Diagnostic Accuracy of Rating Scales for Attention-Deficit/Hyperactivity Disorder: A Meta-analysis

Ling-Yin Chang, PhD,* Mei-Yeh Wang, PhD,† Pei-Shan Tsai, PhD

abstract

CONTEXT: The Child Behavior Checklist–Attention Problem (CBCL-AP) scale and Conners Rating Scale–Revised (CRS-R) are commonly used behavioral rating scales for diagnosing attention-deficit/hyperactivity disorder (ADHD) in children and adolescents.

OBJECTIVE: To evaluate and compare the diagnostic performance of CBCL-AP and CRS-R in diagnosing ADHD in children and adolescents.

DATA SOURCES: PubMed, Ovid Medline, and other relevant electronic databases were searched for articles published up to May 2015.

STUDY SELECTION: We included studies evaluating the diagnostic performance of either CBCL-AP scale or CRS-R for diagnosing ADHD in pediatric populations in comparison with a defined reference standard.

DATA EXTRACTION: Bivariate random effects models were used for pooling and comparing diagnostic performance.

RESULTS: We identified and evaluated 14 and 11 articles on CBCL-AP and CRS-R, respectively. The results revealed pooled sensitivities of 0.77, 0.75, 0.72, and 0.83 and pooled specificities of 0.73, 0.75, 0.84, and 0.84 for CBCL-AP, Conners Parent Rating Scale–Revised, Conners Teacher Rating Scale–Revised, and Conners Abbreviated Symptom Questionnaire (ASQ), respectively. No difference was observed in the diagnostic performance of the various scales. Study location, age of participants, and percentage of female participants explained the heterogeneity in the specificity of the CBCL-AP.

CONCLUSIONS: CBCL-AP and CRS-R both yielded moderate sensitivity and specificity in diagnosing ADHD. According to the comparable diagnostic performance of all examined scales, ASQ may be the most effective diagnostic tool in assessing ADHD because of its brevity and high diagnostic accuracy. CBCL is recommended for more comprehensive assessments.

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Dr Chang conceptualized and designed the study, performed the analyses, and drafted the initial manuscript; Professor Wang participated in the study selection and data extraction process, conducted the quality assessment of the study, and reviewed and revised the manuscript; Professor Tsai participated in the study design, coordinated and supervised data collection, and critically reviewed and revised the manuscript; and all authors approved the final manuscript and are accountable for all aspects of the study.

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Attention-deficit/hyperactivity disorder (ADHD), the most prevalent neurodevelopmental disorder among children and adolescents, affects ∼5 in 100 children in the United States.1 The prevalence of ADHD increased by an average 3% annually from 1997 to 2006 and an average ∼5% annually from 2003 to 2011.2 ADHD symptoms can cause functional impairments in numerous settings, such as schools, homes, and communities.3 For example, several negative outcomes, such as poor peer relationships,4 high risk of injury,5 and low academic performance,6 have been associated with ADHD. ADHD considerably affects the society and economy.7,8 Therefore, it is crucial to identify children and adolescents with ADHD so that appropriate treatments and interventions can be applied for preventing the adverse consequences associated with this disorder.

Diagnostic criteria for identifying ADHD are based on behavioral symptoms, because of the lack of reliable biological markers for diagnosing ADHD.9 Behavior rating scales, which comprise checklists that examine various behaviors and symptoms, are the most common ADHD assessment tools in schools and communities because of their uncomplicated administration and high time- and cost-efficiency.10

The Child Behavior Checklist (CBCL)11 and Conners Rating Scale–Revised (CRS-R)12 are commonly used diagnostic tools for identifying ADHD in children and adolescents because of their adequately established reliability and validity. CBCL is a parent-rated questionnaire for assessing a wide range of child emotional and behavioral problems. The CBCL-Attention Problem (CBCL-AP) subscale, 1 of the 8 empirically derived clinical syndrome subscales of the CBCL, is frequently used as a diagnostic tool for ADHD and has strong discriminatory power for detecting ADHD in children and adolescents.13,14 In contrast to CBCL, CRS-R is specifically designed for assessing ADHD and its related behavioral problems in children and adolescents (ages 3 to 17 years). CRS-R includes both long and short versions of parent and teacher rating scales as well as various subscales—namely oppositional, cognitive problem or inattention, and hyperactivity subscales—and an ADHD index. Furthermore, an abridged version of CRS-R, the Conners Abbreviated Symptom Questionnaire (ASQ), contains 10 identical items for parent and teacher rating scales.

