INSTRUCTIONS FOR AACAP COMMITTEES

FOR THE DEVELOPMENT OF

AACAP CLINICAL UPDATES

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

COMMITTEE ON QUALITY ISSUES

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OVERVIEW

Beginning in 2016, 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), will develop a **Clinical Updates Series** 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, primary care, systems of care)
- the application of specific psychiatric **techniques** to children and adolescents (e.g., telepsychiatry, psychiatric assessment).

AACAP Clinical Updates will be different from upcoming AACAP Clinical Practice Guidelines, which will address the assessment and treatment (psychopharmacological and psychosocial) of psychiatric **disorders** in children and adolescents. While Clinical Practice Guidelines will be based upon systematic searches and critical appraisals of the extant literature provided by the US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ), Clinical Updates will be based upon systematic searches and critical appraisals of the extant literature performed by the authoring Committees. While Clinical Practice Guidelines will be developed in close accordance with guideline standards of rigor and transparency promulgated by the Institute of Medicine, Clinical Updates will be informed by these standards but may not reach full accordance because of their more limited evidence base. With the debut of Clinical Updates and Clinical Practice Guidelines, the former AACAP Practice Parameters will be retired.

The steps for the development for Committee-authored Clinical Updates are outlined below.

TOPICS

The CQI may invite a Committee to develop a Clinical Update 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 a Clinical Update on the topic addressed by their Committee.

AUTHORS

Authors of the Clinical Updates are the members of AACAP Committees assigned by the CQI to develop the Update, and members of the CQI.

OTHER CONTRIBUTORS

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

ATTRIBUTION

Clinical Updates will be attributed on the title page 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 Clinical Update document could be attributed on the title page:

AACAP OFFICIAL ACTION

Clinical Update Series

Assessment and Management of Publishing Protocols

AACAP Committee on Publishing Protocols
AACAP Committee on Quality Issues

The [name of committee] chairs and members and Committee on Quality Issues chairs and members who participated in the development of the Clinical Update will be named in the boilerplate of the Update (see boilerplate text under *Development and Attribution* below). 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 Update. The order of Committee on Quality Issues chairs' and members' names will be as follows: CQI shepherd, CQI members who contributed to the development of the Update (listed alphabetically), and CQI chairs.

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 Update boilerplate, as follows:

The Committees acknowledge the following experts for their contributions to this Clinical Update: [experts' names].

COMMITTEE DUTIES

Committees authoring Clinical Updates accept the following responsibilities:

1. Be thoroughly familiar with the *Instructions for AACAP Committees for the Development of AACAP Clinical Updates.*

2. Partner with the CQI shepherd and the AACAP staff liaison to complete all Update development tasks.

3. Collaborate with other relevant AACAP committees, if applicable, in Update development.

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

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

6. Incorporate comments of CQI members into the Update draft.

7. Send the Update draft to topic experts for review and comment.

8. Incorporate comments of topic experts into the Update draft.

9. Present the Update draft to AACAP members through the AACAP website for review and comment.

10. Incorporate comments of AACAP members into the Update draft.

11. Present the Update draft to a Consensus Group of reviewers representing key AACAP stakeholders for review and comment.

12. Incorporate comments of the Consensus Group members into the Update draft.

13. Submit the Update draft to the Consensus Group members for approval vote.

14. Present the Update draft to the AACAP Council for review and comment.

15. Incorporate comments of AACAP Council into the Update draft.

16. Submit the final Update draft to AACAP Council for final approval vote.

17. Submit the approved Update draft to CQI co-chairs for final editing to ensure conformance with these Instructions.

18. Proofread page proofs immediately upon receipt from the Journal of the American Academy of Child and Adolescent Psychiatry.

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CONFLICT OF INTEREST

Clinical Updates 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 Update. 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.

CLINICAL UPDATE DEVELOPMENT PROCESS

The Clinical Update development proceeds as follows, and the process outline is depicted in Appendix I. Please note that *The Instructions for AACAP Committees for the Development of AACAP Clinical Updates* will be periodically revised by the CQI in accordance with changes in national and international standards. As such, authors may be asked to make additional revisions in Updates drafts when new *Instructions* are released.

