:** ADHD diagnosis is confirmed in 48 cases after clinical assessment, group must fulfill DSM-5 criteria of ADHD diagnosis  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Age matched adults not having ADHD or any other psychopathology  **Female:** 20.3%  **Age mean (SD):** 20.3 (1.12)  Min age: 19 Max age: 23  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** EEG (electroencephalography) to record brain activity from 19 scalp electrodes under 3 conditions: eyes-open, eyes-closed, and during the CPT (Continuous Performance Test); EEG signals were preprocessed to remove artifacts, and phase space reconstruction features were extracted to classify ADHD and control adults using machine learning classifiers  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** EEG in the CPT condition provided the highest accuracy, achieving 100% sensitivity and specificity with the Neural Dynamic Classifier NDC; testing accuracy was 93.3% under the eyes-open, 90% under the eyes-closed, and 100% under the CPT condition.  Sensitivity 100% Eyes open condition: 100, Eyes closed condition: 93.3, CPT: 100  Specificity 87% Eyes open condition: 86.7, Eyes closed condition: 86.7, CPT: 100  PPV  NPV  LR+  LR-  Accuracy 93.3 Eyes open condition: 93.3, Eyes closed condition: 90, CPT: 100  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** 17 minutes | **Subgroup analysis:** N/A |
| Kiiski, 202096  N = 134  n ADHD = 38  Ireland  Specialty care | **Target:** Adults with ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** 1st degree relatives of people with ADHD (18 siblings, 27 parents) and healthy controls recruited from the general population, support groups and a secondary mental health care service  **Female:** 50%  **Age mean (SD):** 27.1 (10.4)  Min age: 27 Max age: 38  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Resting-state EEG functional connectivity to assess brain network differences, connectivity patterns analyzed across the delta, theta, alpha, beta, and gamma frequency bands using the weighted phase lag index and machine learning models  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners’ Adult ADHD Rating Scale and the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV) criteria​.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** While EEG connectivity could predict ADHD symptom severity, it did not reliably classify ADHD, 1st-degree relatives, and controls, with modest classification performance (AUC up to 0.669); EEG may serve as a neuromarker for ADHD symptoms, but its diagnostic utility remains limited due to variability in classification accuracy.  Sensitivity 73% Eyes open (ADHD vs relatives 70.13, Control vs relatives 49), Eyes closed (ADHD vs relatives 69.12, Controls vs relatives 49)  Specificity 37% Eyes open (ADHD vs relatives 46.41, Control vs relatives 63.1), Eyes closed (ADHD vs relatives 57.79, Controls vs relatives 63.1)  PPV  NPV  LR+  LR-  Accuracy  AUC 0.575 Eyes open (ADHD vs relatives 0.578, Control vs relatives 0.548), Eyes closed (ADHD vs relatives 0.669, Controls vs relatives 0.617)  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** 6 minutes | **Subgroup analysis:** N/A |
| Kim, 202197  N = 79  n ADHD = 34  Korea  Specialty care | **Target:** Participants with ADHD (DSM-V) from the Department of Psychiatry in a hospital, all were drug-naïve  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Healthy controls with no history of disorders  **Female:** 17.6%  **Age mean (SD):** 24.76 (7.02)  Min age: 18 Max age: 45  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Mismatch negativity sensor level plus source level, an event-related potential component representing pre-attentive auditory processing closely associated with cognitive status assessed via EEG (electroencephalography); source localization was performed using standardized low-resolution brain electromagnetic tomography to estimate cortical distributions of mismatch negativity activity in the frontal, temporal, and limbic lobes  Machine learning: Yes  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on full DSM-V criteria evaluated by a board-certified psychiatrist specializing in adult ADHD  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The best classification performance showed an 81.01% accuracy, 82.35% sensitivity, and 80.00% specificity based on source activity features; results suggest that abnormal mismatch negativity reflects the adult ADHD patients’ pathophysiological characteristics and might serve clinically as a neuromarker of adult ADHD.  Sensitivity 82%  Specificity 80%  PPV  NPV  LR+  LR-  Accuracy 81  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** About 10 minutes | **Subgroup analysis:** N/A |
| Mueller, 2011115  N = 167  n ADHD = 75  Multiple countries  Setting varies | **Target:** Adults aged 20-50 diagnosed with ADHD based on DSM-IV criteria, including combined, inattentive, or hyperactive-impulsive subtypes, unmedicated or off methylphenidate for 24 hours before testing, no history of neurological or systemic medical diseases, no psychosis symptoms, no significant head injuries  **ADHD presentation:** inattentive : 56,hyperactive : 12,combined : 32  **Comorbidity:** N/A  **Other:** Age- and sex-matched neurotypical adults from the community with no ADHD diagnosis, no significant head injuries, no neurological or systemic medical diseases, scoring below clinical significance on the Brief Symptom Inventory, and not receiving medication  **Female:** 49.33%  **Age mean (SD):** 36.05 (8.42)  Min age: 20 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Public funding | **Test description:** Event-related potentials recorded while participants performed a visual two-stimulus go/no-go task  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria assessed through a structured clinical interview conducted by trained psychologists  **Diagnosed by:** Specialist (e.g., mental health) Psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** A classification accuracy of 91% using a 10-fold cross-validation approach to differentiate adult ADHD patients from controls based on independent ERP components.  The predictive power of the SVM was validated with an independent ADHD sample, achieving a classification accuracy of 94%.  Sensitivity 91%  Specificity 91%  PPV  NPV  LR+  LR-  Accuracy 91  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Mueller, 2020116  N = 328  n ADHD = 181  Switzerland  Setting varies | **Target:** Adults diagnosed with ADHD based on DSM-5 criteria, recruited via media advertisements, local psychiatrists, and ADHD associations, excluding those with IQ <80, neuropsychological performance quotient <75, history of brain injury requiring rehabilitation, epilepsy, primary mental disorders other than ADHD, or insufficient knowledge of German or French.  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical adults recruited through media, schools, companies, and associations, excluding those with psychiatric diagnoses or histories of psychotropic medication intake.  **Female:** 49.72%  **Age mean (SD):** 34.54 (10.16)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Other funding | **Test description:** EEG/ERP measures to capture brain activity patterns analyzed using a machine-learning framework, incorporating spectral power, event-related potential amplitudes, and latencies  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria verified by a psychiatric specialist through clinical interviews, ADHD screening questionnaires, and structured diagnostic assessments.  **Diagnosed by:** Specialist (e.g., mental health) Psychiatric specialists  **Timing:** Concurrent | **Diagnostic accuracy summary:** ADHD patients and healthy controls could be classified with a sensitivity of 75% to 83% and a specificity of 71% to 77%. In the analysis of the repeated measurements, sensitivity values of the selected logistic regression model remained high (72% and 76%), while specificity values slightly decreased over time (64% and 67%).  Sensitivity 75% after 12 months: 72; after 24 months: 76  Specificity 77% after 12 months: 64; after 24 month: 67  PPV  NPV  LR+  LR-  Accuracy  AUC 0.84 after 12 months: 0.68; after 24 months: 0.72  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:** Measurment 1 or 2 years later  0.623 CI (0.560, 0.683), good consistency of classification performance over time  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** 26 minutes | **Subgroup analysis:** N/A |
| Poil, 2014125  N = 49  n ADHD = 48  Switzerland  Specialty care | **Target:** Adults diagnosed with ADHD using clinical interviews and standardized diagnostic tools  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical individuals recruited from personal contacts and public science presentations, with no current or past neurological or psychiatric diagnoses, matched for demographic variables and IQ to the ADHD group  **Female:** 55% 37.5 in larger group  **Age mean (SD):** 37.9 (11.3)  Min age: Max age: 61  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** Resting-state EEG was recorded during a 2.5-minute eyes-closed session using 60 scalp electrode positions, analyzing spectral power and central frequency across delta, theta, alpha-1, alpha-2, beta, and gamma frequency bands to identify diagnostic biomarkers for ADHD.  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interviews conducted by experienced psychiatrists for adults and the Kiddie-SADS-PL for children following standardized diagnostic criteria  **Diagnosed by:** Specialist (e.g., mental health) psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Support vector machine classification of ADHD adults versus controls yielded a notable cross validated sensitivity of 67% and specificity of 83% using power and central frequency from all frequency bands.  Sensitivity 67%  Specificity 83%  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** 2.5 minutes | **Subgroup analysis:** N/A |
| Ponomarev, 2014126  N = 472  n ADHD = 96  Multiple countries  College | **Target:** Adults aged 20–50 with symptoms meeting modified DSM-IV criteria for ADHD (at least 4 inattention and/or hyperactivity/impulsivity symptoms in childhood and the past 6 months), no head injury or neurological/systemic medical diseases, mostly unmedicated, with 63 meeting full DSM-IV criteria and 33 classified as subclinical  **ADHD presentation:** inattentive : 23.96,hyperactive : 7.29,combined : 68.75  **Comorbidity:** N/A  **Other:** Neurotypical adults recruited from university students, research staff, and general community members, with no neurological or psychiatric conditions, average or better academic performance, no current medication or substance use, and normal mental and physical development  **Female:** 48%  **Age mean (SD):** 36.4 (8.36)  Min age: 20 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Other funding | **Test description:** EEG (electroencephalography) with group independent component analysis and current source density  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed based on DSM-IV criteria assessed through clinical interviews and ADHD questionnaires conducted by an independent psychiatrist, including retrospective recall of childhood symptoms and current symptomatology  **Diagnosed by:** Specialist (e.g., mental health) psychiatrist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Spectral power of local EEG activity isolated by gICA or CSD in the fronto-central areas may be a suitable marker for discrimination of ADHD and healthy adults.  Sensitivity 94%  Specificity 90%  PPV  NPV  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Robeva, 2004132  N = 12  n ADHD = 6  US  College | **Target:** Female college students with a current ADHD diagnosis, taking ADHD medication for at least three years, not on anxiety or depression medication, without significant health conditions affecting EEG recordings, diagnosed in childhood according to Utah standards  **ADHD presentation:** combined : 100  **Comorbidity:** N/A  **Other:** Female college students with no history of ADHD or disruptive behavioral disorders, never prescribed or taken stimulant medication, not on anxiety or depression medication, without significant medical conditions affecting EEG data collection, screened to confirm the absence of ADHD symptoms  **Female:** 100%  **Age mean (SD):** 20.7 (1.5)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Other funding | **Test description:** EEG-based physiological markers  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a prior clinical diagnosis made during childhood following Utah criteria, confirmed through self-report screening using the Brown Attention-Deficit Disorder Scale and the ADHD Symptom Inventory, with additional verification th  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The procedure significantly improved the score separation between ADHD and non-ADHD groups. The final average probabilities for ADHD were 76% for the ADHD group and 8% for the control group. These probabilities correlated (r 0.87) with the Brown ADD scale and (r 0.84) with the ADHD-Symptom Inventory used for screening the participants.  Sensitivity %  Specificity %  PPV  NPV  LR+  LR-  Accuracy classification less than 85%  AUC  **Concordance:**  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** N/A |
| Shahaf, 2012139  N = 26  n ADHD = 13  Israel  Specialty care | **Target:** Adults diagnosed with the combined subtype of ADHD based on DSM-IV criteria, aged-matched and gender-matched, right-handed, with normal hearing and vision or corrected-to-normal vision, screened to exclude co-morbid disorders such as depression, anxiety, substance abuse, or learning disabilities, with 24-hour medication washout for those receiving methylphenidate therapy​  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical adults without ADHD recruited as student volunteers from the Institute of Technology, who underwent comprehensive neurological and neuropsychological evaluation, matching the ADHD group in age and gender​  **Female:** % N/A  **Age mean (SD):** 29.2 (6.1)  Min age: 18 Max age: 39  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** Brain network activation utilizes EEG-based neurophysiological markers to analyze event-related potentials (ERPs) to identify patterns of brain activity associated with ADHD  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria using clinical interviews, confirmed by fulfilling ADHD symptoms on the Conners Adult ADHD Rating Scales and excluding co-morbid disorders through comprehensive neurological and neuropsychological evaluation​  **Diagnosed by:** Specialist (e.g., mental health) Specialists in the Neuro-Cognitive Unit at Rambam Health Care Campus​  **Timing:** Concurrent | **Diagnostic accuracy summary:** The ADHD group was more characterized by the process of exerting attention in the early monitoring stages of the No-go signal, while the controls were more characterized by the process of inhibiting the response to that signal.  Sensitivity 84%  Specificity 92%  PPV 91.67 computed  NPV 85.71 computed  LR+ 11 computed  LR- 0.17 computed  Accuracy 88 computed  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Table C.7. Evidence table biomarkers as index test