Despite the availability of several comprehensive reviews on the psychometric properties of CBCL and CRS-R,10,15–18 the sensitivity, specificity, and diagnostic odds ratio (DOR) of these tools, indicative of their diagnostic performance, have been rarely examined. To the best of our knowledge, no meta-analyses have reported pooled estimates of the diagnostic accuracy of CBCL-AP and CRS-R. Moreover, no published systematic review has compared the diagnostic performance of CBCL-AP and CRS-R. Therefore, in this study, we identified and compared the diagnostic accuracy of these 2 ADHD diagnostic tools in children and adolescents. Our findings can help clinicians make more informed decisions regarding the selection of the most suitable rating scales for assessments. Rating scales with a comparatively high accuracy can facilitate early detection of ADHD and ensure timely treatment.

METHODS

Data Sources and Search
We conducted this study according to the recommendations of the Cochrane Collaboration Diagnostic Test Accuracy Working Group. We searched for studies in 6 databases: PubMed, Ovid Medline, Embase, Cumulative Index to Nursing and Allied Health Literature, PsycINFO, and Web of Science. All search processes were conducted from January 30, 2015, to May 21, 2015. We used a combination of MeSH terms and keywords pertaining to ADHD (“attention-deficit hyperactivity disorder” OR “ADHD” OR “hyperkinetic disorder”), diagnostic accuracy (“sensitivity” OR “specificity” OR “AUC” OR “ROC” OR “predictive value” OR “diagnostic accuracy” OR “diagnostic performance” OR “diagnostic utility”), AND the name of the reviewed scale (“CBCL” OR “Child Behavior Checklist” OR “Conners” OR “CPRS” OR “CTRS” OR “ASQ”). Additional eligible studies were identified by manually searching the reference lists of all the included studies.

Study Selection

Titles and abstracts were independently screened by 2 reviewers (Drs Chang and Wang). After the exclusion of duplicates from the eligible articles, full-text articles were retrieved and reviewed. The following criteria were considered for study inclusion: type of study, participants, index test, target condition, and reference standards. Studies were excluded if they failed to meet the inclusion criteria or if essential information was missing and could not be obtained from the authors.

Types of Studies

Cross-sectional, cohort, and case-control studies were included. These studies evaluated the diagnostic accuracy of the reviewed behavioral rating scale in assessing ADHD in children and adolescents in comparison with a defined reference standard. The studies were included irrespective of publication status and language.
Participants
Studies in which the study populations were children and adolescents aged 3 to 18 years were included. Participants were not restricted to specific settings; specifically, participants from both clinical and community settings were included.

Index Test
Studies evaluating CBCL-AP or CRS-R were included.

Target Condition
We included studies on all ADHD types: predominantly inattentive, predominantly hyperactive–impulsive, and combined.

Reference Standard
The reference standard was a clinical examination performed by qualified professionals, psychiatrists, nurses, and other trained personnel by using criterion of Diagnostic and Statistical Manual of Mental Disorders, Third Edition and Fourth Edition and International Classification of Diseases, Ninth Revision, Clinical Modification and Tenth Revision, Clinical Modification.

Data Extraction
Data were independently extracted by 2 reviewers (Drs Chang and Wang), and they resolved any discrepancies through discussion. The extracted study characteristics are listed in Supplemental Table 3. Furthermore, we recorded the number of true-positive, true-negative, false-positive, and false-negative results to construct a 2 × 2 table for each study. If such data were unavailable, we attempted to derive them from summary statistics, such as sensitivity, specificity, or likelihood ratios, if reported. When studies reported different cutoff values for an index test, data from the optimal cutoff value were extracted. If a study presented different index test cutoff values for male and female participants, the data of the different genders were analyzed separately.

