INSTRUCTIONS FOR COMMITTEES
FOR THE DEVELOPMENT OF
AACAP PRACTICE PRINCIPLES

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

COMMITTEE ON QUALITY ISSUES

Revised February 2017
INTRODUCTION

The Committee on Quality Issues (CQI) of the American Academy of Child and Adolescent Psychiatry (AACAP), in collaboration with other AACAP Committees (hereafter known as Committee), develops principles for best practices in child and adolescent psychiatry in three broad topic areas:

- the psychiatric assessment and management of special populations of children and adolescents (e.g., physically ill youth, youth in military families)
- the psychiatric assessment and management of children and adolescents in specific settings (e.g., schools, juvenile justice, systems of care)
- the application of specific psychiatric techniques (e.g., telepsychiatry, assessment of infants and toddlers).

Beginning in 2014, these documents, called AACAP “practice principles,” will be distinct from AACAP “clinical practice guidelines,” which address the assessment and treatment of psychiatric disorders. As such, practice principles are developed under a separate process from clinical practice guidelines, as outlined below.

PRINCIPLES TOPICS

The CQI may invite a Committee to develop principles on a specific topic deemed to be of interest to the AACAP membership. Alternatively, a Committee may suggest to the CQI that they wish to develop principles on the topic addressed by their Committee.

PRINCIPLES AUTHORS

Authors of the practice principles are the members of AACAP Committees assigned by the CQI to develop the principles, and members of the CQI.

OTHER PRINCIPLES CONTRIBUTORS

Committees may invite other topic experts outside of their Committee or outside of AACAP to contribute to the principles. In some situations, trainees or research assistants may provide assistance to the authors.

PRINCIPLES ATTRIBUTION

Title Page

Practice Principles will be attributed as official AACAP Actions authored by the American Academy of Child and Adolescent Psychiatry [name of committee] and Committee on Quality Issues.

Although the Journal of the American Academy of Child and Adolescent Psychiatry (JAACAP) has jurisdiction over the final wording and layout of the title page, the following is an example of how authorship of a fictional practice principle could be attributed on the Principles title page:
AACAP OFFICIAL ACTION

Practice Principles for the Assessment and Management of Publishing Protocols

American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Publishing Protocols (CPP) and AACAP Committee on Quality Issues (CQI)

Boilerplate

The [name of committee] chairs and members and Committee on Quality Issues chairs and members who participated in the development of the principles will be named in the boilerplate of the practice principles. The order of [name of committee] chairs’ and members’ names will be determined by the [name of committee] chairs according to the chairs’ and members’ relative contributions to the development of the principles. The order of Committee on Quality Issues chairs’ and members’ names will be as follows: CQI chairs (alternating), CQI shepherd, and CQI members (listed alphabetically).

Although the Journal of the American Academy of Child and Adolescent Psychiatry has jurisdiction over the final wording and layout of the boilerplate, the following is an example of how authorship of a fictional practice principle could be attributed in the Principles boilerplate:

This Practice Principle was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Publishing Protocols (CPP): John Pink, MD and Lynn Purple, MD, Co-Chairs, and Jeff White, MD, Susan Black, MD, and Jack Blue, MD, Members; and the AACAP Committee on Quality Issues (CQI): Heather J Walter, MD, MPH and Oscar G Bukstein, MD, MPH, Co-Chairs, Christopher Bellonci, MD, Shepherd, and Scott Benson, MD and John Hamilton, MD, Members.

Committee authors should understand that PubMed listings are idiosyncratic and may or may not include author names as listed in the boilerplate.

Topic experts, reviewers, and other contributors will be attributed alphabetically by name in the principles boilerplate, as follows:

The Committees acknowledge the following experts for their contributions to this Practice Principle: [experts’ names].

COMMITTEE DUTIES

Committees authoring practice principles accept the following responsibilities:

1. Be thoroughly familiar with the Instructions for Committees for the Development of AACAP Practice Principles.

2. Partner with the CQI principles shepherd and the AACAP liaison to complete all practice principles development tasks.
3. Collaborate with other relevant AACAP committees, if applicable, in practice principles development.