| **Study ID** | **Population** | **Clinician Tools Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Andrikopoulos, 202449  N = 76  n ADHD = 32  Greece  Specialty care | **Target:** Adults diagnosed with ADHD based on DSM-5 criteria, aged 18 years or older, IQ above 70, proficient in Greek, willing and able to provide informed consent, without major psychiatric disorders, significant neurological conditions, or severe learning disabilities  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical adults without an ADHD diagnosis, recruited from the same specialty care setting, meeting the same inclusion criteria as the ADHD group except for the diagnosis, including being aged 18 years or older, IQ above 70, proficient in Greek, and without major psychiatric disorders, significant neurological conditions, or severe learning disabilities  **Female:** 34.38%  **Age mean (SD):** 33.26 (12.18)  Min age: 18 Max age: 59  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** Physiological data, including electrodermal activity, heart rate variability, and skin temperature, using a wrist-worn wearable device during neuropsychological evaluations; biomarkers were analyzed using machine learning algorithms  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria through a semi-structured Diagnostic Interview for ADHD in Adults (DIVA) conducted by an experienced psychiatrist, complemented by a psychiatric examination and additional information from relatives.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Results indicate that the SVM-based model yielded the optimal performance, achieving 81.6% accuracy, maintaining a balance between the experimental and control groups, with sensitivity and specificity of 81.4% and 81.9%, respectively  Sensitivity 81%  Specificity 82%  PPV  NPV  LR+  LR-  Accuracy 82  AUC  **Concordance:** N/A  **Rater agreement:**  N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Grünblatt, 201279  N = 143  n ADHD = 108  Germany  College | **Target:** Adults diagnosed with ADHD recruited from outpatient clinics at the university's psychiatry department  **ADHD presentation:** inattentive : 21.3,hyperactive : 5.5,combined : 70.4  **Comorbidity:** N/A  **Other:** Control participants recruited from newspaper ad  **Female:** 45.7%  **Age mean (SD):** 34.7 (1.61) non-ADHD 39.6 (9.49)  Min age: 24 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** Gene expression levels of 4 ADHD-associated genes—SLC6A3, DRD5, TPH1, and SNAP25—in peripheral blood, cut-off point 0.69  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by team of psychiatrists through retrospective assessment using DSM-IV during structured clinical interview  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Combining the gene expression levels of SLC6A3, DRD5, TPH1, and SNAP25 as predictors in a regression model resulted in sensitivity and specificity of over 80% (ROC: max R² 0.587, AUC 0.917, p < 0.001, 95% CI 0.900–0.985), distinguishing adult ADHD from healthy controls.  Sensitivity 81% SLC6A3 70%, DRD5 75%, SNAP25 64, TPH1 78  Specificity 82% SLC6A3 65%, DRD5 63%, SNAP25 62%, TPH1 71%  PPV  NPV  LR+  LR-  Accuracy  AUC 0.917 0.9-0.985 SLC6A3 0.694, DRD5 0.749, SNAP25 0.689, TPH1 0.812  **Concordance:** N/A  **Rater agreement:**  N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Jimenez, 202188  N = 144  n ADHD = 108  Multiple countries  Specialty care | **Target:** Adults aged 18-65 diagnosed with ADHD without mental retardation, fluent in Spanish or English, no history of head injury or neurological illness, assessed with DSM criteria and confirmed through psychiatric and psychological evaluations  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Age- and sex-matched clinical participants with conduct disorder diagnoses, recruited from specialty care clinics and hospitals in Spain and the UK  **Female:** 37.5%  **Age mean (SD):** 29.4 (12.4)  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  Public funding | **Test description:** Eye tracker, measuring modulation in the angle of eye vergence during an attention task using the BGaze eye-tracking system; participants were to maintain fixation on a central point while responding to visual stimuli, and the vergence angle (convergence or divergence of the eyes) was calculated using gaze vector data; a random forest classifier analyzed signals based on differential patterns in their eye vergence responses  Machine learning: Yes  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Diagnostic and Statistical Manual of Mental Disorders criteria through psychiatric and psychological evaluations, including a semistructured interview, assessment of symptom onset before 12 years of age, and persistence of dysfunction in at least two settings  **Diagnosed by:** Specialist (e.g., mental health) Clinical psychiatrists and psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Eye Vergence Responses showed a diagnostic accuracy of 79%, with an AUC of 0.77, a false positive rate of 25%, and a false negative rate of 20.55%.  Sensitivity 80%  Specificity 83%  PPV 4.8  NPV 56  LR+ 72.92  LR- 0.24  Accuracy 72.92  AUC 0.77  **Concordance:** N/A  **Rater agreement:**  N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Approximately 15 minutes | **Subgroup analysis:** N/A |
| Selek, 2012138  N = 87  n ADHD = 50  Turkey  Specialty care | **Target:** Adults aged 18–45 years diagnosed with ADHD using Turgay’s Turkish version of the DSM-IV Adult ADD/ADHD Diagnostic Screening and Rating Scale, free from stimulant or ADHD medications, without severe organic conditions, epilepsy, infectious diseases, excessive obesity, or use of antioxidant agents, and scoring below 2 on the Clinical Global Impression-Severity Scale.  **ADHD presentation:** inattentive : 34,hyperactive : 16,combined : 38,combined\_other : 12  **Comorbidity:** N/A  **Other:** Non-ADHD participants were healthy adults from the same hospital, including doctors and staff, free of medication for at least six weeks, and without a history or family history of psychiatric disorders.  **Female:** 30%  **Age mean (SD):** 24.7 (7.5)  Min age: 18 Max age: 45  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** Blood total oxidative status levels above 9.8575 mmol H₂O₂ Eqv./L  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on Turgay’s Turkish version of the DSM-IV Adult ADD/ADHD Diagnostic Screening and Rating Scale conducted by two psychiatrists.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** ADHD can be predicted for TOS over 9.8575 mmol H2O2 Eqv./L level with 86% positive predictive value and 100% negative predictive value.  Sensitivity %  Specificity %  PPV 86  NPV 100  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Age  The study reported a positive correlation between age and oxidative biomarkers (TOS and OSI) in ADHD patients, suggesting that oxidative stress may increase with the duration of the disease, but this correlation was not observed in the control group. |
| Udal, 2024150  N = 115  n ADHD = 91  Norway  Specialty care | **Target:** Adults referred to a psychiatric outpatient clinic for diagnostic assessment, excluding those with schizophrenia, psychotic disorders, ongoing drug abuse, rheumatic, orthopedic, or neurological disorders, or medications affecting motor function  **ADHD presentation:** inattentive : 34.1,combined : 65.0  **Comorbidity:** N/A  **Other:** Adults from a psychiatric outpatient clinic presenting with various psychiatric diagnoses or subthreshold ADHD symptoms but not meeting full diagnostic criteria for ADHD  **Female:** 59.3%  **Age mean (SD):** 33.0 (9.9)  Min age: 18 Max age: 66  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** MFNU (Motor Function Neurological Assessment), neuromuscular assessment, assessing neuroromuscular dysregulation, analyzing maximum summed problem score  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Mini International Neuropsychiatric Interview (MINI-plus) and/or the Diagnostic Interview for ADHD in Adults 2.0 (DIVA-2.0) following structured clinical interviews conducted by a physician or clinical psychologist.  **Diagnosed by:** Specialist (e.g., mental health) Physician or clinical psychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** A MFNU-TS cut-off score of 13.5 yielded a near 98% sensitivity for ADHD diagnosis, both when including and excluding those with subthreshold ADHD symptoms.  Sensitivity 98% 98% when excluding subthreshold from control group  Specificity 25% 77% when excluding subthreshold ADHD from control group  PPV  NPV  LR+  LR-  Accuracy Youden index 0.23 (0.74 when excluding subthreshold ADHD from control group)  AUC 0.66 AUC 0.90 when excluding subthreshold ADHD from control group  **Concordance:** N/A  **Rater agreement:**  N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator)  Participants with subthreshold ADHD symptoms had MFNU scores similar to the ADHD group, suggesting possible diagnostic overlap and the need for further evaluation in these cases. |

Table C.8. Evidence table clinician tools as index test

| **Study ID** | **Population** | **Clinician Tools Index Test** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Kumar, 2011100  N = 110  n ADHD = 6  US  Specialty care | **Target:** Adults recruited from psychiatric inpatient unit of a general hospital with a chart diagnosis of ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults with different mental disorders recruited from psychiatric inpatient unit of a general hospital  **Female:** 50%  **Age mean (SD):** 36.6 (11.1)  Min age: 25 Max age: 49  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 8  % Black/African American : 16  % White : 64  % Multiracial : 12,Other : other ethnic backgrounds  Single center  Funding unclear | **Test description:** MINI (International Neuropsychiatric Interview), a short, structured diagnostic interview designed to assess a range of different mental health disorders  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Chart diagnosis, diagnosed with ADHD by board certified psychiatrists after inpatient admission through DSM-IV-TR  **Diagnosed by:** Specialist (e.g., mental health) Psychiatrist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The CAARS-S–S: SV indicated adequate disrimination.  The MINI ADHD module was most effective for identifying inpatients without ADHD.  Sensitivity 83% (CI 36, 100)  Specificity 52% (CI 42, 62)  PPV 9 (CI 3, 20)  NPV 98 (CI 90, 100)  LR+  LR-  Accuracy 54 (CI 44, 63)  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 10-25 minutes. | **Subgroup analysis:** Age,Sex  ADHD diagnosis based on CAARS-S or MINI were not correlated with age.  ADHD diagnosis based on CAARS-S or MINI were not correlated with sex. |
| Palma-Alvarez, 2023121  N = 1263  n ADHD = 179  Multiple countries  Setting varies | **Target:** Adults aged 18–65 years starting a new treatment episode in addiction treatment centers, screened for ADHD using the MINI-Plus ADHD module, with no severe cognitive impairment, substance intoxication, acute psychiatric crisis, or severe somatic problems, and who provided informed consent​  **ADHD presentation:** N/A  **Comorbidity:** SUD : seeking treatment for SUD  **Other:** Adults in addiction treatment centers who did not meet ADHD criteria based on the CAADID, with similar inclusion settings focusing on treatment for substance use disorders​  **Female:** 26.5%  **Age mean (SD):**  mean 39.98  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** Other : 9.7  % White : 90.3  Multicenter  Public funding | **Test description:** MINI-Plus (Mini International Neuropsychiatric Interview), a structured diagnostic interview designed to assess psychiatric disorders, including ADHD, based on DSM-IV and ICD-10 criteria targeting core symptoms of inattention and hyperactivity-impulsivity, without differentiating ADHD subtypes  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on the Conners’ Adult ADHD Diagnostic Interview for DSM-IV conducted by trained clinicians  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Sensitivity of the MINI-Plus ADHD module was 74%, specificity was 91%.  Sensitivity 75% (CI 68, 80)  Specificity 91% (CI 90, 93)  PPV 60 (CI 52, 65)  NPV 95.6 (CI 95, 97)  LR+  LR-  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Pettersson, 2018123  N = 108  n ADHD = 60  Sweden  Specialty care | **Target:** Adults referred for ADHD assessment, required availability of a collateral historian to provide information on childhood symptoms, excluded if treated with ADHD medications, had an IQ ≤ 70, or substance-related disorders  **ADHD presentation:** inattentive : 21.7,hyperactive : 7.1,combined : 76.7  **Comorbidity:** N/A  **Other:** Adults referred to the same specialty neuropsychological clinic for assessment, did not meet the diagnostic criteria for ADHD, included individuals with other psychiatric conditions for comparison  **Female:** 46.7%  **Age mean (SD):** 28.18 (9.09)  Min age: 18 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Public funding | **Test description:** DIVA (Diagnostic Interview for ADHD in Adults), dichotomized as ADHD if 6 or more symptom criteria in both adulthood and childhood, and in either or both of the domains Attention Deficit and Hyperactivity–Impulsivity, and as non-ADHD if fewer than 6 symptom criteria  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Clinical consensus decision by a multidisciplinary assessment team using clinical interviews, neuropsychological test results, self-report measures, collateral historian input, and DSM criteria  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** All instruments showed poor discriminative ability except for the DIVA, which showed a relatively good ability to discriminate between the groups (sensitivity 90.0; specificity 72.9). A logistic regression analysis model with the DIVA and measures of inattention, impulsivity, and activity from continuous performance tests (CPTs) showed a sensitivity of 90.0 and a specificity of 83.3.  Sensitivity 90%  Specificity 73%  PPV 81  NPV 85  LR+  LR-  Accuracy 82  AUC 0.828  **Concordance:**  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** N/A |

Table C.9. Evidence table feigning ADHD

| **Study ID** | **Population** | **Feigning ADHD** | **Results** | **Subgroup** |
| --- | --- | --- | --- | --- |