Quality Assessment
The 2 reviewers individually conducted a quality assessment for each included study by using the revised version of the Quality Assessment of Diagnostic Accuracy Studies (QUADAS-2) tool. This tool comprises 4 key domains: patient selection, index test, reference standard, and flow and timing. Each domain was assessed in terms of the risk of bias, and the first 3 domains were also assessed for concern regarding applicability to the research question. Any disagreements between the reviewers were resolved through discussion and by consulting the corresponding author, if necessary.

Statistical Analysis
Data analyses were performed by using Review Manager 5.2, Stata Version 13 (metandi and midas commands), and SAS Version 9.3.

Data Synthesis
Diagnostic data from each study were fitted in a bivariate random effects model,19 which estimates pairs of logit-transformed sensitivity and specificity from studies and considers the correlation between the sensitivity and specificity observed among studies.20 We also estimated pooled sensitivity, specificity, likelihood ratios (LRs), and DORs. DORs, defined as the odds of obtaining a positive test result in patients with a disease compared with the odds of obtaining a positive test result in participants without a disease, were computed as positive LRs (LR+) divided by negative LRs (LR–).21 Statistical differences in sensitivity, specificity, and DORs between different scales were further examined to compare the diagnostic performance of the selected diagnostic tools. We plotted hierarchical summary receiver operating characteristic (HSROC) curves and estimated the corresponding areas under the curves (AUCs), which measure global diagnostic accuracy by estimating the probability of accurately classifying a randomly selected participant as a case or a control.22 According to the guidelines for interpreting AUC values,22 the diagnostic accuracy of a test was categorized as low, moderate, and high when AUC values were 0.5–0.7, 0.7–0.9, and 0.9–1.0, respectively.

Heterogeneity Evaluation
The heterogeneity of the diagnostic test parameters was evaluated by using R statistics, with 0% and >50% indicating no observed heterogeneity and substantial heterogeneity, respectively.23 The threshold effect was an essential source of heterogeneity in this meta-analysis. To determine whether a threshold effect existed, we calculated the Spearman correlation between sensitivity and specificity.24 A significant negative correlation (P < .05) suggested a threshold effect. We explored other sources of heterogeneity in pooled sensitivity and specificity by including the following study characteristics, one at a time, into a bivariate random effects model: sample sources, study location, number of participants, cutoff values, study year, age of participants, percentage of female participants, and QUADAS-2 items. LR tests were performed to determine the statistical significance of the results.

Publication Bias
Publication bias was detected by regressing log DORs on the inverse root of the effective sample size26 to examine funnel plot asymmetry, with P < .10 for the slope coefficient indicating significant asymmetry.

Sensitivity Analyses
We performed sensitivity analyses to examine the robustness of the
results. First, we examined for a particularly influential study by using the Cook distance and generated a scatter plot for identifying outliers by using standardized predicted random effects (standardized level 2 residuals). Outliers and highly influential studies were individually excluded from the model to examine the robustness of the results.27

RESULTS

Search Results

Figure 1 illustrates a flow diagram of the current systematic review and meta-analysis. The initial search identified 1037 articles, of which 70 full-text articles were reviewed. Of these potentially eligible articles, 31 were excluded for lack of sufficient information to construct 2 × 2 tables, 6 were excluded for reporting unrelated diagnostic tools, and 4 were excluded for involving different reference standards. We also excluded 4 studies that included various modified versions of CRS-R. The search results allowed us to conduct meta-analyses only for the Conners Parent Rating Scale–Revised Short Form (CPRS-R:S), Conners Teacher Rating Scale-Revised Short Form (CTRS-R:S), and ASQ, each of which was used in >3 studies. Therefore, we conducted a systematic review and meta-analysis on the remaining 25 articles.13,28–51

Study Characteristics

Supplemental Table 3 shows a summary of the characteristics of the 25 studies. Fourteen and 11 studies reported accuracy estimates for CBCL-AP and CRS-R, respectively; 1 study applied CPRS-R:S alone, 2 applied CTRS-R:S alone, 5 applied ASQ alone, and 3 applied both CTRS-R:S and CPRS-R:S for ADHD assessment in children and adolescents. Because of the limited number of studies examining the diagnostic performance of CRS-R, diagnostic accuracy estimates were extracted and pooled only from the ADHD index within CPRS-R:S and CTRS-R:S. Information from other CRS-R subscales were not used for generating the pooled diagnostic performance.