4. Prepare the initial practice principles draft and subsequent revisions in a timely fashion (approximately 12 months from initiation to approval).

5. Present practice principles drafts to the CQI either by telephone conference call or electronically.

6. Incorporate comments of CQI members into subsequent practice principles drafts.

7. Select and incorporate comments of expert reviewers.

8. Present the practice principles to AACAP members through the AACAP website.

9. Incorporate comments of AACAP members into the practice principles.

10. Incorporate comments of CQI Consensus Group (defined below) into the practice principles.

11. Incorporate comments of AACAP Council (if applicable) into the practice principles.

12. Write (or suggest other authors to write) periodic updates of the practice principles as invited by the CQI.

**COPYRIGHT**

Copyright to the practice principles belongs to AACAP.

**CONFLICT OF INTEREST**

Practice principles incorporate the values expressed in the AACAP *Code of Ethics*. Committee and CQI chairs, Committee and CQI members, topic experts, and reviewers are required to disclose potential conflicts of interest related to the principles. Potential conflicts of interest will be available to the public on the AACAP website. Authors with conflicts or biases that could affect scientific objectivity are asked to decline participation.

**PRINCIPLES DEVELOPMENT PROCESS**

Practice Principles development proceeds as follows:

1. **Identification of Topics and Authors.** The CQI identifies new practice principles topics and potential Committees for principles authorship. The CQI also considers suggestions for principles topics offered by AACAP Committees, members, and executive leadership.

2. **Identification of CQI Shepherd and AACAP Liaison.** The CQI assigns one of its members to “shepherd” the Committee in practice principles development, assisted by the AACAP liaison. The shepherd and liaison will be responsible for assisting the Committee in following the *Instructions for Committees*, incorporating CQI members’
and other reviewers’ comments into drafts of the principles, and inviting the Committee to present principles drafts to the CQI.

3. **Preparation of Practice Principles Drafts.** Preparation of the practice principles should begin with a literature search of potential issues to be addressed in the principles. This search should be performed and documented according to the guidelines outlined under the METHODOLOGY section below. The results of the literature search should be used to generate a list of approximately 8-12 principles for best practices in the topic area. The results of the literature search and list of principles are presented to the CQI either by telephone conference call or electronically.

After the literature review and principles have been approved by the CQI, the Committee works with the CQI shepherd to develop a complete draft of the principles. When a complete first draft has been written and preliminarily reviewed by the shepherd, the shepherd invites the Committee to present the draft to the CQI either by telephone conference call or electronically. After CQI review, the Committee works with the CQI shepherd to incorporate the comments of CQI members. Follow-up drafts will be presented (at the shepherd’s invitation) to the CQI via telephone conference call or electronically.

4. **Expert Review.** Following iterative CQI review, the Committee asks acknowledged experts in the principles topic area for additional review by email. Topic experts may include members of other relevant AACAP committees, professionals from other disciplines, or representatives from relevant professional or consumer organizations. The Committee incorporates experts’ comments into a subsequent principles draft.

5. **AACAP Member Review.** Following expert review, the draft of the principles is posted on the AACAP website for member review. The author incorporates members’ comments into a subsequent principles draft.

6. **Consensus Group.** Following AACAP member review, the draft of the principles is reviewed by email (and conference call if indicated) by a Consensus Group convened by the CQI. The Consensus Group typically comprises the following:

   A. A chair of the CQI
   B. The practice principles shepherd
   C. One or two additional CQI members
   D. Several experts in the practice principles topic area
   E. One or two representatives from other relevant AACAP Committees (if applicable)
   F. Two representatives from the AACAP Assembly of Regional Organizations, who are expected to represent the interests of AACAP members
   G. Two representatives from the AACAP Council, who are expected to represent the interests and authority of the AACAP leadership

If consensus cannot be achieved by email or telephone communication, members of the Consensus Group may meet face-to-face, preferably at the AACAP Annual Meeting, to resolve differences.
7. **Final Edits.** Following Consensus Group approval, the draft of the practice principles is edited by the CQI chairs and liaison as needed to assure conformity to the *Instructions for Committees*.