| Abramson, 202344  N = 242  n ADHD = 175  US  College | **Target:** Adult patients referred for neuropsychological evaluation at an academic medical center from 2018 to 2021, with clinical diagnosis of ADHD based on the comprehensive protocol of the study  **ADHD presentation:** inattentive : 45,combined : 55  **Comorbidity:** N/A  **Other:** Adult patients referred for neuropsychological evaluation at an academic medical center from 2018 to 2021, constituting the invalid group (failed two or more criterion measures of the performance validity test)  **Female:** 58%  **Age mean (SD):** 27.47 (6.89)  Min age: 21 Max age: 35  **Age subgroup**: Adults  **Ethnicity:** Other : 7% were other race/ethnicity  % Hispanic or Latino : 22  % Black/African American : 12  % Asian : 9  % White : 49  Single center  Other funding | **Test description:** DCT (Dot Counting Test), a freestanding performance validity test  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  (1) a full medical/psychiatric record review (including review of prior ADHD evaluations/diagnostic work ups, when available); (2) a semistructured clinical interview which systematically gathered all relevant background information (e.g., ADHD symptom onset/course and associated functional impairment; medical, psychiatric, substance use, developmental, academic, and psychosocial history) and thoroughly assessed formal DSM-5 ADHD diagnostic criteria as well as comorbid psychopathology; (3) administration of an ADHD symptom inventory (i.e., Clinical Assessment of Attention Deficit—Adult [CAT-A]), which contains embedded symptom validity scales to identify noncredible symptom reporting and provides objective, normative-based qualification of ADHD symptomatology in both childhood and adulthood; (4) administration of a standardized core neuropsychological test battery which comprehensively assessed examinees’ cognition across all major cognitive domains; and (5) administration of a validity-controlled inventory of personality and psychopathology (i.e., Minnesota Multiphasic Personality Inventory-2-Restructured Form [MMPI-2-RF]) to objectively assess for active comorbid psychological symptoms  **Diagnosed by:** Unclear/NR  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Classification accuracy was excellent, with 54.3% sensitivity and 92% specificity at optimal cut-scores of ≥14 (rounded) and ≥13.38.  Sensitivity 54%  Specificity 92%  PPV  NPV  +LR  -LR  Accuracy  AUC 0.843  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** Brief administration time and scoring procedures. | **Subgroup analysis:** ADHD presentation,Comorbidity (e.g. anxiety, depression)  A series of ANOVAs revealed nearly identical test performance between ADHD subtypes (i.e., predominately inattentive vs combined), suggesting that these clinical factors did not meaningfully affect DCT performance.  A series of ANOVAs revealed nearly identical test performance between the presence/absence of comorbid psychopathology, suggesting that these clinical factors did not meaningfully affect DCT performance. |
| Aita, 201846  N = 280  n ADHD = 142  US  Specialty care | **Target:** Individuals from one of two university-affiliated psychology training clinics, diagnosed with ADHD  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Mood/Anxiety Disorder group or Clinic No Diagnosis group: Individuals from one of two university-affiliated psychology training clinics, not diagnosed with ADHD  Control group or ADHD Simulator group: Students were prospectively recruited from three southeastern universities  **Female:** 45.1% Study 1 - ADHD group: 45.1%; ADHD Simulators group: 73.9%; Mood/Anxiety Disorder group: 65.0%; Clinic No Diagnosis group: 42.3%; Healthy Controls group: 69.2%; Study 2 - ADHD group: 43.8%; ADHD Simulators group: 73.9%; Mood/Anxiety Disorder group: 65.4%; Clinic No Diagnosis group: 37.8%; Healthy Controls group: 75.5%  **Age mean (SD):** 20.29 (1.87) Study 1 - ADHD group: 21.77 (3.99); ADHD Simulators group: 19.83 (1.54); Mood/Anxiety Disorder group: 22.71 (4.58); Clinic No Diagnosis group: 22.05 (5.07); Healthy Controls group: 19.18 (1.57)  Study 2 - ADHD group: 22.33 (3.93); ADHD Simulators group: 19.83 (1.54); Mood/Anxiety Disorder group: 21.98 (4.26); Clinic No Diagnosis group: 22.80 (5.13); Healthy Controls group: 19.45 (1.35)  Min age: 18 Max age: 25  **Age subgroup**: Adults  **Ethnicity:** Other : Other Race: Study 1 - ADHD Simulators group: 4.3%; Clinic No Diagnosis group: 0.9%; Healthy Controls group: 3.8%; Study 2 - ADHD Simulators group: 4.3%; Clinic No Diagnosis group: 2.2%; Healthy Controls group: 3.8%  Other : Study 1 - ADHD group: 5.8%; ADHD Simulators group: 7.2%; Mood/Anxiety Disorder group: 1.5%; Clinic No Diagnosis group: 1.8%; Healthy Controls group: 3.8%; Study 2 - ADHD group: 9.6%; ADHD Simulators group: 7.2%; Healthy Controls group: 5.7%  Other : Study 1 - ADHD group: 10.1%; ADHD Simulators group: 10.1%; Mood/Anxiety Disorder group: 8.8%; Clinic No Diagnosis group: 10.8%; Healthy Controls group: 24.1%; Study 2 - ADHD group: 9.6%; ADHD Simulators group: 10.1%; Mood/Anxiety Disorder group: 5.8%; Clinic No Diagnosis group: 8.9%; Healthy Controls group: 9.4%  Other : Study 1 - ADHD group: 1.4%; ADHD Simulators group: 5.8%; Mood/Anxiety Disorder group: 2.2%; Clinic No Diagnosis group: 1.8%; Healthy Controls group: 3.8%; Study 2 - ADHD group: 2.7%; ADHD Simulators: 5.8%; Mood/Anxiety Disorder group: 1.9%; Clinic No Diagnosis group: 4.4%; Healthy Controls group: 1.9%  Other : Study 1 - ADHD group: 82.7%; ADHD Simulators group: 72.5%; Mood/Anxiety Disorder group: 87.6%; Clinic No Diagnosis group: 84.7%; Healthy Controls group: 64.7%; Study 2 - ADHD group: 75.3%; ADHD Simulators: 72.5%; Mood/Anxiety Disorder group: 92.3%; Clinic No Diagnosis group: 84.4%; Healthy Controls: 79.2%  Multicenter  Other funding | **Test description:** PAI (Personality Assessment Inventory), a self-report personality measure comprised of 344 items on a 4-point scale with anchor points of false and very true; items are categorized into 4 scales that assess validity of responding, 11 clinical syndrome scales, 5 treatment scales, and 2 interpersonal scales  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  All evaluations were conducted by doctoral graduate students in a clinical psychology program. Evaluations included a thorough clinical interview and all diagnoses were made under the supervision of a licensed psychologist.  **Diagnosed by:** Researcher Doctoral graduate students in a clinical psychology program, under supervision of a licensed psychologist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The new index's classification accuracy was superior to most existing PAI validity scales across groups. An item-level PAI algorithm had a sensitivity of 85% and specificity of 97% for identifying feigned ADHD.  Sensitivity 46%  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Becke, 202352  N = 117  n ADHD = 57  Netherlands  Setting varies | **Target:** Individuals with suspected ADHD referred to the Department of Psychiatry and Psychotherapy for clinical evaluation, clinical interviews, gathering corroborating evidence of ADHD-realted impairments via asking parents, partners and/or employees  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Students who reported low levels of ADHD symptoms currently and retrospectively, differing significantly from the ADHD group; in addition to a group randomly assigned to 3 simulation instructions (general instructions to feign ADHD with no additional information, symptom-coached simulators who were given the DSM diagnostic criteria of ADHD, and fully coached simulators who received information on both the neuropsychological assessment of ADHD and its diagnostic criteria  **Female:** 33%  **Age mean (SD):** 32 (12)  Min age: 20 Max age: 44  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** WAFS CE (Perceptual and Attention Functions selective attention assessed with VTS (Vienna Test System), a computerized neuropsychological test battery for assessing cognitive functions in adult ADHD evaluates cognitive domains such as attention and executive functions, aiding in diagnosing ADHD and treatment planning  Machine learning: Yes  Validation dataset: Yes  **Reference standard:** Other  Diagnosed with ADHD based on clinical interviews conducted by two experienced professionals using the Diagnostic and Statistical Manual of Mental Disorders criteria, with corroborating evidence gathered from parents, partners, and employers when available​  **Diagnosed by:** Researcher  **Timing:** Later diagnosis | **Diagnostic accuracy summary:** Although all ensured at least 90% specificity in the ADHD Group, sensitivity differed significantly between tests, ranging from 0% to 64.9%. Tests of selective attention, vigilance, and inhibition were most useful in detecting the instructed simulation of adult ADHD, whereas figural fluency and task switching lacked sensitivity.  Sensitivity 65%  Specificity 91%  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Berger, 202153  N = 189  n ADHD = 96  Israel  Setting varies | **Target:** Undergraduate students with a diagnosis of ADHD confirmed using the Structured Clinical Interview for DSM-5 (SCID-5) were excluded if they had neurological or psychiatric disorders. Study 1: 49, Study 2: 47  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Healthy controls who feigned ADHD and histoic healthy controls  **Female:** 63.83%  **Age mean (SD):** 23.79 (2.17)  Min age: 18 Max age: 65  **Age subgroup**: Adults  **Ethnicity:** N/A  Multicenter  No COI | **Test description:** MOXO-d-CPT  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a previous diagnosis by a licensed clinician (psychiatrist and/or clinical psychologist) following DSM-5 criteria, confirmed using the Structured Clinical Interview for DSM-5 (SCID-5-RV) upon study entry  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Simulators performed significantly worse on all MOXO-d-CPT indices than healthy controls and ADHD patients. Three MOXO-d-CPT indices (attention, hyperactivity, impulsivity) and a scale combining these indices showed adequate discriminative capacity.  Sensitivity 62%  Specificity 91%  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** 18.2 minutes | **Subgroup analysis:** ADHD diagnosis (effect of different reference status or comparator)  No significant differences were found between archival and prospective data of ADHD patients. |
| Cook, 201660  N = 86  n ADHD = 4  US  College | **Target:** Adults aged 18 and older referred to a university psychology training clinic for neuropsychological evaluation for concerns about ADHD and/or a learning disability, with exclusion criteria including any self-reported history of neurological illness or injury  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Adults without ADHD, referred to a university psychology training clinic for evaluation of mood disorders, anxiety disorders, adjustment disorders, substance abuse disorders, learning disabilities, or schizotypal personality disorders, with the setting being a specialty care clinic focused on neuropsychological assessment  Participants with non-credible performance were identified with a Word Memory Test  **Female:** 53%  **Age mean (SD):** 22 (5)  Min age: 18 Max age: 42  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 2.3  % Black/African American : 3.5  % Asian : 3.5  % White : 79.1  Single center  No COI | **Test description:** CII (Conner’s Adult Attention Deficit/Hyperactivity Rating Scale Infrequency Index) to identify non-credible symptom reporting  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive neuropsychological evaluation conducted by advanced graduate students under the supervision of a licensed psychologist in a university psychology training clinic  **Diagnosed by:** Specialist (e.g., mental health) licensed psychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The CII was 52% sensitive to extreme scores on CAARS DSM symptom subscales (with 97% specificity) and 20%-36% sensitive to invalid responding on MMPI-2-RF validity scales (with near 90% specificity), providing further evidence for the interpretation of the CII as an indicator of non-credible ADHD symptom report. However, the CII detected only 18% of individuals who failed a standalone performance validity test (WordMemoryTest), with 87.8% specificity, and was not accurate in detecting non-credible performance using embedded digit span cutoffs.  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC 0.87  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Courrege, 201961  N = 402  n ADHD = 83  US  Community | **Target:** Participants with ADHD were included based on self-reported history of ADHD diagnosis, diagnosis details such as the type of professional providing the assessment, methods used in the assessment (interviews, symptom questionnaires, cognitive testing), and whether medication was prescribed  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included control individuals without ADHD, individuals who suspected they had ADHD but were not diagnosed, and simulators instructed to feign ADHD symptoms; participants were recruited online through Amazon Mechanical Turk and completed assessments in a general, non-clinical setting  **Female:** 60.37%  **Age mean (SD):** 36 (13.0)  Min age: 19 Max age: 75  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 4  % Black/African American : 5.3  % American Indian or Alaska Native : 1.3  % Asian : 5.3  % White : 81.5  % Multiracial : 2.6  Single center  Funding unclear | **Test description:** ASIS INF (Infrequency Scale), tool to assess self-reported ADHD symptoms and identify exaggeration or feigned responses, scales map onto DSM-5 criteria and items designed to detect symptom infrequency  Machine learning: No  Validation dataset: Partially  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on self-reported history, details of prior assessments including the type of professional conducting the evaluation, methods such as interviews, symptom questionnaires, cognitive testing, and whether medication was prescribed.  **Diagnosed by:** Specialist (e.g., mental health) psychiatrists, physicians, and psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** Demonstrated strong sensitivity (.79–.86) and excellent specificity (.89) in detecting feigned ADHD symptoms compared to a sample of individuals self-reporting a history of ADHD diagnosis. Using a malingering base rate of 29%, the ASIS INF scale achieved a positive predictive value of .71–.79 and a negative predictive value of .92–.93, indicating strong diagnostic accuracy in differentiating simulated from genuine ADHD.  Sensitivity 79%  Specificity 89%  PPV 71  NPV 92  +LR 7.18  -LR 0.24  Accuracy 79  AUC 0.92  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha 0.96  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Finley, 202372  Finley, 202473  N = 599  n ADHD = 600  US  Other setting | **Target:** Adults referred to a Midwestern academic medical center for neuropsychological evaluation diagnosed with ADHD based on clinical interviews, self-reported symptom questionnaires, and neurocognitive testing according to DSM criteria. Finley 2023: 176 individuals were diagnosed with ADHD out of 585 total participants​. 