Among the 25 analyzed studies, 10 recruited participants from clinical settings only, 11 recruited participants from community or school settings only, and the rest recruited participants from both communities and clinical settings. These studies were published from 1991 to 2015. Approximately half of the studies (n = 11) were conducted in the United States. The total number of participants ranged from 18 to 763, ages 5.50 to 14.59 years. The percentage of female participants ranged from 0% to 54%. Various cutoff values were used for each included scale.

Supplemental Figure 6 shows methodological quality assessments of the reviewed studies according to the QUADAS-2 tool. Regarding patient selection, studies were categorized as low or high risk on the basis of the following criteria: lack of a random or consecutive sample, a case-control design, or an inappropriate exclusion of participants. Of the 25 studies, 11 were low risk and the rest were high risk. Regarding index tests, approximately half of the studies (n = 13) had a low risk of bias for not applying a prespecified threshold and interpreting the index test results without a knowledge of the reference standard results. Only 1 study had a high risk of bias in the reference standard domain. Finally, 9 studies had a high risk of bias for flow and timing because they did not apply the reference standard to all participants.
or failed to include all participants in the analysis.

**Meta-Analysis**

**Pooled Performance**

Figure 2 illustrates a forest plot of the coupled sensitivity and specificity with 95% confidence intervals (CIs) for each study included in this meta-analysis. Table 1 shows a summary of the pooled estimates of the sensitivity, specificity, LR+, LR−, and DORs obtained from the bivariate model for each diagnostic tool. Among the studies on CBCL-AP, the pooled sensitivity, specificity, and DOR were 0.77 (95% CI 0.69–0.84), 0.73 (95% CI 0.64–0.81), and 9.37 (95% CI 5.71–15.38), respectively. For CRS-R, 83% of participants with ADHD were accurately identified using ASQ (95% CI 0.59–0.95), whereas 75% were identified using CPRS-R:S (95% CI 0.64–0.84) and 72% using CTRS-R:S (95% CI 0.63–0.79). Regarding specificity, 84% of participants without ADHD were accurately identified by using ASQ and CTRS-R:S (95% CI 0.68–0.93 and 0.69–0.93, respectively), whereas 75% were identified using CPRS-R:S (95% CI 0.64–0.84). In addition, pooled DORs for CPRS-R:S, CTRS-R:S, and ASQ were 8.95, 13.68, and 26.72, respectively. No significant differences were observed in sensitivity, specificity, or DORs for any of the assessed tools (all P > .05, Table 1).

Figure 3 shows HSROC curves and associated AUCs for the included diagnostic tools. The AUCs were 0.82, 0.81, 0.82, and 0.90 for CBCL-AP, CPRS-R:S, CTRS-R:S, and ASQ, respectively. The prediction region, which indicates the area most likely to contain the true mean test accuracy values of the sensitivity and specificity for each diagnostic tool, can be used as a means of illustrating the extent of statistical heterogeneity. Heterogeneity was observed in the included studies, with a higher heterogeneity in sensitivity than in specificity for CBCL-AP and CPRS-R:S (Fig 3). Conversely, a higher heterogeneity was observed in specificity than in sensitivity for CTRS-R:S and ASQ. The results of the bivariate model revealed substantial heterogeneity among studies for each diagnostic tool (all R² > 50%).

**Sources of Heterogeneity**

The nonsignificant Spearman correlations between sensitivity and specificity of the reviewed scales (all P > .05) suggested the lack of a threshold effect in the present meta-analysis (correlation coefficients for CBCL-AP, CPRS-R:S, CTRS-R:S, and ASQ were −0.31, 0.8, 0.6, and 0.5, respectively). Table 2 shows the sources of heterogeneity in studies examining the diagnostic performance of CBCL-AP. Because the number of included studies was low, analyses were not performed for other included diagnostic tools. CBCL-AP specificity was significantly higher in studies conducted in the United States than in those conducted in other countries (0.81 and 0.64, respectively; P = .03) and in older participants (age ≥11 years) than in younger ones (<11 years) (0.84 and 0.63, respectively; P < .01). Compared with studies with a lower percentage of female participants (<35%), those with a higher percentage (≥35%) demonstrated a significantly higher specificity (0.64 and 0.83, respectively; P = .04). No statistical significance in sensitivity or specificity was observed between other subgroups, namely sample sources (clinic versus nonclinic), number of participants (≥200 vs <200), cut-off value (≥65 vs <65), study year (before 2005 vs after 2005), and study quality (high vs low risk), indicating that these subgroups are unlikely sources of heterogeneity.

