

**INSTRUCTIONS FOR AUTHORS**  
**FOR THE DEVELOPMENT OF**  
**AACAP PRACTICE PARAMETERS**

**AMERICAN ACADEMY OF CHILD AND ADOLESCENT  
PSYCHIATRY**

**COMMITTEE ON QUALITY ISSUES**

**Heather J Walter, MD, MPH**  
**Oscar G. Bukstein, MD, MPH**  
**Co-Chairs, Committee on Quality Issues**

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## GENERAL PRINCIPLES

The Committee on Quality Issues (CQI) develops expert-authored practice parameters for the American Academy of Child and Adolescent Psychiatry (AACAP) to encourage best practices in child and adolescent psychiatry. The expert-authored parameters fall into two categories:

- Patient-oriented Practice Parameters
  - These parameters address the psychiatric assessment and treatment of specific child and adolescent **psychiatric disorders**
- Clinician-oriented Practice Parameters
  - These parameters address the:
    - psychiatric assessment and management of **special populations** of children and adolescents (e.g., physically ill youth, sexual/gender minority youth)
    - psychiatric assessment and management of children and adolescents in **specific settings** (e.g., foster care, juvenile justice, schools)
    - application of **specific psychiatric techniques** (e.g., telepsychiatry, assessment of infants/toddlers)

Parameter development is guided by standards promulgated by the American Medical Association (*AMA Policy H-410.968*), the Institute of Medicine (*Clinical Practice Guidelines We Can Trust*), and the Agency for Healthcare Research and Quality National Guideline Clearinghouse (AHRQ NGC). The development of the parameters is an iterative process involving principal authors, CQI chairs and members, topic experts, and representatives of key constituent groups, including the AACAP membership, relevant committees, Assembly of Regional Organizations, and Council. Responsibility for parameter content rests with the parameters authors, the CQI, the CQI Consensus Group (defined below), and Council.

## AUTHORS AND OTHER CONTRIBUTORS

### QUALIFICATIONS

Parameter first authors are selected by the CQI on the basis of their nationally recognized expertise in the topic area addressed by the parameter. The first author may select up to two co-authors, for a recommended total of three principal authors (including the first author). All principal authors must reach the standard for authorship set by the Journal of the AACAP, which requires “substantial” contributions to all of the following: 1) conception and design of the study or analysis and interpretation of the data; 2) drafting the article or revising it critically for important intellectual content; and 3) final approval

of the version to be published. Moreover, authors must have participated sufficiently to take public responsibility for the content.

The order of the co-authors is determined by the first author. If the first author cannot make a determination about the order of the authors, the CQI will order the authors alphabetically after the first author.

If the first author decides to relinquish that role during the course of parameter development, the CQI will re-assign first authorship to another individual. The Committee also may re-assign first authorship if the parameter development exceeds the 18 month timeline.

With few exceptions, authors are child and adolescent psychiatrists and members of AACAP. The exceptions may include authors of parameters requiring interdisciplinary expertise (e.g., a practice parameter on neuropsychological testing) or authors of parameters developed in collaboration with other professional organizations.

Experts in the topic area asked to review the parameters (may include members of AACAP committees) will be acknowledged in the Attributions section of the parameters. In some cases, trainees or research assistants may provide assistance to authors; they also will be acknowledged in the attribution section.

## **DUTIES**

Authors of practice parameters accept the following responsibilities:

1. Be thoroughly familiar with the *Instructions for Authors for the Development of AACAP Practice Parameters*.
2. Partner with the CQI parameter shepherd and the AACAP staff liaison to complete all parameter development tasks.
3. Collaborate with relevant AACAP committees (if applicable) in parameter development.
4. Prepare the initial parameter draft and subsequent revisions in a timely fashion (approximately 18 months from initiation to approval).
5. Present parameter drafts to CQI members either by telephone conference call or electronically.
6. Incorporate comments of CQI members into the parameter draft.
7. Send the parameter to topic experts for review and comment.
8. Incorporate comments of topic experts into the parameter draft.

9. Present the parameter draft to AACAP members through the AACAP website for review and comment.
10. Incorporate comments of AACAP members into the parameter draft.
11. Present the parameter 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 parameter draft.
13. Submit the parameter draft to the Consensus Group members for approval vote.
14. Present the parameter draft to AACAP Council for review and comment.
15. Incorporate comments of AACAP Council into the parameter draft.
16. Submit the final parameter draft for AACAP Council for final approval vote.
17. Submit the approved parameter draft to CQI co-chairs for final editing to ensure conformance with these *Instructions*.

### **AUTHORSHIP AND COPYRIGHT**

Attribution in the Journal of the AACAP (JAACAP) is given under the article title to principal authors by name along with “Committee on Quality Issues). Attribution is also given in the Attributions section of the parameter (where CQI members are named after the principal authors). In PubMed, authorship typically is attributed to the principal authors, with CQI members as collaborators. However, AACAP cannot assure how authors will be represented in PubMed.

Responsibility for parameter content and review rests with the author(s), the Committee on Quality Issues, the CQI Consensus Group, and the AACAP Council. Responsibility for stylistic issues rests with the Journal of the AACAP.

Copyright to the practice parameters belongs to AACAP.