161 individuals were diagnosed with ADHD only, and 263 with ADHD plus a comorbid psychiatric disorder  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Individuals with psychiatric disorders such as depression, anxiety, PTSD, or no mental health diagnosis, evaluated in a specialty care setting; exclusions: intellectual disabilities, major neurocognitive disorders, severe mental illnesses, or invalid inconsistency scores to ensure accurate comparisons; participants were categorized into invalid and valid performance groups determined by scores from empirical performance validity indicators.  **Female:** 62%  **Age mean (SD):** 28.12 (6.85)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 22  % Black/African American : 15  % Asian : 10  % White : 47  % Multiracial : 6  Single center  Funding unclear | **Test description:** Integrating 6 indicators - Combination of WAIS-IV Symbol Search age-corrected scaled score (equal to smaller than 6), WAIS-IV Coding age-corrected scaled score (equal or smaler than6), WAIS-IV Letter-Number Sequencing age-corrected scaled score (equal or smaller than 7), SCWT Word Reading T-score (equal or smaller than 25), TMT-B T-score (equal or smaller than 34), and Lexical Fluency FAS T-score (equl or smaller than 34); cut-off failing 2; adminstered together with the NI (Negative Impression), IF (Infrequency), and PI (Positive Impression) scales  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interview, review of medical and academic records, symptom questionnaires, and neurocognitive testing following DSM criteria. Comprehensive neuropsychological evaluation and symptom questionnaires were key components of the diagnostic process. Both studies used a clinical diagnosis from mental health clinicians as the gold standard  **Diagnosed by:** Specialist (e.g., mental health) psychiatrists, neuropsychologists, and psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** AUC was 0.86 for the integrated neuropsychological test indicators.  Self report results varied (Negative Impression scale ≤51; 30% sensitivity / 90% specificity; Infrequency scale ≥4; 18% sensitivity / 90% specificity; Positive Impression scale ≥27; 36% sensitivity / 90% specificity).73  Sensitivity 60% NI scale: 30%, IF scale: 18%  Specificity 91% NI scale: 90%, IF scale: 90%  PPV  NPV  +LR  -LR  Accuracy  AUC 0.86 IF scale: 0.64 and 0.58  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Fuermaier, 201674  N = 329  n ADHD = 62  Germany  Other setting | **Target:** Adults diagnosed with ADHD referred by psychiatrists or neurologists meeting DSM-IV criteria confirmed by psychiatric interviews, scoring above cutoff on standardized self-report scales, and demonstrating objective impairments and multiple informant support for diagnosis. Fifty-one adults diagnosed with ADHD participated in the main sample. 11 adults in an independent validation sample.  **ADHD presentation:** inattentive : 43.21,hyperactive : 2,combined : 54.9  **Comorbidity:** N/A  **Other:** Non-ADHD participants recruited through public announcements and word-of-mouth, selected to match the ADHD participants in age, gender, and intellectual functioning; in addition, undergraduate students were randomly assigned to a control group, a naive simulation group, a symptom-coached simulation group, or a test-coached simulation group  **Female:** 41%  **Age mean (SD):** 34.0 (11.3)  Min age: 18 Max age: 56  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** Embedded Figures Test developed for the detection of feigned ADHD in adulthood  Machine learning: No  Validation dataset: Yes  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interviews according to DSM-IV criteria, including retrospective assessment of childhood symptoms and evidence from multiple informants such as employer and partner reports  **Diagnosed by:** Specialist (e.g., mental health) Mental health specialists  **Timing:** Concurrent | **Diagnostic accuracy summary:** The EFT (Embedded Figures Test) developed in the study demonstrated strong performance in distinguishing between individuals with genuine ADHD and those feigning ADHD. The test showed high sensitivity (88%) and specificity (90%). The EFT demonstrated excellent discriminatory power with an AUC of 0.948  Sensitivity 88%  Specificity 90%  PPV 89.8  NPV 88.2  +LR 8.8  -LR 0.13  Accuracy 89  AUC 0.948  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harp, 201181  N = 88  n ADHD = 38  US  College | **Target:** Participants with ADHD were college students with written documentation of an ADHD diagnosis from a licensed professional, diagnosed using cognitive testing, structured interview, or classroom observation, without comorbid psychiatric, neurological, reading, or intellectual disorders, and who abstained from stimulant medication for at least 12 hours prior to testing​  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** College students without psychiatric diagnoses, recruited from a university subject pool, who reported no ADHD diagnosis and no comorbid psychiatric, neurological, reading, or intellectual disabilities​  **Female:** 54.5%  **Age mean (SD):** 19.3 (1.28)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** Other : HON:10.7, ADHD: 5  Other : FGN: 18.2  Other : HON:21.4, FGN:18.2  Other : HON:67.9, FGN:77.3, ADHD:95, EXAG:100  Single center  Public funding | **Test description:** MMPI-2-RF (Minnesota Multiphasic Personality Inventory—2 Restructured Form) validity scales (specifically Fp-r, F-r, and Fs) were used as symptom validity tests to detect feigned or exaggerated ADHD symptoms​  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on written documentation by a licensed professional using cognitive testing structured interview or classroom observation  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** MMPI-2-RF validity scales assessed the ability to distinguish participants feigning ADHD from honest participants, with the Fp-r scale at an experimental cut score of ≥77, achieving a sensitivity of 64% and specificity of 96%.  Sensitivity % Fp-r (≥77) FGN: 63.6, EXAG: 16.7  Specificity % Fp-r (≥77) HON: 100, ADHD:90  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harrison, 200784  N = 142  n ADHD = 72  Canada  College | **Target:** College or university students diagnosed using DSM-IV ADHD criteria with evidence of childhood and current impairments corroborated by collateral informants showing substantial academic or life impairments  **ADHD presentation:** inattentive : 47.2,hyperactive : 52.8  **Comorbidity:** N/A  **Other:** University undergraduates without ADHD, including a group instructed to simulate ADHD symptoms (Faking group) and a control group instructed to perform tasks honestly (Honest Normals)  **Female:** 54.17%  **Age mean (SD):** 22.90 (7.01)  Min age: 17 Max age: 22  **Age subgroup**: Young  **Ethnicity:** Other : Student population self-identify as visible minorities  Single center  Public funding | **Test description:** Integrated CAARS, Reading Fluency subtest, and the 2 Processing Speed subtests from the Woodcock Johnson Psychoeducational Battery-III  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-IV criteria, including objective evidence of childhood impairment, self-reported symptoms consistent with observed and documented behavioral problems, and confirmation from reliable collateral informants  **Diagnosed by:** Specialist (e.g., mental health) Clinical psychologists  **Timing:** Concurrent | **Diagnostic accuracy summary:** There was 75% correct classification across all groups. ADHD symptoms can be easily fabricated, with individuals feigning ADHD scoring higher on self-report measures (CAARS) and performing worse on cognitive tests (WJPB-III) than genuine ADHD participants.  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy 75 normal group 80%, ADHD group 78%, faking group 66% correct classifications  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harrison, 201682  N = 608  n ADHD = 171  Canada  College | **Target:** Students (>17 years) diagnosed with ADHD by a clinical psychologist using DSM-IV, participants recruited from community colleges or universities  **ADHD presentation:** inattentive : 24.6,hyperactive : 5.2,combined : 20.7,combined\_other : exaggerating, feigning responses  **Comorbidity:** N/A  **Other:** Students seeking treatment diagnosed with other non-ADHD mental disorders eg anxiety, depression  **Female:** 44.4%  **Age mean (SD):** 21.4 (4.5)  Min age: 17 Max age: 38  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** E-CAARS (Experimental Conners’ Adult ADHD Rating Scale) added 18 items on atypical dissociative symptoms to capture exaggerated symptom responses, items were adapted to a 4-point CAARS format, cutoff >3  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Students diagnosed with ADHD by a clinical psychologist following DSM-IV criteria  **Diagnosed by:** Specialist (e.g., mental health) Psychologist  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** While the tool demonstrated high specificity (97%), reducing false positives, its low sensitivity (24%) resulted in a significant number of false negatives, limiting its effectiveness in accurately identifying all true ADHD cases.  Sensitivity 24%  Specificity 97%  PPV 0.58  NPV 0.88  +LR  -LR  Accuracy 86 correct classification rate  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harrison, 201985  N = 331  n ADHD = 111  Canada  College | **Target:** Post-secondary students (age >17) from an archival database who sought assessment for ADHD as a possible cause of their reported difficulties, completed the PAI, were administered a PVT, and consented to their data being used for research  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Post-secondary students with no formal diagnosis served as no diagnosis group, students with primary mental health Non-ADHD condition served as clinical controls, students with definite malingering condition were in the malingering group  **Female:** 36.9%  **Age mean (SD):** 21.9 (5.3)  Min age: 17 Max age: 57  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** PAI (Personality Assessment Inventory), a 344-item self-report inventory rated on a four-point Likert scale, providing clinicians with data on four validity scales, 11 clinical scales, five treatment scales, and two interpersonal scales to detect feigned ADHD  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on all five criteria listed in DSM-IV or DSM-5 depending on the date assessed, with assessments conducted by a licensed clinical psychologist or a graduate student trainee under supervision​.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The two proposed PAI algorithms were found to have poor positive predictive value (.19 and .17). Self-report validity measures from the Connors’ Adult Attention Rating Scale, and the Negative Impression Management scale on the PAI returned more positive results.  Sensitivity %  Specificity %  PPV 19  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Harrison, 202083  N = 245  n ADHD = 13  Canada  College | **Target:** Emerging adults referred to a university-based ADHD screening clinic, no prior ADHD diagnosis, seeking evaluation due to self-reported difficulties, completed measures including TOVA and CAARS, provided evidence of substantial impairment in multiple major life activities prior to age 12 and currently  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Emerging adults referred to a university-based ADHD screening clinic, presenting with self-reported ADHD-like symptoms but not meeting diagnostic criteria for ADHD, included those with good effort scores on validity testing and no substantial impairments documented in major life activities  **Female:** 49.4%  **Age mean (SD):** 20.4 (1.8)  Min age: 17 Max age: 24  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** TOVA ACS score, Test of Variables of Attention as an embedded performance validity measure administered with CAARS measures  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive clinical assessment including a semi-structured interview, retrospective symptom ratings from parents/caregivers, review of childhood report cards, documentation of substantial impairment in major life activities prior to age 12 and currently, and evaluation of DSM criteria.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Of all TOVA and CAARS measures, the Attention Comparison Score had excellent discrimination; AUC was 0.797 (sensitivity 90%, specificity 47%). Commission Errors in the first half of the TOVA also showed good AUC and specificity but not sensitivity (AUC 0.818, sensitivity 12%, specificity 92%). Results support the use of the TOVA as an embedded performance validity measure in assessing late adolescents/emerging adults and support previous findings that symptom reports alone cannot distinguish credible from noncredible ADHD presentation.  Sensitivity 47%  Specificity 90%  PPV  NPV  +LR  -LR  Accuracy  AUC 0.797  **Concordance:** N/A  **Rater agreement:** Rater agreement between self-reported ADHD symptoms (CAARS) and objective performance validity measures (TOVA)  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Khan, 202295  N = 317  n ADHD = 226  US  Specialty care | **Target:** Adults referred for outpatient neuropsychological evaluation for suspected or confirmed ADHD, reported English as their primary language, underwent a standardized diagnostic protocol including record review, clinical interview, and neuropsychological testing, and were evaluated for ADHD using DSM-5 criteria  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included adults referred for neuropsychological evaluation who failed performance validity tests, with evaluations conducted in a specialty care setting focused on diagnostic clarification for conditions other than ADHD  **Female:** 62.46%  **Age mean (SD):** 27.7 (6.67)  Min age: 18 Max age: 60  **Age subgroup**: Adults  **Ethnicity:** Other : 5  % Black/African American : 24  % Asian : 10  % White : 46  Single center  Funding unclear | **Test description:** SCWT (Stroop Color and Word Test) assesses cognitive flexibility and processing speed through 3 trials: word reading, color naming, and color-word interference; the word reading and color naming trials were used as embedded performance validity tests to evaluate the validity of neuropsychological test performance  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria by a board-certified clinical neuropsychologist  **Diagnosed by:** Specialist (e.g., mental health) Clinical neuropsychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The embedded validity indicators from the Stroop Color and Word Test were effective in determining validity status. Word Reading and Color Naming trials demonstrated acceptable classification accuracy (AUCs 0.750–0.794), with optimal cut scores of WR raw ≤75 (54% sensitivity, 89-90% specificity), WR T score ≤28 (54% sensitivity, 87-88% specificity), CN raw ≤57 (42% sensitivity, 90% specificity), and CN T score ≤30 (40% sensitivity, 90% specificity).  