**Publication Bias**

Figure 4 illustrates funnel plots with superimposed regression lines for each included diagnostic tool. The statistically nonsignificant P values (.61, .56, .47, and .85 for CBCL-AP, CPRS-R:S, CTRS-R:S, and ASQ, respectively) for the slope coefficient suggest symmetry in data and a low likelihood of publication bias.

**Sensitivity Analyses**

Based on the Cook distance, studies conducted by Roessner et al44 and Gargaro et al36 were the most influential (Fig 5) for CBCL-AP and CPRS-R:S, respectively. However, only Roessner et al44 was identified as an outlier, with the highest standardized residuals for sensitivity (Fig 5). After we excluded this study and refitted the model for CBCL-AP, we observed no changes in specificity (0.75 vs 0.75); however, the sensitivity dropped from 0.77 to 0.74.

**DISCUSSION**

The current study is the first systematic review and meta-analysis assessing and comparing the diagnostic performance of CBCL-AP and CRS-R in diagnosing ADHD in children and adolescents. Our results suggest that CBCL-AP and CRS-R have comparable diagnostic performance in sensitivity, specificity, and DORs. The reviewed scales yielded satisfactory sensitivity and specificity. In addition, the overall ability of each tool to accurately classify participants as cases or noncases was moderate to high. Some systematic reviews have evaluated the psychometric properties of CBCL and CRS-R in children and adolescents10,15–18; however, information regarding the diagnostic performance of these tools has rarely been reviewed comprehensively.
Therefore, the overall diagnostic performance of CBCL and CRS-R remains inconclusive. In addition, no conclusion has been drawn regarding the comparison of CBCL and diverse versions of CRS-R. Furthermore, no previous meta-analysis has evaluated the utility of the CBCL and CRS-R in assessing ADHD. In the current study, no difference was observed in the diagnostic performance of the 2 scales in detecting ADHD in children and adolescents. The American Academy of Pediatrics Diagnostic Guidelines does not recommend using a broadband
rating scale, such as CBCL, for diagnosing ADHD, because the broad domain factors do not distinguish young people referred for ADHD from their nonreferred peers. In a recent review, the authors challenged this recommendation by concluding that CBCL-AP can accurately identify young people with ADHD. Our findings are consistent with this observation; thus, a comparable diagnostic performance was observed between broadband CBCL-AP and narrowband CRS-R. The use of a broadband rating scale, such as CBCL, is suggested as an initial step in the assessment of ADHD because of its coverage of several dimensions of childhood psychopathology. Moreover, considering other medical and psychosocial problems, including sleep disorders, substance use, and depression, is crucial during diagnosis because the manifestations of such problems are similar to those of ADHD. The latest clinical practice guidelines have further addressed the need for clinicians to assess other conditions that might coexist with ADHD. Therefore, the broadband measures of the CBCL can benefit diagnostic processes by facilitating professionals in making an accurate differential diagnosis and modifying management plans accordingly.

Overall, the satisfactory diagnostic performance of CBCL-AP and the ability of CBCL to identify other comorbid conditions suggest that CBCL provides valuable diagnostic information for ADHD assessments.
All CRS-R versions exhibited a favorable diagnostic performance, and ASQ demonstrated the highest sensitivity, specificity, and AUC, although the differences were not significant. The satisfactory diagnostic utility of the ADHD index within CPRS-R:S and CTRS-R:S observed in the current study is consistent with those reported in previous reviews, suggesting that the ADHD index contains the most favorable set of items for distinguishing children with ADHD from those without ADHD. In contrast to the conventional notion that ASQ is a global measure of psychopathology and not a specific indicator of ADHD diagnosis, we observed that ASQ had high diagnostic ability in distinguishing children and adolescents with and without ADHD. Therefore, on the basis of the current findings regarding the diagnostic utility of ASQ and the advantages of its brevity, it can be considered an ideal tool for diagnosing ADHD. The information obtained from ASQ can also facilitate the process of determining the requirements for a more comprehensive evaluation.