8. **Approval by AACAP Council.** The final, edited practice principles draft must be approved by a majority of a quorum of the AACAP Council. It is anticipated that the Council will make substantive changes to the practice principles only in extraordinary circumstances. Any substantive changes suggested by Council will be submitted to the CQI Consensus Group for consideration.

9. **Publication.** The approved practice principles will be published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, and will be posted on the AACAP website. The practice principles may also be published and distributed by AACAP in other ways.

10. **Update.** The Committee will be asked to update the principles at periodic intervals.

**CONTENT AND FORMAT OF PRACTICE PRINCIPLES**

**CONTENT**

Following a brief background review of the topic, practice principles are designed to succinctly present the most important principles pertinent to the topic. Practice Principles have a 10,000-word limit, including references and tables; therefore, material presented in the background review should not be duplicated under the principles; material presented in tables should not be duplicated in the text, and references should be pertinent, important, and recent.

**TITLE**

Typical titles of practice principles are as follows:

- Practice Principles for the Psychiatric Assessment and Management of Physically Ill Children and Adolescents
- Practice Principles for Psychiatric Consultation and Intervention in Schools
- Practice Principles for Telepsychiatry with Children and Adolescents

**ABSTRACT**

A one-paragraph (150-word limit) abstract should summarize the content of the practice principles. Up to five key terms are listed at the end of the abstract. The terms “practice principles” and “child and adolescent psychiatry,” and other terms of the Committee’s choice can be used.

**DEVELOPMENT AND ATTRIBUTION**

The development and attribution section (“boilerplate”) summarizes the process of practice principles development, and indicates the name(s) of all Committee and CQI members and reviewers. Correct titles should be provided (e.g., M.D., Ph.D.). Academic affiliations are not included. Potential conflicts of interest are disclosed in the boilerplate for the Committee
and CQI chairs. Disclosures for all other named individuals are available on the AACAP website. The attribution boilerplate is as follows (subject to editing by JAACAP):

This Practice Principles was developed by the American Academy of Child and Adolescent Psychiatry (AACAP) [Committee name (initials)]: [names of Committee co-chairs, names of Committee members] and the AACAP Committee on Quality Issues (CQI): [names of CQI co-chairs, name of CQI shepherd, names of CQI members].

AACAP Practice Principles are developed by AACAP Committees under the direction of the AACAP CQI. Principles development is an iterative process between the Committee, the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, other relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Practice Principles development process can be accessed on the AACAP Web site. Responsibility for Practice Principles content and review rests with the Committee, the CQI, the CQI Consensus Group, and the AACAP Council.

The primary intended audience for the AACAP Practice Principles is child and adolescent psychiatrists; however, the information contained therein may also be useful for other medical or mental health clinicians.

The authors wish to acknowledge the following topic experts for their contributions to this Practice Principles: [experts’ names].

[Name] served as the AACAP staff liaison for the [Committee name] and the CQI.

This Practice Principles was reviewed by AACAP members from [month, year] to [month, year].

From [month, year] to [month, year], this Practice Principles was reviewed by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were as follows: [co-chair’s name, shepherd’s name, members’ names] (CQI); [names] (Topic Experts); [names and committee affiliations] (AACAP Committees); [names] (AACAP Assembly of Regional Organizations); and [names] (AACAP Council).

This Practice Principles was approved by the AACAP Council on [date].

This Practice Principles is available on the internet (www.aacap.org).

Disclosures: [Committee chairs and CQI chairs].

Correspondence to the AACAP Communications Department, 3615 Wisconsin Ave., NW, Washington, D.C. 20016.