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Lee Booksh, 2010103  N = 166  n ADHD = 56  US  College | **Target:** Patients diagnosed with ADHD with clinical data obtained from previous archival records  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Undergraduate students (>18years) enrolled in psychology courses without ADHD or learning disabilities, screened for the absence of ADHD symptoms and neurological issues, were assigned to either control or simulated ADHD group  **Female:** 70%  **Age mean (SD):** 21.11 (3.1) ADHD group age data collected retrospectively  Min age: 18 Max age: 29  **Age subgroup**: Adults  **Ethnicity:** Other : This is the ethnicity data for ADHD group  % Black/African American : 5.4  % Asian : 1.8  % White : 93  Single center  Funding unclear | **Test description:** WMT (Word Memory Test) evaluates verbal memory and effort by presenting participants with a list of 20 word pairs on a computer to learn  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by a psycho-educational team in a university psychological clinic  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Simulators successfully feigned ADHD symptoms on a retrospective self-report measure. Knowledge of ADHD was unrelated to objective attentional measure performance. Participants who simulated ADHD on some objective measures (i.e., specific Wechsler Adult Intelligence Scale–III [WAISIII] subtests) showed similar performance to the clinical ADHD comparison sample.  Sensitivity % There are no established cut scores or validity measures specific to ADHD assessment that provide guidance on specificity or sensitivity values  Specificity % There are no established cut scores or validity measures specific to ADHD assessment that provide guidance on specificity or sensitivity values  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Marshall, 2010110  N = 268  n ADHD = 80  US  Specialty care | **Target:** Patients referred for ADHD assessment in a neuropsychological clinic, without neurological conditions, head injuries, learning disabilities, psychiatric disorders other than depression or anxiety, substance abuse dependence, or physical illnesses causing cognitive deficits, minimum estimated IQ of 70.  **ADHD presentation:** inattentive : 45,combined : 36  **Comorbidity:** N/A  **Other:** Patients referred for ADHD assessment in a neuropsychological clinic, many had other mental health conditions such as depression or anxiety, and it included patients suspected of exaggerating sypmptoms  **Female:** 39%  **Age mean (SD):** 27.8 (9.1)  Min age: 17 Max age: 55  **Age subgroup**: Adults  **Ethnicity:** Other : 10  % Hispanic or Latino : 10  % Black/African American : 9  % American Indian or Alaska Native : 10  % Asian : 10  % White : 81  Single center  Funding unclear | **Test description:** Word Memory test immediate recall  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on cognitive testing, behavior rating scales, and clinical interviews.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The Word Memory test immediate recall and consistency score (both 64%), TOVA omission errors (63%) and reaction time variability (54%), CAT-A infrequency scale (58%), and b Test (47%) had good sensitivity as well as at least 90% specificity.  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Morey, 2019113  N = 368  n ADHD = 32  US  College | **Target:** Participants self-identified with ADHD, with 32 indicating a current diagnosis, 29 having received medication for ADHD, and 21 holding a current prescription  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included neurotypical college students without a history of ADHD, divided into standard instruction and feigning instruction groups, recruited from an introductory psychology pool in a university setting  **Female:** 56.3%  **Age mean (SD):** 18.9 (1.38)  Min age: 18 Max age: 21  **Age subgroup**: Young  **Ethnicity:**  % Hispanic or Latino : 22.3  % Black/African American : 6.3  % Asian : 7.6  % White : 55.2  Single center  Funding unclear | **Test description:** Integrating PAI (Personality Assessment Inventory) and TOAD (Tests of Attentional Distraction) NIM (Negative Impression) T-score ≥ 64 or TOAD total error rate ≥ 3.67%  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Self-reported ADHD diagnosis confirmed by a history of medication use, with clinically significant attention problems inferred from a Conners Adult Attention Rating Scale-Self-Report Short Version raw score of 21  **Diagnosed by:** Unclear/NR  **Timing:** Concurrent | **Diagnostic accuracy summary:** Moderate to large effects differentiating the feigning group from control participants, both ADHD and non-ADHD, were observed for both the TOAD and PAI indicators. The disjunction rule enhances sensitivity beyond that of the invididual procesures at the expense of a decrease in specificity.  Sensitivity 59%  Specificity 82%  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Musso, 2016117  N = 779  n ADHD = 142  US  College | **Target:** Individuals aged 17-29, diagnosed with ADHD or ADHD with comorbid mood or anxiety disorders, who completed psychoeducational evaluations and were assessed using the PAI validity indices  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Undergraduate college students aged 18-25 with no reported history of psychopathology, learning disorders, or ADHD, recruited from a large university in the Southeastern United States for extra credit, and instructed to simulate ADHD symptoms or respond honestly  **Female:** 33.6%  **Age mean (SD):** 21.16 (2.91) Student volunteers: 19.72 (1.42)  Min age: 17 Max age: 29  **Age subgroup**: Adults  **Ethnicity:** Other : Clinical:1.7; student volunteers: 2.9  % Hispanic or Latino : Clinical: 3.2; student volunteers: 5.8  % Black/African American : Clinical: 9.1; student volunteers: 7.9  % Asian : Clinical: 1.5; student volunteers: 4.2  % White : Clinical: 84.4; student volunteers:79.2  Multicenter  Other funding | **Test description:** Effort tests and symptoms validity tests are designed to assess the credibility of self-reported symptoms and detect intentional exaggeration or malingering. These tests include validity indices like the Negative Impression Management (NIM), Malingering Index (MAL), and Rogers Discriminant Function (RDF) in the Personality Assessment Inventory (PAI), which evaluate patterns of responses to identify response distortion. By analyzing these patterns, the tests differentiate genuine cases of ADHD from individuals feigning symptoms, providing insights into the reliability of the reported symptoms.  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive psychoeducational evaluation conducted by clinical graduate students under the supervision of a licensed psychologist using diagnostic criteria and standardized assessments  **Diagnosed by:** Specialist (e.g., mental health) clinical graduate students under the supervision of a licensed psychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The alternative cutoff scores of ≥77 on the Negative Impression Management (NIM) scale, ≥ three on the Malingering Index (MAL), and ≥ one on the Rogers Discriminant Function (RDF) yielded excellent specificity in all groups and sensitivities of 33, 30, and 20%, respectively.  Sensitivity 33% MAL cutoff >3: 22; RDF cutoff>1: 30  Specificity 98% MAL cutoff >3: 98; RDF cutoff>1: 96  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** Comparing self-reported ADHD symptoms (from ADHD simulators) to clinical data from individuals diagnosed with ADHD  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** Comorbidity (e.g. anxiety, depression)  Misdiagnosis was more likely in individuals presenting with comorbid psychiatric conditions, such as anxiety or depression, as these conditions impacted validity index scores, potentially complicating differentiation between genuine and feigned symptoms. |
| Phillips, 2023124  N = 317  n ADHD = 229  US  Specialty care | **Target:** Adults referred for outpatient neuropsychological evaluation of known or suspected ADHD, the majority were actively enrolled college students, diagnoses based on DSM-5 criteria using a standardized multimodal diagnostic assessment protocol including history, symptom questionnaires, clinical interviews, and neuropsychological testing  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included adults referred for outpatient neuropsychological evaluation who had attention complaints but did not meet DSM-5 criteria for ADHD, evaluated in a specialty care setting using standardized diagnostic protocols; participants were classified as having valid or invalid test performance based on performance validity tests  **Female:** 61%  **Age mean (SD):** 27.7 (6.67)  Min age: 18 Max age: 45  **Age subgroup**: Adults  **Ethnicity:** Other : 5  % Hispanic or Latino : 24  % Black/African American : 15  % American Indian or Alaska Native : 46  % Asian : 10  Single center  Funding unclear | **Test description:** RAVLT (Rey Auditory Verbal Learning Test), which assesses verbal/auditory learning and memory, and the BVMT-R (Brief Visuospatial Memory Test-Revised), which evaluates visuospatial learning and memory; incorporates embedded PVTs (performance validity tests) to differentiate valid from invalid cognitive performance among individuals referred for ADHD evaluation  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on DSM-5 criteria using a standardized multimodal diagnostic assessment protocol that included a detailed clinical interview, review of medical and psychiatric history, symptom questionnaires, and a comprehensive neuropsychological test battery  **Diagnosed by:** Specialist (e.g., mental health) Primary care physicians or psychiatrists  **Timing:** Concurrent | **Diagnostic accuracy summary:** These memory-based RAVLT and BVMT-R PVTs were able to accurately identify invalid neuropsychological test performance among adults undergoing evaluation for ADHD, regardless of whether diagnostic criteria for ADHD were met.  Sensitivity 43% FC<14: 49; RD<5: 35  Specificity 90% FC<14: 92; RD<5: 90  PPV  NPV  +LR  -LR  Accuracy  AUC 0.74 FC<14: 0.70; RD<5: 0.63  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Potts, 2022127  N = 68  n ADHD = 34  US  College | **Target:** Participants with ADHD were young adults recruited from undergraduate psychology classes, diagnosed by a qualified professional with symptom onset before age 12, elevated scores on CAT-A symptom indexes, and substantial impairment in academic, occupational, or social areas  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants included young adults from the same undergraduate psychology classes instructed to feign ADHD symptoms for the purpose of the study  **Female:** 52.9%  **Age mean (SD):** 18.82 (1.51)  Min age: 18 Max age: 20  **Age subgroup**: Young  **Ethnicity:**  % Black/African American : 5.9  % Asian : 5.9  % White : 88.2  % Multiracial : 5.9  Single center  Other funding | **Test description:** MARS Symptom Validity Index 4 (SV-index 4) and CAT-A Infrequency Scale evaluate whether individuals over-endorse unlikely ADHD symptoms. Effort tests like the Word Memory Test (WMT) assess cognitive performance consistency to detect poor effort.  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a semi-structured clinical interview conducted by a licensed psychologist or advanced doctoral student, confirming diagnosis by a qualified professional with symptom onset before age 12, substantial functional impairment, and elevated T-scores on relevant symptom scales  **Diagnosed by:** Specialist (e.g., mental health) Psychologist  **Timing:** Concurrent | **Diagnostic accuracy summary:** The MARS SV index-4 demonstrated higher sensitivity rates for simulated malingering (61.8%) at close to optimal specificity (88.2%) compared to two published tests (which had sensitivity <42% at specificity >90%).  Sensitivity 61.8%  Specificity 88.2%  PPV 84  NPV 69.8  +LR 5.2  -LR 0.4  Accuracy 75  AUC 0.79 0.68, 0.90  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Quinn, 2003128  N = 60  n ADHD = 16  US  College | **Target:** Undergraduate students previously diagnosed with ADHD by a trained psychiatrist using DSM criteria, aged 17-29 years, recruited through a university disability office, with 50% currently prescribed stimulant medication but refraining for at least 12 hours prior to testing  **ADHD presentation:** inattentive : 25,combined : 75  **Comorbidity:** N/A  **Other:** Neurotypical undergraduate psychology students aged 17-29 years, randomly assigned to control or simulated malingerer conditions, with the control group instructed to perform accurately and malingerers instructed to convincingly simulate ADHD symptoms  **Female:** 50%  **Age mean (SD):** 19.8 (N/A)  Min age: 17 Max age: 29  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 25  % Asian : 12.5  % White : 62.5  Single center  Funding unclear | **Test description:** Self-report (ADHD Behavior Checklist) and neuropsychological testing (IVA CPT) are both used to assess feigning ADHD. Malingerers successfully faked symptoms on self-reports but overcompensated on the IVA CPT. The IVA CPT served as a symptom validity test by detecting inconsistencies in response patterns and reaction times. Effort testing was implicit in the CPT, as malingerers exhibited unnatural response patterns.  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by a trained psychiatrist using DSM criteria, based on clinical interview and self-report questionnaire, with some participants previously assessed using a Continuous Performance Test (CPT)  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** IVA CPT could not be faked on 81% of its scales. The CPT’s impairment index results revealed: sensitivity 94%, specificity 91%, PPP 88%, NPP 95%.  Sensitivity 94%  Specificity 91%  PPV 88  NPV 95  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Ramachandran, 2019129  N = 637  n ADHD = 102  US  College | **Target:** Participants self-reported a previous formal diagnosis of ADHD, provided details about the approximate time since diagnosis, the time spent during their first diagnostic appointment, and the specialty of the diagnosing practitioner; individuals with ADHD were asked to respond honestly to the survey  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD participants were either instructed to respond honestly (control group) or to feign ADHD symptoms (malingering group); the sample consisted of college students recruited from a university setting, primarily through online recruitment and incentives such as class credit  **Female:** 49.5%  **Age mean (SD):** 20.9 (2.12)  Min age: 18 Max age: 25  **Age subgroup**: Young  **Ethnicity:** Other : 1.9  % Hispanic or Latino : 1.9  % Black/African American : 5.8  % Asian : 1.9  % White : 85.4  % Multiracial : 2.9  Single center  Other funding | **Test description:** SAMS (Subtle ADHD Malingering Screener), a symptom validity test designed to detect individuals feigning ADHD symptoms through a self-report measure, evaluates effort and response patterns by distinguishing genuine ADHD from exaggerated or fabricated symptom presentations; administered together with the PAI (Personality Assessment Inventory cut offNIM score 92 or above or a Malingering Index score greater than 3)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on self-reported previous formal diagnosis, time since diagnosis, duration of the diagnostic appointment, and the specialty of the diagnosing practitioner  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** SAMS showed a sensitivity of 90% and specificity of 80%. The PAI was found to have a sensitivity of 51% and a specificity of 89%; the PAI’s rate of false positives (10.8%) was somewhat lower than the SAMS, but the rate of false negatives (49.0%) was much higher.  