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

2. **Identification of CQI Shepherd and AACAP Staff Liaison.** The CQI assigns one of its members to "shepherd" the Committee in Update development, assisted by the AACAP staff liaison. The shepherd and liaison will be responsible for assisting the Committee in following the *Instructions for AACAP Committees* and incorporating CQI members' and other reviewers' comments into drafts of the Update.

3. **Preparation of Drafts.** Preparation of the Update should begin with a literature search of potential issues to be addressed in the Update. 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 the content of the Update. After the literature review, the Committee works with the CQI shepherd to develop a complete draft of the Update. 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.

4. **Expert Review.** Following CQI review, the Committee asks acknowledged experts in the Update 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 Update draft.

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

6. **Consensus Group.** Concurrent with AACAP member review, the draft of the Update is reviewed by email (and conference call if indicated) by a Consensus Group convened by the CQI. The Committee incorporates Consensus Group members' comments into a subsequent Update draft. The Consensus Group typically comprises the following:

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

The Consensus Group process must result in unanimous approval of the Update. If necessary, a telephone conference call can be arranged to resolve differences among Consensus Group members and Committee authors.

7. **Approval by AACAP Council.** Following the Consensus Group review, the final Update draft is reviewed and approved by a majority of a quorum of the AACAP Council. It is anticipated that the Council will make substantive changes to the Update only in extraordinary circumstances.

8. **Final Edits.** Following Council approval, the draft of the Update is edited by the CQI chairs and staff liaison to assure conformity to the *Instructions for AACAP Committees*.

9. **Submission/Posting**. The Council-approved and edited Update is submitted to the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP) and is posted on the AACAP website.

10. **Proof-Reading.** The Update JAACAP page proofs are proof-read by the Committee co-chairs (with final approval of proof edits by CQI co-chairs).

11. **Publication.** The Clinical Update is published in JAACAP as an *AACAP Official Action*. The Clinical Update may also be published and distributed by AACAP in other ways.

CONTENT AND FORMAT OF CLINICAL UPDATES

CONTENT

Following a brief background review, Clinical Updates are designed to succinctly present an update of the topic. Clinical Updates have an approximately 10,000 word limit, including references and tables; therefore, material presented in the background review should not be duplicated in the update review; material presented in tables should not be duplicated in the text, and references should be pertinent, important, and recent.

TITLE

Typical titles of Clinical Updates are as follows:

- Clinical Update Series - Telepsychiatry with Children and Adolescents
- Clinical Update Series - Psychiatric Consultation to Schools

ABSTRACT

A one-paragraph (150 word limit) abstract should summarize the content of the Clinical Update. Up to five key terms are listed at the end of the abstract. The terms "clinical update", "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 Clinical Update development, and indicates the name(s) of all Committee and CQI members and reviewers. Correct degrees 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 presented below (subject to editing by JAACAP). Please copy and paste this boilerplate into the Clinical Update document, filling in blanks as appropriate.

This Clinical Update 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): [name of CQI shepherd, names of CQI members, names of CQI co-chairs].

AACAP Clinical Updates are developed by AACAP Committees under the direction of the AACAP CQI, with review by representatives of multiple constituent groups including topic experts, AACAP members, other relevant AACAP Committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Final approval for publishing Clinical Updates as an AACAP Official Action is conferred by the AACAP Council. The development process for Clinical Updates is described on the AACAP website (www.aacap.org).

The primary intended audience for the AACAP Clinical Updates is child and adolescent psychiatrists; however, the information presented may also be useful for other medical or behavioral health clinicians.

The [Committee Name] wishes to acknowledge the following topic experts for their contributions to this Update: [experts' names].

[Names] served as the AACAP staff liaisons for the [Committee initials] and the CQI.

This Clinical Update was reviewed by AACAP members from [month, year] to [month, year].