The heterogeneity observed in CBCL-AP among the included studies was explained by the age of participants and percentage of female participants. The specificity was high in studies with older participants and a high percentage of female participants. Expressions of ADHD symptoms vary among children and adolescents with different demographic characteristics; therefore, studies have reported that CBCL subscale scores varied according to age and gender. However, the age and gender differences disappeared when other demographic factors were included in the multivariate analyses.

Similar phenomena may exist in the current study, because our results were obtained from a univariate metaregression, as suggested by the Cochrane Handbook for small sample sizes. Different results may be observed when other potential sources of heterogeneity are simultaneously considered in regression models. In addition, no previous study has evaluated age and gender differences in the sensitivity and specificity of CBCL-AP; therefore, the present findings should be interpreted with caution.

Our study has several strengths. This is the first systematic review and meta-analysis generating and comparing the pooled diagnostic performance of different behavioral

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### Table 2: Univariate Metaregression Analysis for Identifying Potential Sources of Heterogeneity in the Diagnostic Performance of CBCL-AP scale

<table>
<thead>
<tr>
<th>Study characteristic</th>
<th>Studies, n</th>
<th>Sensitivity Pooled estimate (95% CI)</th>
<th>P</th>
<th>Specificity Pooled estimate (95% CI)</th>
<th>P</th>
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<td>Sample source</td>
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<td></td>
<td>1.00</td>
<td></td>
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<td>Clinic</td>
<td>8</td>
<td>0.78 (0.64–0.88) 0.67 (0.54–0.78)</td>
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<tr>
<td>Nonclinic</td>
<td>7</td>
<td>0.78 (0.68–0.83) 0.79 (0.68–0.88)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Study location</td>
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<td></td>
<td>.03</td>
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<td>United States</td>
<td>8</td>
<td>0.70 (0.61–0.78) 0.81 (0.73–0.87)</td>
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<tr>
<td>Other countries</td>
<td>8</td>
<td>0.83 (0.72–0.90) 0.64 (0.49–0.77)</td>
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<td></td>
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<tr>
<td>No. of participants</td>
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<td>.82</td>
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<tr>
<td>≥200</td>
<td>7</td>
<td>0.77 (0.61–0.88) 0.75 (0.63–0.84)</td>
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<tr>
<td>&lt;200</td>
<td>9</td>
<td>0.75 (0.68–0.80) 0.72 (0.57–0.84)</td>
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<tr>
<td>Cutoff value</td>
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<tr>
<td>≥65</td>
<td>8</td>
<td>0.69 (0.59–0.77) 0.74 (0.60–0.84)</td>
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<tr>
<td>&lt;65</td>
<td>6</td>
<td>0.86 (0.75–0.92) 0.72 (0.53–0.88)</td>
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<td></td>
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<tr>
<td>Study year</td>
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<td>.05</td>
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<tr>
<td>After or during 2005</td>
<td>11</td>
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<td></td>
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<tr>
<td>Before 2005</td>
<td>5</td>
<td>0.71 (0.57–0.81) 0.83 (0.76–0.89)</td>
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<tr>
<td>Age</td>
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<tr>
<td>≥11</td>
<td>7</td>
<td>0.77 (0.67–0.85) 0.84 (0.75–0.90)</td>
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<tr>
<td>&lt;11</td>
<td>9</td>
<td>0.77 (0.65–0.86) 0.63 (0.52–0.72)</td>
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<tr>
<td>Female participants, %</td>
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<tr>
<td>&lt;35</td>
<td>9</td>
<td>0.80 (0.67–0.88) 0.64 (0.51–0.76)</td>
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<tr>
<td>Study quality</td>
<td></td>
<td>.13</td>
<td></td>
<td>.17</td>
<td></td>
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<tr>
<td>Patient selection</td>
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<td>.17</td>
<td></td>
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<td>High risk</td>
<td>8</td>
<td>0.83 (0.70–0.91) 0.67 (0.53–0.78)</td>
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<td></td>
<td></td>
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<tr>
<td>Low risk</td>
<td>8</td>
<td>0.75 (0.67–0.78) 0.79 (0.67–0.87)</td>
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<tr>
<td>Index test</td>
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<td>.61</td>
<td></td>
<td>.95</td>
<td></td>
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<tr>
<td>High risk</td>
<td>10</td>
<td>0.74 (0.67–0.80) 0.74 (0.60–0.84)</td>
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<tr>
<td>Low risk</td>
<td>6</td>
<td>0.78 (0.62–0.89) 0.71 (0.58–0.82)</td>
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<tr>
<td>Flow and timing</td>
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<td>.31</td>
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<tr>
<td>High risk</td>
<td>4</td>
<td>0.67 (0.52–0.79) 0.80 (0.62–0.91)</td>
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<tr>
<td>Low risk</td>
<td>12</td>
<td>0.80 (0.72–0.87) 0.71 (0.60–0.80)</td>
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diagnostic tools in assessing ADHD in children and adolescents. Moreover, the bivariate random effects model and HSROC analyses used in this study are the most statistically rigorous methods in diagnostic meta-analysis. We also followed a standard protocol and used a comprehensive search strategy for including all relevant studies fulfilling our selection criteria. In addition, we supplemented the search by carefully identifying appropriate articles from the reference lists of the relevant review articles. Finally, potential sources of heterogeneity were identified by adding covariates to the bivariate metaregression models.