© [year] by the American Academy of Child and Adolescent Psychiatry.
INTRODUCTION

The following information should be included in the introduction section of the principles:

- The purpose of the practice principles
- The rationale for the principles (Example: “Because the process of evaluating child custody disputes is complex and requires special expertise and unique approaches, this practice principles can be of help for clinicians and ultimately, for the families they evaluate.”)
- The patient population for whom the practice principles is appropriate (Example: “Principles in this document are applicable to children and adolescents under the age of 18.”)

Other information that should be included in the introduction:

- Any important assumptions underlying the principles (Example: “This practice principles assumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment.”)
- Clarification of terminology (Example: “In this practice principles, unless otherwise noted, the term ‘child’ refers to both children and adolescents unless otherwise noted. Also, unless otherwise noted, ‘parents’ refers to the child’s primary caregivers, regardless of whether they are the biological or adoptive parents or legal guardians.”)

The Introduction section should approximate 200 words.

METHODOLOGY

AACAP practice principles should critically appraise evidence using transparent literature review methodology consistent with worldwide standards. The single most useful guide for this process is The Cochrane Library’s Handbook for Authors.

The following outline can help guide committee authors to produce high-quality literature searches:

1. For each of the potential issues under study in the principles, create search terms, using Boolean operators (e.g., OR, AND) to join individual terms and sets of terms as appropriate. To ensure a complete search (i.e., all relevant results are found), use Medical Index Subject Heading (MeSH) terms for all searches in MEDLINE and thesaurus terms for all searches in PsycINFO. Keyword searches can also be used, but only as a supplement to MeSH and thesaurus terms.

2. Search multiple databases. The most fruitful databases in child and adolescent psychiatry are MEDLINE, PsycINFO, CENTRAL, and EMBASE. Searching these four databases will generally suffice if the bibliographies of retrieved articles are also examined for relevant references not included in the databases.

3. Search first for systematic reviews and meta-analyses that used well-defined methodology as the highest level of empirical evidence. The Cochrane Database of Systematic Reviews (CDSR) contains many systematic reviews (SR); however,
if the topic is not found in CDSR, search other databases using the “article types” filter that retrieves only systematic reviews and/or meta-analyses.

4. Next use the “article types” filter to search for individual studies, choosing the appropriate types of studies (e.g., randomized controlled trial, cohort study, case-control study, case study) as indicated by the issue under study.

5. Use additional filters to specify additional “winnowing” criteria (e.g., human, English language, ages, publication dates). Avoid using these filters in the initial search; rather include them in subsequent searches so the reader can follow how the search began with a sensitive, inclusive search, but then became highly specific by focusing on the most relevant studies. Report the results for each search as the numbers narrow (“winnowing”). This ensures transparency, as anyone should be able to duplicate the search and obtain the same results. Do not ask the reader to take “on faith” a large reduction from over 2000 references in the initial search to the 50 listed in the principle’s bibliography without documenting the winnowing process.

6. Finally, the entire search process summarized above should be documented in the Methodology section of the principles, including the following specific information:

- An explicit statement that the principles is based on a systematic review of the literature
- Listing of databases searched
- Summary of search terms used
- Specific time period covered by the search, including the beginning date (month/year) and end date (month/year)
- Date(s) (month/year) when the search was done
- Number of hits in initial searches and at each stage of the winnowing process
- Description of study selection that includes the number of studies identified, the number of studies included, and a summary of inclusion and exclusion criteria

Examples of required documentation for MEDLINE and PsychINFO searches is provided in Appendix I; an example of required description of study selection (“winnowing”) is provided in Appendix II.

DEFINITIONS

Unfamiliar terms should be defined in this section, listed alphabetically.

HISTORICAL REVIEW

Brief history of the topic can be provided, describing changes over time in approach to the issue (e.g., changes in policies of seclusion and restraint, changes in federal mandates pertaining to the education of children with disabilities, changes in the power of the state in child welfare decisions).

The Historical Review section should be approximately 400 words.
DESCRIPTION OF PROCEDURE

This section is appropriate for practice principles pertaining to specific tests or procedures (e.g., neuropsychological testing, telepsychiatry).