From [month, year] to [month, year], this Clinical Update 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 Clinical Update was approved by the AACAP Council on [date].

This Clinical Update is available on the AACAP website at www.aacap.org.

Disclosures: During preparation of this Clinical Update, [names of Committee chairs and CQI chairs] have had/have not had [potential conflicts of interest].

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

INTRODUCTION

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

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

Other information that should be included in the introduction:

- Any important assumptions underlying the Update (Example: "This Update assumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment.")
- Clarification of terminology (Example: "In this Update, unless otherwise noted, the term 'child' refers to both children and adolescents. 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.")

METHODOLOGY

AACAP Clinical Updates 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 Update, 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 Update's bibliography without documenting the winnowing process.

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

    - An explicit statement that the update 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 II; an example of required description of study selection ("winnowing") is provided in Appendix III.

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).

UPDATE

This section should succinctly update the topic based upon recent findings from the literature review. Evidence tables should be provided when empirical evidence pertaining to the topic is available (see example in Appendix IV). When empirical evidence is not available, the source of the opinion stated in the Update should be noted (e.g., "Clinical consensus supports"…")

ALGORITHMS/TABLES/FIGURES

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

PRACTICE LIMITATIONS

The following disclaimer is included as boilerplate:

AACAP Clinical Updates are developed to assist clinicians in psychiatric decision making. The information in this Update not intended to define the sole standard of care or guarantee successful treatment of individual patients, nor should the information be deemed inclusive of all proper methods of care nor exclusive of other methods of care directed at obtaining the desired results. This Clinical Update does not usurp sound clinical judgment. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances, values, and preferences presented by the patient and his/her family, the diagnostic and treatment options available, and accessible resources.

REFERENCES

It is not necessary to be exhaustive in developing the references. The purpose of the Update is to present literature that is compelling, relevant, and integral to the Update topic. The reference list should be consistent with the yield of searched articles that were retrieved for

full-text review, along with references obtained in other ways (e.g., chapter bibliographies, websites, etc.)

PREPARATION OF DRAFTS

At all phases of production, drafts are submitted to the CQI co-chairs and AACAP staff liaison for distribution to the Committees, the general membership, reviewers, Council, and Assembly. Drafts are submitted via email.

LENGTH

The draft should approximate 10,000 words, including abstract, introduction, methodology, background, update, tables and references. All drafts should have an accurate word count on the cover sheet.

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.

COVER SHEET AND FIRST PAGE

The first page of the Clinical Update should list the title, draft date and word count followed by the 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 CQI..

HEADING LEVELS

Heading levels for the narrative portion of the Clinical Update are as follows:

- -

TITLE: Uppercase, boldface, centered at the top of the page.

Example:

CLINICAL UPDATE SERIES

TELEPSYCHIATRY WITH 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 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 AUTHORS FOR REVISION.** Every effort should be made to list references accurately from primary source materials.