Sensitivity 90.3%  Specificity 80.1%  PPV  NPV  +LR  -LR  Accuracy  AUC 0.901  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Robinson, 2023133  N = 201  n ADHD = 109  US  College | **Target:** Adults referred to a university-affiliated clinic for psychoeducational evaluations due to concerns related to ADHD and/or specific learning disorder, assessed using the Conners Continuous Performance Test-3 and multiple performance validity tests, credible participants failed 0 performance validity tests  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Non-ADHD included individuals referred to the same specialty care clinic for psychoeducational evaluations who did not meet the ADHD diagnostic criteria, including those assessed for specific learning disorders or presenting with unrelated concerns, non-credible participants failed 2 or more paerformance validity tests  **Female:** 72.4%  **Age mean (SD):** 23.04 (6.80)  Min age: 18 Max age: 50  **Age subgroup**: Adults  **Ethnicity:** Other : 83.3  % Hispanic or Latino : 23  % Black/African American : 66.7  % Asian : 66.7  % White : 81.4  Single center  Other funding | **Test description:** CPT-3 (Conners Continuous Performance Test-3) as an embedded validity indicator (EVI) to detect non-credible responders, which includes individuals feigning ADHD.  PVTs used as the reference standard, with non-credible responders classified based on failure of ≥2 PVTs. The CPT-3 indicators, including omissions, commissions, detectability, variability, and reaction time measures, are tested for their ability to distinguish between credible and feigned ADHD presentations.  CPT-3 indicators classification accuracy threshold (AUC ≥ 0.70)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a combination of clinical interview, psychoeducational evaluation, and performance validity tests using established cutoffs to classify credible and non-credible responders  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Receiver operating characteristic curves (ROC) revealed that 5/9 individual indicators and 2/4 composite indicators met a minimally acceptable classification accuracy of ≥ 0.70 (AUC = 0.43–0.78). Individual (0.16–0.45) and composite indicators (0.23–0.35) demonstrated low sensitivity when using cutoffs that maintained specificity ≥90%.  Sensitivity 45% Omission>59: 38; Commission>68: 36; VAR>59: 38; HRTSD>65: 29  Specificity 90% Omission>59: 91; Commission>68: 90; VAR>59: 90; HRTSD>65: 91  PPV  NPV  +LR  -LR  Accuracy  AUC 0.76 Omission>59: 0.72; Commission>68: 0.70; VAR>59: 0.78; HRTSD>65: 0.73  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Rogers, 2021134  N = 147  n ADHD = 73  US  College | **Target:** Adults with a prior clinical diagnosis of ADHD, assessed using comprehensive psychological evaluations, with common comorbidities including major depressive disorder, learning disorders, and anxiety disorders  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Undergraduate students enrolled in psychology courses, with no history of ADHD or ADHD medication use, instructed to simulate ADHD symptoms for the purpose of the study  **Female:** 54.8%  **Age mean (SD):** 25.59 (4.17)  Min age: 18 Max age: 34  **Age subgroup**: Adults  **Ethnicity:**  % Hispanic or Latino : 23.8  % Black/African American : 10.2  % Asian : 4.8  % White : 51  % Multiracial : 6.1  Single center  No COI | **Test description:** WAIS-IV (Wechsler Adult Intelligence Scale–4h Edition)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on comprehensive psychological assessments conducted by clinicians, including clinical interviews and standardized testing to confirm the diagnosis.  **Diagnosed by:** Specialist (e.g., mental health) Clinician mental specialist  **Timing:** Concurrent | **Diagnostic accuracy summary:** Very large effect sizes (Cohen’s ds from 1.66 to 1.90) differentiated between genuine and feigned ADHD. Two strategies (significantly below-chance performance and floor effect) showed strong promise if cross-validated for other feigning presentations.  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy 64  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Smith, 2017143  N = 129  n ADHD = 63  US  College | **Target:** Participants were diagnosed with ADHD through a semi-structured clinical interview assessing DSM criteria, including at least six symptoms of inattention or hyperactivity/impulsivity in at least two domains, evidence of impairment before age 7, and verification through self-reported ADHD diagnosis or treatment history. 22 undergraduate students who met diagnostic criteria for ADHD based on clinical interviews and semi-structured evaluations. 41 individuals from an archival sample diagnosed at a university psychology clinic  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** The non-ADHD participants included individuals recruited from a university psychology research pool, with one group instructed to simulate ADHD symptoms and another consisting of archival clinical records of individuals evaluated for ADHD at a university psychology training clinic  **Female:** 45.5% male: 54.5  **Age mean (SD):** 18.77 (1.19)  Min age: 18 Max age: 23  **Age subgroup**: Young  **Ethnicity:** Other : Simulation sample: 7.60; clinical comparison procedure: 4.5; archival comparison sample: 4.9  Other : Simulation sample: 21.20; clinical comparison procedure: 4.5; archival comparison sample:26.8  Other : Simulation sample: 1.5; archival conparison sample: 22  Other : Simulation sample: 69.70; clinical comparison: 90.0; archival comparisoon: 46.3  Single center  Funding unclear | **Test description:** PAI (Personality Assessment Inventory) to evaluate symptom validity and distinguish between genuine and simulated ADHD presentations  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a semi-structured clinical interview assessing DSM criteria, including six or more symptoms of inattention or hyperactivity/impulsivity in at least two domains, evidence of impairment before age 7, and verification through self-reported diagnosis or treatment history.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The PAI may be informative as an indicator of potentially exaggerated or malingered symptom presentation, but alternative cut scores for symptom validity indicators may be necessary to maximize its utility in these particular types of psychological evaluations.  Sensitivity 68% NIM(27.3); INF(65.2); MAL(76.2); PIM(56.1)  Specificity 83% NIM(95.2); INF(74.6); MAL(60.9); PIM(68.3)  PPV  NPV  +LR  -LR  Accuracy  AUC 0.75 (CI 0.67, 0.83) NIM(0.75); INF(0.75); MAL(0.64); PIM(0.67)  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Sollman, 2010146  N = 73  n ADHD = 29  US  College | **Target:** College students with a verifiable diagnosis of ADHD confirmed through neuropsychological or psychological evaluation, including corroborative interviews with parents or teachers, medication washout for 12 hours before testing, excluding those with comorbid learning disabilities, psychiatric or neurological conditions, or substance abuse  **ADHD presentation:** inattentive : 20,hyperactive : 5,combined : 75  **Comorbidity:** N/A  **Other:** College students recruited from the same university setting, divided into two groups: a normal honest-responding group with no history of ADHD or related disorders, and a feigning group instructed to simulate ADHD based on provided materials; participants were screened to exclude those with learning disabilities, psychiatric or neurological conditions, or substance abuse  **Female:** 44.8%  **Age mean (SD):** 19.40 (1.21)  Min age: 18 Max age: 21  **Age subgroup**: Young  **Ethnicity:**  % Black/African American : 6.90  % Asian : 0  % White : 86.20  % Multiracial : 6.90  Single center  Funding unclear | **Test description:** CAARS and Conner's Continuous Performance Test-II  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on a comprehensive clinical evaluation including neuropsychological testing, symptom self-report measures, corroborative interviews with parents or teachers, and confirmation of developmental origin of symptoms  **Diagnosed by:** Specialist (e.g., mental health) Mental health clinicians  **Timing:** Concurrent | **Diagnostic accuracy summary:** The detectability index in Connor's CPT-II had a sensitivity of 17% to detect ADHD and a specificity of 90% for feigning ADHD. Failing 1 or more, 2 or more, 3 or more, 4 or more cognitive feigning test indices lowered the sensitivity from 63 to 50, 47, and 35%, while the specificity increased from 82, to 93, 100%, and 100%. Indicates limited sensitivity in distinguishing ADHD from controls and susceptible to manipulation by feigning participants; results point to a need for a thorough evaluation of history, cognitive and emotional functioning, and the consideration of exaggerated symptomatology in the diagnosis of ADHD.  Sensitivity 63%  Specificity 83%  PPV 78.6  NPV 69.3  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Spenceley, 2022147  N = 150  n ADHD = 30  US  College | **Target:** College students with a prior professional diagnosis of ADHD confirmed through self-report at multiple time points and reporting significant current symptoms of inattention or hyperactivity/impulsivity (at least four symptoms meeting the 95th percentile per a symptom checklist)  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** College students recruited from a midsized public university and a midsized private college, including a control group instructed to respond honestly and a simulated group instructed to feign ADHD symptoms for the purpose of the study  **Female:** 50%  **Age mean (SD):** 19.93 (2.32)  Min age: 18 Max age: 23  **Age subgroup**: Young  **Ethnicity:**  % Hispanic or Latino : 3.3,Other : Simulated ADHD group: 8.3, control group: 3.3  % Black/African American : 3.3,Other : Simulated ADHD group: 13.3, control group: 21.7  % Asian : 0,Other : Simulated ADHD group: 5, control group: 5  % Native Hawaiian or Pacific Islander : 0,Other info : Simulated ADHD group: 1.7, control group: 0  % White : 76.7,Other : Simulated ADHD group: 63.3, control group: 58.3  % Multiracial : 16.7,Other : Simulated ADHD group: 8.3, control group: 11.7  Multicenter  Other funding | **Test description:** Medical Symptom Validity Test admistered together with the Woodcock-Johnson IV Tests of Cognitive Abilities (assess neuropsychological functioning, specifically focusing on processing speed, working memory, and cognitive efficiency as potential markers for feigned ADHD)and the BAARS (Barkley Adult ADHD Rating Scale IV)  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by a physician, psychologist, or other health professional, confirmed through participant self-report at multiple time points and screened with an ADHD symptom checklist to ensure significant current symptoms at or above the 95th percentile  **Diagnosed by:** Specialist (e.g., mental health) The ADHD diagnosis was made by a physician, psychologist, or other mental health professional  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** Medical Symptom Validity Test showed the best performance (AUC 0.89, sensitivity 0.78, specificity 97). Several processing speed and working memory scores from the WJ-IV effectively identified students feigning ADHD, detecting at least 50% of those students at score cutoffs that also maintained specificity of 90% or more, close to the efficiency of the standalone PVT. The study found that individuals simulating ADHD showed significantly lower scores on these measures compared to those with genuine ADHD, suggesting that working memory and processing speed deficits may help detect feigned ADHD.  Sensitivity 78%  Specificity 97%  PPV  NPV  +LR  -LR  Accuracy  AUC 0.89 0.58 - 0.89  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Suhr, 2008148  N = 85  n ADHD = 15  US  Primary care | **Target:** Adults who showed evidence of childhood ADHD symptoms from at least two sources (self-report, parent report, school records, prior medical/psychological records), exhibited clinically significant current ADHD symptoms confirmed by self-report and either collateral report or behavioral observation, and passed the Word Memory Test (WMT) assessing credible performance  **ADHD presentation:** inattentive : 47,combined : 53  **Comorbidity:** N/A  **Other:** Adults with psychological diagnoses other than ADHD who reported no evidence of childhood ADHD-related impairment, had psychological conditions (commonly major depressive disorder), and were evaluated in a university-based psychology specialty clinic.  **Female:** 40%  **Age mean (SD):** 25.4(9.8)  Min age: 18 Max age: 56  **Age subgroup**: Adults  **Ethnicity:**  % Black/African American : 5  % White : 94  % Multiracial : 1  Single center  Funding unclear | **Test description:** WMT (Word Memory Test) used as a symptom validity test to assess noncredible performance by measuring recognition memory under easy conditions with failure cutoffs at ≤82.5% for the first three subtests and ≤70% for the fourth subtest, conducted during neuropsychological evaluation at a university psychology clinic.  Machine learning: No  Validation dataset: N/A  **Reference standard:** Clinical diagnosis  DSM-IV  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Self-report measures (WURS and CAARS) could not reliably distinguish ADHD from psychological controls, with substantial overlap in symptom endorsement between groups.  Neuropsychological tests did not reliably distinguish ADHD from psychological controls, except for the Stroop Interference score where ADHD participants performed worse.  Feigning ADHD was effectively identified by the Word Memory Test (WMT), with a 31% failure rate among referrals, and WMT failure associated with worse neuropsychological performance and higher symptom self-report across groups.  Sensitivity %  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** WMT failure was associated with increased symptom reporting and worse neuropsychological performance, suggesting noncredible performance may distort both self-report and objective cognitive testing results.  