PRINCIPLES

Authors should think of this section as the most important practical “do’s and don’ts” regarding this topic (approximately 8-12) as derived from the findings of the literature search. Principles should be a single declarative statement; any modifying or additional information should be placed in the text following the principle. Principles should be clustered by topic area and sequenced in a logical order.

The following are examples of practice principles on school consultation:

- Clinicians should understand how to initiate, develop, and maintain consultative relationships with schools.
- Clinicians should be knowledgeable about legislation that establishes and protects the educational rights of students with mental disabilities.
- Clinicians should be able to conduct a comprehensive assessment of a student with an emphasis on understanding barriers to learning.

To be considered for inclusion in the National Guideline Clearinghouse, each principle must be supported by an “evidence synthesis” and “evidence summary” as well as a statement regarding benefits and harms.

- Evidence synthesis. The evidence base for each principle should be reviewed in the text following the principle or in an evidence synthesis table (see Appendix III for an example of an evidence table).
- Evidence summary. The evidence synthesis for each principle should be followed by an “evidence summary” which links the empirical evidence to the stated principle (see Appendix IV for an example).
- If empirical evidence for a given principle is lacking, it should be stated that the principle is based upon consensus of the practice principles authors and reviewers.
- Statement regarding benefits and harms. The potential benefits and harms of actions recommended in each principle should be addressed in the text under the principle.

ALGORITHMS/TABLES/FIGURES

Committees are encouraged to develop visual summaries of practice principles content. Tables and figures are formatted in the style of the JAACAP and authors are referred to recent issues for examples.

PRINCIPLES LIMITATIONS

The following disclaimer is included as boilerplate:

AACAP Practice Principles are developed to assist clinicians in psychiatric decision making. These Principles are not intended to define the sole standard of care.
As such, the Principles should not be deemed inclusive of all proper methods of care nor exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

REFERENCES

It is not necessary to be exhaustive in developing the references. The purpose of the practice principles is to present literature that is compelling, relevant, and integral to the practice principles topic.

PREPARATION OF DRAFTS

At all phases of production, drafts are submitted to the AACAP Clinical Practice Department for reproduction and distribution to the Committees, the general membership, reviewers, Council, and Assembly. Drafts are submitted via email.

LENGTH

The draft should not exceed 10,000 words, including abstract, introduction, methodology, background, principles, tables and references. All drafts should have an accurate word count on the cover sheet. Some practice principles will be much less than 10,000 words.

STYLE

Style refers to the preferred usage for spelling, punctuation, and references. The AACAP uses the AMA Manual of Style, the APA American Psychiatric Glossary, and Webster’s Collegiate Dictionary.

The text should be justified to the left side of the page. Do not attempt to hyphenate words in order to justify the right side of the page, since the hyphenation changes as the drafts evolve.

After the draft has been submitted, the staff of the Clinical Practice Department will copyedit the material and prepare it for distribution. The staff will take care of the headers, the footers, and line numbers. Staff will return the edited version of the practice principles to the Committees. Please use this copy to make revisions for the next draft.

COVER SHEET AND FIRST PAGE

The first page of practice principles should list the title, draft date and word count followed by the principles content beginning with the abstract section.

Do not indicate the draft number (e.g., Draft #1 or Draft #4). Simply put the date on which the author finished the draft and is submitting it to the Clinical Affairs Department.

HEADING LEVELS

Heading levels for the narrative portion of the practice principles are as follows:
TITLE: Uppercase, boldface, centered at the top of the page.

Example:

**PRACTICE PRINCIPLES FOR THE PSYCHIATRIC ASSESSMENT AND MANAGEMENT OF PHYSICALLY ILL CHILDREN AND ADOLESCENTS**

LEVEL 1: Upper case, boldface, flush left, freestanding.

Example:

**ASSESSMENT**

LEVEL 2: Upper case, roman (non-bold), flush left, freestanding.

Example:

**SYMPTOM RATING SCALES**

LEVEL 3: Mixed case, roman (non-bold), flush left, freestanding.