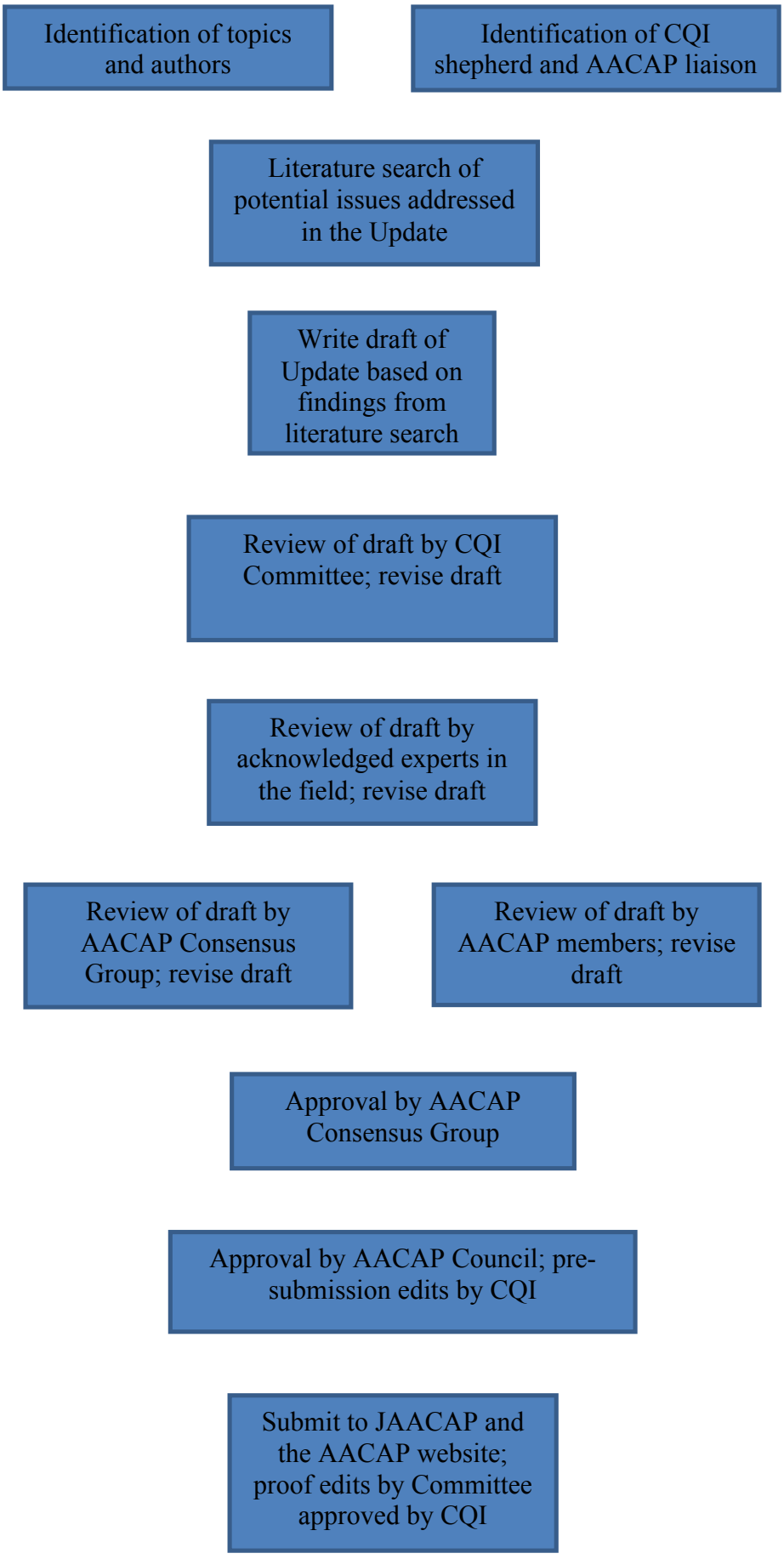
Authors should make sure that every citation in the text of the Update has an appropriate entry in the References, that all items in the References were actually cited in the text, and that there are no duplicate references.

APPENDICES

Source for Appendix II-IV material:
http://www.effectivehealthcare.ahrq.gov/ehc/products/555/2133/disruptive-behavior-disorder-report-151201.pdf