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Suhr, 2011149  N = 1297  n ADHD = 71  US  College | **Target:** Participants self-reported a prior ADHD diagnosis were either university students participating in research or individuals seeking psychological evaluation at a university clinic; inclusion required documented evidence of childhood impairment, clinically significant current ADHD symptoms from multiple sources, and passing a cognitive validity test  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** University students without an ADHD diagnosis and individuals seeking psychological evaluation at a university clinic; categorized into a psychological control group (diagnosed with/treatment for a non-ADHD psychological condition or meeting criteria for a psychological disorder) and a normal control group (no history of ADHD or psychological disorders)  **Female:** 47%  **Age mean (SD):**  mean 19  Min age: 18 Max age: 59  **Age subgroup**: Adults  **Ethnicity:** N/A  Single center  Other funding | **Test description:** CII (CAARS Infrequency Index) for detecting feigned ADHD (not for diagnosing ADHD). A cutoff score of ≥21 was used to indicate noncredible symptom reporting  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical evaluation, including evidence of childhood impairment, clinically significant current ADHD symptoms from multiple sources (self-report, behavioral observation, collateral report), and passing a cognitive validity test.  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** The CAARS Infrequency Index (CII) demonstrated moderate sensitivity (30-80%) but high specificity (>99%) in identifying feigned ADHD based on extreme scores on CAARS DSM-IV subscales, with an AUC of 0.92 for the Hyperactive/Impulsive Subscale (F). The Word Memory Test (WMT) showed low sensitivity (24%) but high specificity (95%) for detecting noncredible cognitive performance, distinguishing individuals feigning ADHD from those with genuine ADHD.  Sensitivity 24% CAARS Inattentive Subscale E: 30, Hyperactive/Impulsive Subscale F: 80  Specificity 95% CAARS Inattentive Subscale E: >99, CAARS Hyperactive/Impulsive Subscale F: 93  PPV  NPV  +LR  -LR  Accuracy 67 Distinguishing feigned ADHD vs. genuine ADHD  AUC CAARS E scores: 0.78, CAARS F scores: 0.92  **Concordance:**  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha 0.86  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:**  **Admin time:** | **Subgroup analysis:** Sex  Males scored higher than females on the CAARS Infrequency Index (CII), suggesting possible gender differences in noncredible symptom reporting and a higher cutoff (≥22) may be needed for males to maintain specificity. |
| Walls, 2017156  N = 139  n ADHD = 21  US  College | **Target:** Diagnosed with ADHD before age 12 by a mental health professional, no comorbid psychiatric, neurological, or intellectual disorders, no history of significant brain injury, asked to abstain from stimulant medication for 12 hours prior to testing  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical developing undergraduate students, randomly assigned to honest responding, feigning ADHD, or random responding conditions  **Female:** 42.9%  **Age mean (SD):** 18.90 (0.94)  Min age: 18 Max age: 22  **Age subgroup**: Young  **Ethnicity:** Other : HON: 3.4, FGN: 11.4, FR: 3.6  Other : HON: 3.4, ADHD: 9.5, FGN: 2.9, FR: 7.  Other : HON: 17.2, ADHD: 4.8, FGN: 25.7, HR: 23.1, FR: 10.7  Other : HON: 10.3, , FGN: 5.7, FR: 7.1  Other : HON: 65.5, ADHD: 85.7, FGN: 54.30, HR: 76.9, FR: 71.4  Single center  Other funding | **Test description:** CAARS (Conners’ Adult ADHD Rating Scale), focusing on the validity scales: Inconsistency Index (INC) and Conners' Infrequency Index (CII), used to detect feigned ADHD symptoms; cutoff for CII was ≥21 for identifying feigning, cutoff for INC was ≥8 for random responding  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD by a mental health professional before age 12 based on clinical evaluation  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Prior diagnosis | **Diagnostic accuracy summary:** The CAARS Infrequency Index (CII) demonstrated excellent specificity (95%) but low sensitivity (34%) for distinguishing adults instructed to feign ADHD from adults with a genuine ADHD diagnosis.  The CAARS Inconsistency Index (INC) showed fair to moderate sensitivity (44–63%) and high specificity (86–91%) for detecting random responding among participants.  Sensitivity % INC: .44-.63, CII: .31-.46  Specificity % INC: .86-.91, CII: .91-.95  PPV  NPV  +LR  -LR  Accuracy INC: .69-.76, CII: .57-.69  AUC  **Concordance:** N/A  **Rater agreement:** N/A  Kappa ICC  **Test-retest:** N/A  **Internal consistency:**  Cronbach’s alpha  N/A  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Williamson, 2014159  N = 76  n ADHD = 44  US  College | **Target:** Adults with a history of ADHD diagnosis confirmed by a mental health practitioner based on more than self-reported symptoms, to have received their diagnosis before age 18, and to have abstained from stimulant medication for 12 hours prior to the study. 22 with ADHD only (ADHD-O). 22 with ADHD and comorbid psychological disorder  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Neurotypical individuals without a history of diagnosed or suspected ADHD, learning disorders, neurological disorders, or psychological disorders, recruited from an introductory psychology participant pool or a university disability resource center, with a subset instructed to feign ADHD  **Female:** 36.36%  **Age mean (SD):** 19.05 (1.29)  Min age: 18 Max age: 23  **Age subgroup**: Young  **Ethnicity:** N/A  Single center  Funding unclear | **Test description:** WAIS-IV PSI (Wechsler Adult Intelligence Scale-IV Processing Speed Index) lower than 97, administered together with the Woodcock-Johnson III Test of Achievement, and the CTIP (Computerized Test of Information Processing) assessed cognitive abilities such as processing speed, reading fluency, and attention control under controlled conditions  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on evaluation by a mental health practitioner using clinical interviews, self-report symptom scales, and cognitive or neuropsychological testing, with diagnosis required to be established before age 18  **Diagnosed by:** Specialist (e.g., mental health)  **Timing:** Concurrent | **Diagnostic accuracy summary:** Sensitivity of the WAIS-IV PSI was 65% for feigning ADHD, specificity for detecting ADHD decreased from 73% to 59% in a subgroup of participants with comorbidity. Performance validity tests such as the Test of Memory Malingering (TOMM), the Letter Memory Test (LMT), and the Nonverbal Medical Symptom Validity Test (NV-MSVT) were effective in differentiating both ADHD groups from normal participants feigning ADHD.  Sensitivity 65%  Specificity %  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:**  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |
| Young, 2011162  N = 69  n ADHD = 34  US  College | **Target:** Adults aged 18-25 diagnosed with ADHD through clinical interviews, third-person symptom reports, intelligence and achievement measures, personality questionnaires, behavior checklists, and team-based faculty-supervised assessments at a campus psychological assessment center  **ADHD presentation:** N/A  **Comorbidity:** N/A  **Other:** Clinical sample and neurotypical adults recruited from a university setting, including a control group with no history of ADHD or psychological disorders and a malingering group instructed to feign ADHD symptoms  **Female:** % MMPI-2: 21 female (30.4%); WAIS-III 9 female (26.5%)  **Age mean (SD):**  MMPI-2: 18.97 (1.29); WAIS-III: 20.29 (1.87)  Min age: 18 Max age: 25  **Age subgroup**: Young  **Ethnicity:**  Other : MMPI-2: 1%  Other : MMPI-2: 20%; WAIS-III: 3%  Other info : MMPI-2: 6%  Other : MMPI-2: 72%; WAIS-III: 97%  Single center  Funding unclear | **Test description:** The MMPI-2 (Minnesota Multiphasic Personality Inventory-2), focusing on validity scales such as the Infrequency-Psychopathology (Fp), Fake Bad Scale (FBS), Response Bias Scale (RBS), and Henry–Heilbronner Index (HHI) to detect response bias and differentiate between genuine ADHD and malingering.  Machine learning: No  Validation dataset: No  **Reference standard:** Clinical diagnosis  Diagnosed with ADHD based on clinical interviews, third-person symptom reports, intelligence and achievement measures, personality questionnaires, and behavior checklists conducted by a faculty-supervised assessment team at a campus psychological assessment center  **Diagnosed by:** Specialist (e.g., mental health) Faculty-supervised assessment team at a campus psychological assessment center  **Timing:** Concurrent | **Diagnostic accuracy summary:** The MMPI-2 offers a number of validity indices that may assist in detecting individuals attempting to feign ADHD.  Sensitivity 59% Sensitivity was calculated for the Infrequency-Psychopathology (Fp) scale at a cutoff of ≥5, which showed the highest balance of sensitivity and specificity among the MMPI-2 validity scales.  Specificity 94% Specificity was calculated for the Fp scale at a cutoff of ≥5 and was the highest among scales evaluated in this study.  PPV  NPV  +LR  -LR  Accuracy  AUC  **Concordance:** N/A  **Rater agreement:** Compares self-reported ADHD symptoms with MMPI-2 validity scale results  Kappa ICC  **Test-retest:**  **Internal consistency:**  Cronbach’s alpha  **Misdiagnosis impact:** N/A  **Diagnosis impact:** N/A  **Labeling:** N/A  **Side effects:** N/A  **Cost:** N/A  **Admin time:** N/A | **Subgroup analysis:** N/A |

Appendix D. Critical Appraisal and Applicability Tables

Table D.1. Critical appraisal for included studies

| **Author, year** | **Patient selection and confounding** | **Tool/Index test** | **Reference standard** | **Flow and timing** | **Overall RoB** |
| --- | --- | --- | --- | --- | --- |
| Abramson, 202344 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Adamou, 202245 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Aita, 201846 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Amen, 200847 | High risk | High risk | Low risk | High risk | High risk |
| Amen, 202148 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Andrikopoulos, 202449 | High risk | High risk | Low risk | High risk | High risk |
| Baghdassarian, 201889 | Low risk | High risk | Low risk | High risk | High risk |
| Bakare, 202050 | Low risk | Low risk | Low risk | High risk | High risk |
| Bastiaens, 201751 | Low risk | Low risk | Unclear risk | Low risk | Moderate risk |
| Becke, 202352 | Low risk | High risk | Unclear risk | High risk | Moderate risk |
| Berger, 202153 | Low risk | Low risk | Low risk | Low risk | Low risk |
| Biederman, 201754 | High risk | High risk | Low risk | High risk | Moderate risk |
| Brunkhorst-Kanaan, 202055 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Chaim-Avancini, 201756 | Low risk | Low risk | Low risk | Low risk | Moderate risk |
| Chen, 202157 | Low risk | Low risk | Low risk | Low risk | Low risk |
| Chiasson, 201258 | High risk | High risk | Low risk | Low risk | Moderate risk |
| Cohen, 200759 | High risk | High risk | High risk | Unclear risk | High risk |
| Cook, 201660 | High risk | High risk | Low risk | High risk | High risk |
| Courrege, 201961 | High risk | High risk | High risk | High risk | High risk |
| Dakwar, 201262 | High risk | High risk | Low risk | Low risk | Moderate risk |
| De Quiros, 200163 | Unclear risk | High risk | Low risk | High risk | High risk |
| Dunlop, 201864 | High risk | High risk | Low risk | High risk | High risk |
| Dvorsky, 201665 | High risk | High risk | Low risk | Low risk | Moderate risk |
| Edebol, 201266 | High risk | High risk | Low risk | High risk | High risk |
| Elbaum, 202068 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Emser, 201869 | High risk | High risk | Low risk | High risk | High risk |
| Erhardt, 199970 | Unclear risk | High risk | Low risk | High risk | High risk |
| Faraone, 201071 | High risk | High risk | Low risk | Unclear risk | Moderate risk |
| Finley, 202372 | Low risk | High risk | Low risk | High risk | Moderate risk |
| Fuermaier, 201674 | High risk | High risk | Low risk | Unclear risk | Moderate risk |
| Galloway-Long, 202275 | Low risk | High risk | Low risk | High risk | Moderate risk |
| Grogan, 201877 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Groom, 201678 | Unclear risk | Unclear risk | Low risk | Unclear risk | Moderate risk |
| Grünblatt, 201279 | Unclear risk | Unclear risk | Low risk | Unclear risk | Moderate risk |
| Hadas, 202180 | Unclear risk | Unclear risk | High risk | Unclear risk | Moderate risk |
| Harp, 201181 | High risk | High risk | Low risk | High risk | High risk |
| Harrison, 200784 | High risk | High risk | Low risk | High risk | High risk |
| Harrison, 201682 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Harrison, 201985 | High risk | High risk | High risk | High risk | High risk |
| Harrison, 201986 | High risk | High risk | Low risk | Low risk | High risk |
| Harrison, 202083 | High risk | High risk | Low risk | High risk | High risk |
| Houston, 201187 | Low risk | Low risk | Low risk | Low risk | Low risk |
| Jimenez, 202188 | High risk | Low risk | Low risk | High risk | High risk |
| Katz, 199890 | High risk | High risk | Low risk | High risk | High risk |
| Kaur, 202091 | High risk | Low risk | Low risk | High risk | Moderate risk |
| Kessler, 200592 | Low risk | High risk | Low risk | Unclear risk | Moderate risk |
| Kessler, 200793 | High risk | High risk | Low risk | Unclear risk | High risk |
| Kessler, 201094 | High risk | Low risk | Low risk | Unclear risk | Moderate risk |
| Khan, 202295 | Low risk | High risk | Low risk | Unclear risk | Moderate risk |
| Kiiski, 202096 | Low risk | Low risk | Low risk | Low risk | Low risk |
| Kim, 202197 | Low risk | Low risk | Low risk | Low risk | Low risk |
| Kingston, 201398 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Kovner, 199899 | High risk | High risk | Low risk | High risk | High risk |
| Kumar, 2011100 | Unclear risk | Unclear risk | High risk | Unclear risk | High risk |
| Kwan, 2024101 | High risk | High risk | Low risk | High risk | High risk |
| Lancaster, 2018102 | High risk | High risk | Low risk | High risk | High risk |
| Lee Booksh, 2010103 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Lev, 2022104 | High risk | High risk | Low risk | High risk | High risk |
| Lewandowski, 2008105 | High risk | High risk | Low risk | High risk | High risk |
| Liu, 2023106 | High risk | High risk | Low risk | High risk | High risk |
| Lovejoy, 1999107 | High risk | High risk | Low risk | High risk | High risk |
| Luty, 2009108 | High risk | Unclear risk | Low risk | Unclear risk | Moderate risk |
| Marchant, 2015109 | Unclear risk | High risk | Unclear risk | High risk | High risk |