Example:

Types of Symptom Rating Scales

LEVEL 4: First word capitalized, indented as for a paragraph, italic, with a period at the end of the phrase.

Example:

*Illness coping scales.*

REFERENCES

References should be in the style of the *Journal*. Double check [www.jaacap.org](http://www.jaacap.org) if unsure of which style to use. If using bibliographic software please be sure that the software is formatted appropriately. **DRAFTS WITH REFERENCES IN INCORRECT STYLE WILL BE RETURNED TO THE AUTHOR FOR REVISION.** Every effort should be made to list references accurately from primary source materials.

Authors should make sure that every citation in the text of the practice principles has an appropriate entry in the References, that all items in the References were actually cited in the text, and that there are no duplicate references.
APPENDICES

Source for all appendix material:
## APPENDIX I

### Table A-1. MEDLINE search strategies updated (PubMed interface) December 11, 2013

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychosocial interventions</strong></td>
<td></td>
</tr>
<tr>
<td>#3 engl[a] AND child[mh] OR adolescent[mh]</td>
<td>1775464</td>
</tr>
<tr>
<td>#5 (#1 AND #2 AND #3) NOT #4</td>
<td>3181</td>
</tr>
</tbody>
</table>

### Table A-3. PsycINFO (via ProQuest interface) search results, November 26, 2013

<table>
<thead>
<tr>
<th>Search terms</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PsycINFO: psychosocial</strong></td>
<td></td>
</tr>
<tr>
<td>#1 SU EXACT(&quot;Conduct Disorder&quot;) OR SU EXACT(&quot;Oppositional Defiant Disorder&quot;) OR SU EXACT(&quot;Antisocial Personality Disorder&quot;) OR (disruptive behavior disorder OR disruptive behavior disorders)</td>
<td>11181</td>
</tr>
<tr>
<td>#2 SU EXACT EXPLODE(&quot;Treatment&quot;) OR SU EXACT EXPLODE(&quot;Medicinal Herbs and Plants&quot;) OR SU EXACT EXPLODE(&quot;Dietary Supplements&quot;) OR SU EXACT EXPLODE(&quot;Nutrition&quot;) OR SU EXACT EXPLODE(&quot;Vitamins&quot;) OR SU EXACT(&quot;Drug Therapy&quot;) OR SU EXACT EXPLODE(&quot;Behavior Therapy&quot;)</td>
<td>573194</td>
</tr>
<tr>
<td>#3 #1 and #2</td>
<td>2580</td>
</tr>
<tr>
<td>#4 #3, limited children and adolescents</td>
<td>1558</td>
</tr>
<tr>
<td>#5 #3, limited to 2003-2013 publication date</td>
<td>1323</td>
</tr>
<tr>
<td>#6 #3 limited to peer reviewed, scholarly journals</td>
<td>1719</td>
</tr>
<tr>
<td>#7 #3 limited to research methodology (Empirical Study OR Quantitative Study OR Treatment Outcome/Clinical Trial OR Longitudinal Study OR Followup Study OR Retrospective Study OR Prospective Study OR Field Study)</td>
<td>1200</td>
</tr>
<tr>
<td>#8 #3 AND #4 AND #5 AND #6 AND #7</td>
<td>412</td>
</tr>
</tbody>
</table>
APPENDIX II

Figure B. Literature flow diagram

Records identified through database searching (n = 7,467)

Records identified through hand searches (n = 47)

Records retrieved (n = 7,514)

Records screened (n = 7,470)\(^a\)

Full-text articles assessed for eligibility (n = 968)

Records included in review (n = 115)\(^b\)

Records excluded at abstract screening (n = 6,502)

Records excluded at full-text screening (n = 855)\(^b\)