APPENDIX I

Process for the Development of AACAP Clinical Updates



APPENDIX II

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

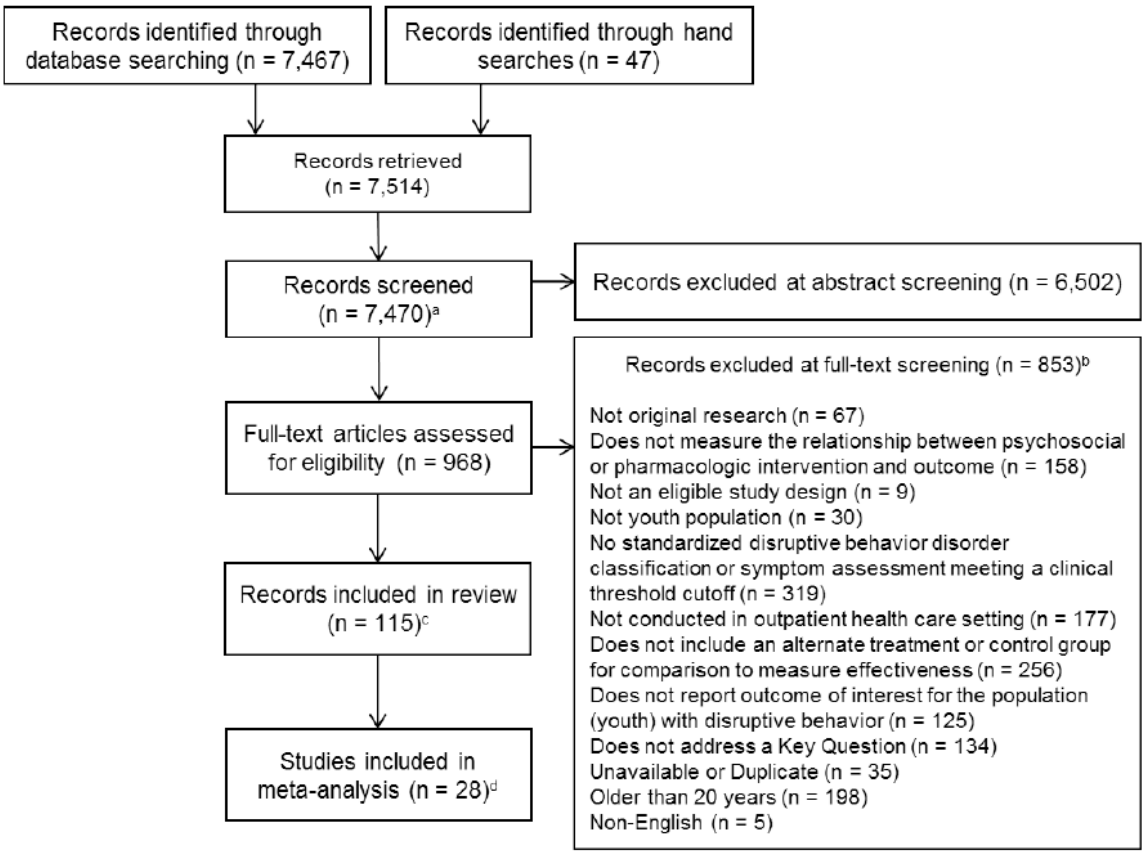
Search terms		Results
Psychosocial interventions		
#1	attention deficit and disruptive behavior disorders[mh:noexp] OR conduct disorder[mh] OR (mental disorders[mh] AND aggression[mh]) OR externalizing behavior*[tiab] OR externalizing behaviour*[tiab] OR oppositional defian*[tiab] OR conduct disorder*[tiab] OR disruptive behavior disorder*[tiab] OR antisocial personality disorder[mh] OR conduct problems[tiab] OR antisocial behavior*[tiab]	23579
#2	therapy[sh] OR therapeutics[mh] OR teaching[mh] OR psychotherapy[mh] OR treatment outcome[mh] OR "Adolescent Transitions Program"[tiab] OR "Anger control training"[tiab] OR "Assertive training"[tiab] OR "Behavioral parent training"[tiab] OR "Brief Strategic Family Therapy"[tiab] OR "Collaborative Problem Solving"[tiab] OR "Coping Power"[tiab] OR "Early Risers Skills for Success"[tiab] OR "Skills for Success Program"[tiab] OR "First Step to Success"[tiab] OR "Functional Family Therapy"[tiab] OR "Helping the Noncompliant Child"[tiab] OR "Incredible Years"[tiab] OR "Interpersonal skills training"[tiab] OR "Multidimensional Family Therapy"[tiab] OR "Multidimensional Treatment Foster Care"[tiab] OR "Multisystemic Therapy"[tiab] OR "Multi-systemic Therapy"[tiab] OR "Parent Management Training"[tiab] OR "Parent-Child Interaction Therapy"[tiab] OR "Positive Parenting Program"[tiab] OR "Problem Solving Skills Training"[tiab] OR "Positive Behavioral Support System"[tiab] OR "Promoting Alternative Thinking Strategies"[tiab] OR "Second Step"[tiab] OR "Self-Control training"[tiab] OR "Teacher-Child Interaction Training"[tiab] OR "Teacher Child Interaction Training"[tiab]	6753849
#3	eng[la] AND (child[mh] OR adolescent[mh])	1775464
#4	newspaper article[pt] OR letter[pt] OR comment[pt] OR case reports[pt] OR review[pt] OR practice guideline[pt] OR news[pt] OR editorial[pt] OR historical article[pt] OR meta-analysis[pt] OR legal cases[pt] OR published erratum[pt] OR congresses[pt] OR jsubsetk	4996769
#5	(#1 AND #2 AND #3) NOT #4	3181