| Marshall, 2010110 | High risk | High risk | High risk | High risk | High risk |
| McCann, 2004111 | High risk | High risk | Low risk | High risk | High risk |
| Mehringer, 2002112 | High risk | High risk | Low risk | Low risk | Moderate risk |
| Morey, 2019113 | Unclear risk | High risk | High risk | High risk | High risk |
| Mostert, 2015114 | Low risk | High risk | Low risk | High risk | Moderate risk |
| Mueller, 2011115 | Low risk | Low risk | Low risk | High risk | Moderate risk |
| Mueller, 2020116 | Low risk | Low risk | Low risk | Unclear risk | Low risk |
| Musso, 2016117 | High risk | High risk | Low risk | High risk | High risk |
| Nielsen, 2011118 | High risk | High risk | Low risk | High risk | High risk |
| Nikolas, 2019119 | Unclear risk | High risk | Low risk | High risk | Moderate risk |
| Palma-Alvarez, 2023121 | Low risk | High risk | Low risk | Low risk | Moderate risk |
| Palmer, 2023122 | Low risk | High risk | Low risk | Low risk | Moderate risk |
| Pettersson, 2018123 | Low risk | High risk | High risk | High risk | High risk |
| Phillips, 2023124 | High risk | High risk | Low risk | High risk | High risk |
| Poil, 2014125 | Unclear risk | High risk | Low risk | High risk | High risk |
| Ponomarev, 2014126 | Unclear risk | High risk | Low risk | High risk | High risk |
| Potts, 2022127 | High risk | High risk | Low risk | High risk | High risk |
| Quinn, 2003128 | Unclear risk | High risk | Low risk | Unclear risk | Moderate risk |
| Ramachandran, 2019129 | Unclear risk | High risk | High risk | High risk | High risk |
| Reimherr, 2021130 | High risk | High risk | Low risk | High risk | High risk |
| Reyes, 2019131 | Low risk | Low risk | Low risk | Unclear risk | Low risk |
| Robeva, 2004132 | High risk | High risk | Unclear risk | High risk | High risk |
| Robinson, 2023133 | Unclear risk | High risk | Unclear risk | High risk | High risk |
| Rogers, 2021134 | High risk | High risk | Low risk | High risk | High risk |
| Roy-Byrne, 1997135 | High risk | High risk | Unclear risk | High risk | High risk |
| Schneider, 2014136 | High risk | High risk | High risk | High risk | High risk |
| Schreiber, 1999137 | High risk | High risk | Low risk | High risk | High risk |
| Selek, 2012138 | High risk | High risk | Low risk | High risk | High risk |
| Shahaf, 2012139 | Unclear risk | High risk | Low risk | High risk | High risk |
| Shepler, 2024140 | High risk | High risk | Low risk | High risk | High risk |
| Singh, 2015141 | High risk | High risk | Low risk | High risk | High risk |
| Skirrow, 2013142 | High risk | Low risk | Low risk | High risk | High risk |
| Smith, 2017143 | High risk | High risk | Low risk | High risk | High risk |
| Soederstroem, 2014144 | High risk | High risk | Low risk | High risk | High risk |
| Solanto, 2004145 | High risk | High risk | Low risk | High risk | High risk |
| Sollman, 2010146 | Low risk | Low risk | Low risk | High risk | Low risk |
| Spenceley, 2022147 | High risk | High risk | High risk | High risk | High risk |
| Suhr, 2008148 | High risk | High risk | Unclear risk | High risk | High risk |
| Suhr, 2011149 | High risk | High risk | Low risk | High risk | High risk |
| Udal, 2024150 | Unclear risk | High risk | Low risk | Unclear risk | Moderate risk |
| Unal, 2019151 | Unclear risk | Unclear risk | High risk | Unclear risk | High risk |
| Ustun, 2017152 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| van de Glind, 2013153 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Van Voorhees, 2011154 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Vizgaitis, 2023155 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Walls, 2017156 | High risk | High risk | Unclear risk | High risk | High risk |
| Wang, 2013157 | Unclear risk | Unclear risk | High risk | Unclear risk | Moderate risk |
| Wiig, 2012158 | High risk | High risk | Low risk | High risk | High risk |
| Williamson, 2014159 | High risk | High risk | Low risk | High risk | High risk |
| Woods, 2002160 | Unclear risk | Unclear risk | Low risk | Unclear risk | Moderate risk |
| Yao, 2018161 | Unclear risk | High risk | Low risk | High risk | High risk |
| Young, 2011162 | Unclear risk | High risk | Low risk | High risk | High risk |
| Young, 2016164 | Unclear risk | Unclear risk | Unclear risk | Unclear risk | Moderate risk |
| Young, 2023163 | High risk | High risk | Low risk | High risk | High risk |

Table D.2. Applicability ratings for included studies

| **Author, year** | **Population** | **Test** | **Reference standard** | **Outcome** | **Setting** |
| --- | --- | --- | --- | --- | --- |
| Abramson, 202344 | N/A | N/A | N/A | N/A | N/A |
| Adamou, 202245 | N/A | N/A | N/A | N/A | N/A |
| Aita, 201846 | N/A | N/A | N/A | N/A | N/A |
| Amen, 200847 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Amen, 202148 | N/A | N/A | N/A | N/A | N/A |
| Andrikopoulos, 202449 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | Level of care different from that in the community |
| Baghdassarian, 201889 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Bakare, 202050 | N/A | N/A | N/A | N/A | Level of care different from that in the community |
| Bastiaens, 201751 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Becke, 202352 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Berger, 202153 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Biederman, 201754 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Brunkhorst-Kanaan, 202055 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Chaim-Avancini, 201756 | Narrow eligibility criteria | Highly selected team or test not representative | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Chen, 202157 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Chiasson, 201258 | More complex patients than typical of the community | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Cohen, 200759 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Cook, 201660 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Courrege, 201961 | Narrow eligibility criteria | Test not used as common in current practice | Other | Surrogate outcomes | Level of care different from that in the community |
| Dakwar, 201262 | More complex patients than typical of the community | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| De Quiros, 200163 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Dunlop, 201864 | More complex patients than typical of the community | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Dvorsky, 201665 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Edebol, 201266 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Elbaum, 202068 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | N/A |
| Emser, 201869 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Erhardt, 199970 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Faraone, 201071 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Finley, 202372 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Fuermaier, 201674 | More complex patients than typical of the community | Test not used as common in current practice | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Galloway-Long, 202275 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Grogan, 201877 | More complex patients than typical of the community | N/A | N/A | N/A | N/A |
| Groom, 201678 | Narrow eligibility criteria | N/A | N/A | N/A | N/A |
| Grünblatt, 201279 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | N/A |
| Hadas, 202180 | Narrow eligibility criteria | Treatment may distort test results | Other | Other issues | N/A |
| Harp, 201181 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Harrison, 200784 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Harrison, 201682 | Narrow eligibility criteria | N/A | N/A | N/A | N/A |
| Harrison, 201985 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Harrison, 201986 | N/A | N/A | N/A | N/A | N/A |
| Harrison, 202083 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Houston, 201187 | N/A | N/A | N/A | N/A | N/A |
| Jimenez, 202188 | Narrow eligibility criteria | Highly selected team or test not representative | N/A | Surrogate outcomes | Level of care different from that in the community |
| Katz, 199890 | N/A | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Kaur, 202091 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | Level of care different from that in the community |
| Kessler, 200592 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | N/A |
| Kessler, 200793 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | N/A |
| Kessler, 201094 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | Level of care different from that in the community |
| Khan, 202295 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Kiiski, 202096 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | Level of care different from that in the community |
| Kim, 202197 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Kingston, 201398 | N/A | N/A | N/A | N/A | N/A |
| Kovner, 199899 | Narrow eligibility criteria | Highly selected team or test not representative | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Kumar, 2011100 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | N/A |
| Kwan, 2024101 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Lancaster, 2018102 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Lee Booksh, 2010103 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | N/A |
| Lev, 2022104 | Narrow eligibility criteria | Test not used as common in current practice | N/A | N/A | Level of care different from that in the community |
| Lewandowski, 2008105 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Liu, 2023106 | More complex patients than typical of the community | N/A | N/A | N/A | Level of care different from that in the community |
| Lovejoy, 1999107 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Luty, 2009108 | More complex patients than typical of the community | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Marchant, 2015109 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Marshall, 2010110 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| McCann, 2004111 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Mehringer, 2002112 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Morey, 2019113 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Mostert, 2015114 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Mueller, 2011115 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Mueller, 2020116 | N/A | N/A | N/A | N/A | Level of care different from that in the community |
| Musso, 2016117 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Nielsen, 2011118 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Nikolas, 2019119 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Palma-Alvarez, 2023121 | More complex patients than typical of the community | N/A | N/A | N/A | Level of care different from that in the community |
| Palmer, 2023122 | More complex patients than typical of the community | N/A | N/A | N/A | Level of care different from that in the community |
| Pettersson, 2018123 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Phillips, 2023124 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Poil, 2014125 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Ponomarev, 2014126 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Potts, 2022127 | Narrow eligibility criteria | N/A | N/A | N/A | Level of care different from that in the community |
| Quinn, 2003128 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Ramachandran, 2019129 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Reimherr, 2021130 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Reyes, 2019131 | More complex patients than typical of the community | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Robeva, 2004132 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Robinson, 2023133 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Rogers, 2021134 | Narrow eligibility criteria | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Roy-Byrne, 1997135 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Schneider, 2014136 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Schreiber, 1999137 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Selek, 2012138 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Shahaf, 2012139 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Shepler, 2024140 | More complex patients than typical of the community | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Singh, 2015141 | More complex patients than typical of the community | Test not used as common in current practice | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Skirrow, 2013142 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Smith, 2017143 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Soederstroem, 2014144 | More complex patients than typical of the community | Test not used as common in current practice | N/A | Surrogate outcomes | Level of care different from that in the community |
| Solanto, 2004145 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Sollman, 2010146 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Spenceley, 2022147 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Suhr, 2008148 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Suhr, 2011149 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Udal, 2024150 | Narrow eligibility criteria | N/A | N/A | Surrogate outcomes | Level of care different from that in the community |
| Unal, 2019151 | N/A | N/A | N/A | N/A | N/A |
| Ustun, 2017152 | N/A | N/A | N/A | N/A | N/A |
| van de Glind, 2013153 | More complex patients than typical of the community | N/A | DSM-5 diagnosis unclear | Other issues | N/A |
| Van Voorhees, 2011154 | More complex patients than typical of the community | N/A | N/A | N/A | N/A |
| Vizgaitis, 2023155 | More complex patients than typical of the community | N/A | N/A | N/A | N/A |
| Walls, 2017156 | Narrow eligibility criteria | N/A | DSM-5 diagnosis unclear | N/A | Level of care different from that in the community |
| Wang, 2013157 | More complex patients than typical of the community | N/A | DSM-5 diagnosis unclear | N/A | N/A |
| Wiig, 2012158 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Williamson, 2014159 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Woods, 2002160 | Narrow eligibility criteria | N/A | N/A | N/A | N/A |
| Yao, 2018161 | Narrow eligibility criteria | Highly selected team or test not representative | N/A | Surrogate outcomes | Level of care different from that in the community |
| Young, 2011162 | Narrow eligibility criteria | Test not used as common in current practice | DSM-5 diagnosis unclear | Surrogate outcomes | Level of care different from that in the community |
| Young, 2016164 | Narrow eligibility criteria | N/A | N/A | N/A | N/A |
| Young, 2023163 | Narrow eligibility criteria | Highly selected team or test not representative | N/A | N/A | Level of care different from that in the community |