- Not original research (n = 67)
- Does not measure the relationship between psychosocial or pharmacologic intervention and outcome (n = 158)
- Not an eligible study design (n = 9)
- Not youth population (n = 30)
- No standardized disruptive behavior disorder classification or symptom assessment meeting a clinical threshold cutoff (n = 319)
- Not conducted in outpatient health care setting (n = 177)
- Does not include an alternate treatment or control group for comparison to measure effectiveness (n = 250)
- Does not report outcome of interest for the population (youth) with disruptive behavior (n = 125)
- Does not address a Key Question (n = 134)
- Unavailable or Duplicate (n = 35)
- Older than 20 years (n = 198)
- Non-English (n = 5)

Studies included in meta-analysis (n = 28)\(^c\)

\(^a\) Excluding discarded duplicates (n = 44).
\(^b\) Records could be excluded for more than one reason.
\(^c\) 115 publications representing 84 unique studies.
\(^d\) A subset of studies (n = 28) met eligibility criteria for inclusion in a quantitative analysis.
# APPENDIX III

Table 7. Summary of behavior outcomes from studies of a parent-only component (IY-PT) in preschool-age children

<table>
<thead>
<tr>
<th>Author, Year</th>
<th>Design (Risk of Bias)</th>
<th>Country: N Randomized</th>
<th>Groups</th>
<th>Behavior Measure</th>
<th>Between-Group Difference*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parrin et al., 2013</td>
<td>RCT (Moderate)</td>
<td>United States: 150</td>
<td>G1: IY-PT G2: WLC</td>
<td>ECBI, Problem</td>
<td>G1 vs. G2: p&lt;0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ECBI, Intensity</td>
<td>G1 vs. G2: p&lt;0.05</td>
</tr>
<tr>
<td>Posthumus et al., 2012</td>
<td>NRCT (Moderate)</td>
<td>Netherlands: 144</td>
<td>G1: IY-PT G2: TAU</td>
<td>ECBI, Problem</td>
<td>G1 vs. G2: p=NS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ECBI, Intensity</td>
<td>G1 vs. G2: p=NS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CBCL, Externalizing</td>
<td>G1 vs. G2: p=NS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CBCL, Externalizing</td>
<td>G2 vs. G3: p=NS</td>
</tr>
<tr>
<td>Hutchings et al., 2007</td>
<td>RCT (Moderate)</td>
<td>United Kingdom: 153</td>
<td>G1: IY-PT G2: WLC</td>
<td>ECBI, Intensity</td>
<td>G1 vs. G2: p&lt;0.05</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ECBI, Problem</td>
<td>G1 vs. G2: p&lt;0.05</td>
</tr>
<tr>
<td>McGilloway et al., 2012 and 2014</td>
<td>RCT (Low)</td>
<td>Ireland: 149</td>
<td>G1: IY-PT G2: WLC</td>
<td>ECBI, Intensity</td>
<td>G1 vs. G2: p&lt;0.001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ECBI, Problem</td>
<td>G1 vs. G2: p&lt;0.001</td>
</tr>
</tbody>
</table>

NRCT = non-randomized controlled trial; RCT = randomized controlled trial; IY = Incredible Years; PT = parent training; MIT = minimal intervention therapy; WLC = waitlist control; TAU = treatment as usual; ECBI = Eyberg Child Behavior Inventory; CBCL = Child Behavior Checklist; NS = nonsignificant; G = group, N = number

*The between group difference refers to the difference in the change from baseline to last follow-up between the intervention and comparison group. Effect favors G1 unless noted otherwise.
APPENDIX IV

The five studies examining IY-PT for preschool disruptive behaviors evaluated several versions of IY-PT (IY-PT + ADVANCE, IY-PT, IY-PT psychologist led, IY-PT nurse led) in comparison to other versions of IY-PT and waitlist controls. All studies used one of the parent-reported ECBI scales or CBCL scales, and most of the studies included direct observation of child disruptive behaviors. On parent-reported measures of child disruptive behaviors, 5 studies reported improvement from baseline to followup (ranging from post-treatment to 2-year followup) for children in IY-PT. Children in the IY-PT arms consistently showed more improvement than children in waitlist control arms. Consistent differences between versions of IY-PT were not reported.