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

Search terms		Results
PsycInfo- psychosocial		
#1	SU.EXACT("Conduct Disorder") OR SU.EXACT("Oppositional Defiant Disorder") OR SU.EXACT("Antisocial Personality Disorder") OR (disruptive behavior disorder OR disruptive behavior disorders)	11181
#2	SU.EXACT.EXPLODE("Treatment") OR SU.EXACT.EXPLODE("Medicinal Herbs and Plants") OR SU.EXACT.EXPLODE("Dietary Supplements") OR SU.EXACT.EXPLODE("Nutrition") OR SU.EXACT.EXPLODE("Vitamins") OR SU.EXACT("Drug Therapy") OR SU.EXACT.EXPLODE("Behavior Therapy")	573194
#3	#1 and #2	2580
#4	#3, limited children and adolescents	1558
#5	#3, limited to 2003-2013 publication date	1323
#6	#3 limited to peer reviewed, scholarly journals	1719
#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)	1200
#8	#3 AND #4 AND #5 AND #6 AND #7	412

APPENDIX III

Figure B. Literature flow diagram



[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 IV

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

Author, Year Design (Risk of Bias) Country: N Randomized	Groups	Behavior Measure	Between-Group Difference[a]
Perrin et al., 2013[93] RCT (Moderate) United States: 150	**G1:** IY-PT **G2:** WLC	ECBI, Problem	**G1 vs. G2:** p<0.05
		ECBI, Intensity	**G1 vs. G2:** p<0.05
Posthumus et al., 2012[87] NRCT (Moderate) Netherlands: 144	**G1:** IY-PT **G2:** TAU	ECBI, Problem	**G1 vs. G2:** p=NS
		ECBI, Intensity	**G1 vs. G2:** p=NS
Lavigne et al., 2008[102] RCT (High) United States: 117	**G1:** PT (Nurse-led) **G2:** PT (Psychologist-led) **G3:** MIT	ECBI, Intensity	**G1 vs. G3:** p=NS **G2 vs. G3:** p=NS **G1 vs. G2:** p=NS
		CBCL, Externalizing	**G1 vs. G3:** p=NS **G2 vs. G3:** p=NS **G1 vs. G2:** p=NS
Hutchings et al., 2007[129] RCT (Moderate) United Kingdom: 153	**G1:** IY-PT **G2:** WLC	ECBI, Intensity	**G1 vs. G2:** p<0.05
		ECBI, Problem	**G1 vs. G2:** p<0.05
McGilloway et al., 2012[138] and 2014[163] RCT (Low) Ireland: 149	**G1:** IY-PT **G2:** WLC	ECBI, Intensity	**G1 vs. G2:** p<0.001
		ECBI, Problem	**G1 vs. G2:** p<0.001

NRCT = nonrandomized 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

[a]The between-group difference refers to the difference in the change from baseline to last followup between the intervention and comparison group. Effect favors G1 unless noted otherwise.