Our study has several limitations. First, the selection criteria and search strategy may have restricted the number of included articles. Second, the small sample size restricted the use of metaregression for determining factors contributing to heterogeneity among studies evaluating CRS-R. Third, although we attempted to explain the considerable heterogeneity in CBCL-AP, heterogeneity might remain unexplained. Some analyses may have been underpowered because of the limited number of studies with adequate data. Fourth, the pooled diagnostic performances of CPRS-R:S and CTRS-R:S were based on diagnostic parameters extracted from the ADHD index subscale. The diagnostic performance may be higher when the scores of other subscales are also considered in the ADHD assessment. Finally, to increase

FIGURE 4
Funnel plot with superimposed regression line.
the number of included studies, the present analyses comparing different diagnostic tools were conducted using studies that have evaluated ≥1 of the tools. However, the included studies were heterogeneous regarding study design and sample characteristics, which may have confounded the results. Future meta-analyses aimed at comparing the diagnostic performance of two different tools should be conducted on the basis of studies that have directly compared the targeted tools by applying both tools to each participant or by randomizing each participant to undergo assessment by using one of the tools.

CONCLUSIONS
Our meta-analysis revealed that CBCL-AP and CRS-R demonstrated moderate sensitivity and specificity in detecting ADHD in children and adolescents. Many symptoms of ADHD are not always observed in clinical settings; therefore, information provided by both scales can enhance clinicians’ understanding of children’s symptoms in different settings. Our findings indicate that ASQ is the optimal diagnostic tool for assessing ADHD because of its brevity and high diagnostic accuracy. Moreover, the CBCL is recommended when more comprehensive assessments are required for detecting other comorbid conditions of ADHD, because the CBCL-AP can be applied together with other CBCL subscales. However, the moderate diagnostic values of CRS-R and CBCL reveal the importance of incorporating clinical examinations to eliminate other disorders and obtain information such as age of onset, intensity and pervasiveness of symptoms, and level of impairment during ADHD diagnosis.

ABBREVIATIONS
ADHD: attention-deficit/hyperactivity disorder
ASQ: Conners Abbreviated Symptom Questionnaire
AUC: area under the curve
CBCL: Child Behavior Checklist
CBCL-AP: CBCL–Attention Problem
CI: confidence interval
CPRS-R:S: Conners Parent Rating Scale–Revised Short Form
CRS-R: Conners Rating Scale–Revised
CTRS-R:S: Conners Teacher Rating Scale–Revised Short Form
DOR: diagnostic odds ratio
HSROC: hierarchical summary receiver operating characteristic
LR: likelihood ratio
QUADAS-2: Quality Assessment of Diagnostic Accuracy Studies

FIGURE 5
Influential analysis and outlier detection.
REFERENCES


Diagnostic Accuracy of Rating Scales for Attention-Deficit/Hyperactivity Disorder: A Meta-analysis
Ling-Yin Chang, Mei-Yeh Wang and Pei-Shan Tsai
Pediatrics originally published online February 29, 2016;

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