### **CONFLICT OF INTEREST**

Practice parameters incorporate the values expressed in the AACAP *Code of Ethics*. Authors, CQI chairs and members, topic experts, and reviewers are required to disclose to the CQI potential conflicts of interest related to the parameter. Authors with conflicts or biases that could affect scientific objectivity are asked to decline participation.

## PRACTICE PARAMETER DEVELOPMENT PROCESS

Parameter development proceeds as follows:

1. **Identification of Topics and Authors.** The CQI identifies new parameter topics, topics due for revision, and potential parameter authors. The CQI also considers suggestions for parameter topics and authors offered by AACAP members, committees, and executive leadership.

2. **Identification of CQI Shepherd and AACAP Staff Liaison.** The CQI assigns one of its members to “shepherd” the author in parameter development, assisted by the AACAP staff liaison. The shepherd and staff liaison will be responsible for assisting the author in following the *Instructions for Authors* and incorporating CQI members’ and other reviewers’ comments into drafts of the parameter.

3. **Preparation of Parameter Drafts.** Preparation of the parameter should begin with a literature search, which 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 recommendations (for patient-oriented parameters) or principles (for clinician-oriented parameters) for best practices in the topic area. The results of the literature search and list of recommendations/principles are presented to the CQI either by telephone conference call or electronically.

After the literature review and recommendations/principles have been reviewed by the CQI, the author works with the CQI shepherd to develop a complete draft of the parameter, incorporating comments of CQI members. When a complete first draft has been written and preliminarily reviewed by the shepherd, the shepherd invites the author to present the draft to the CQI, either by telephone conference call or electronically. After CQI review, the author works with the CQI shepherd to incorporate the comments of CQI members. Follow-up drafts will be presented to the CQI via telephone conference call or electronically. The target timeline for this entire process should approximate 18 months. If the timeline should exceed 18 months, the authorship of the parameter is subject to re-assignment by the CQI.

4. **Revised Author Instructions.** The *Instructions for Authors of AACAP Practice Parameters* will be periodically revised by the CQI in accordance with changes in national and international standards for clinical practice guideline development. As such, authors may be asked to make additional revisions in parameter drafts when new *Instructions* are released.

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

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

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

- A. A chair of the CQI
- B. The parameter author(s)
- C. The parameter shepherd
- D. One or two additional CQI members
- E. Several experts in the parameter topic area
- F. One or two representatives from relevant AACAP Committees (if applicable), who are expected to keep their Committees apprised of the process
- G. One or two representatives from the AACAP Assembly of Regional Organizations, who are expected to represent the interests of AACAP members
- H. 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 parameter. If necessary, a telephone conference call can be arranged to resolve differences among Consensus Group members and Committee authors.

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

9. **Final Edits.** Following Consensus Group approval, the draft of the parameter is edited by the CQI chairs and staff liaison as needed to assure conformity to the *Instructions for Authors*.

10. **Publication.** The approved Practice Parameter will be published in the *Journal of the American Academy of Child and Adolescent Psychiatry* as an AACAP Official Action, and will be posted on the AACAP website. The parameter may also be published and distributed by AACAP in other ways.

11. **Update.** The author (or his/her designee) will be asked to update the parameter at periodic intervals.

## **CONTENT AND FORMAT OF PRACTICE PARAMETERS**

### **CONTENT**

Following a brief background review of the topic, parameters are designed to succinctly present the most important treatment recommendations or clinical principles pertinent to the parameter topic. Assessment and treatment recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support (see **Evidence Base for Practice Parameters** below). Although empirical evidence may be available to support certain principles, principles are primarily based on clinical consensus.

Parameters have an approximately 10,000 word limit, including references and tables; therefore, material presented in the background review should not be duplicated under the recommendations/principles; material presented in tables should not be duplicated in the text, and references should be pertinent, important, and recent.

### **FORMAT**

The format varies somewhat according to the type of parameter. The most common format is as follows:

#### **TITLE**

Typical titles of each of the types of parameters are as follows:

Patient-Oriented Parameters:

1. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders
2. Practice Parameter for the Use of Antipsychotic Medications in Children and Adolescents.

Clinician-Oriented Parameters:

1. Practice Parameter for the Psychiatric Assessment of Children and Adolescents
2. Practice Parameter for the Assessment and Management of Youth Involved with the Child Welfare System

#### **ABSTRACT**

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

## **DEVELOPMENT AND ATTRIBUTION**

The development and attribution section summarizes the process of parameter development, and indicates the name(s) of all authors, CQI members, and reviewers. Correct degrees should be provided (e.g., MD, PhD). Academic affiliations are not included. Potential conflicts of interest are disclosed for all principal authors and the CQI co-chairs. Disclosures for all other named individuals are available on the AACAP website. The attribution boilerplate is as follows:

**This Parameter was developed by [authors' names], and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI): [names of co-chairs, names of members].**

**The AACAP Practice Parameters are developed by the AACAP CQI in accordance with American Medical Association (AMA) policy. Parameter development is an iterative process between the primary author(s), the CQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP committees, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the Parameter development process can be accessed on the AACAP Web site. Responsibility for Parameter content and review rests with the author(s), the CQI, the CQI Consensus Group, and the AACAP Council.**

**The AACAP develops both patient-oriented and clinician-oriented Practice Parameters. Patient-oriented Parameters provide recommendations to guide clinicians toward best assessment and treatment practices. Recommendations are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not), and are graded according to the strength of the empirical and clinical support. Clinician-oriented Parameters provide clinicians with the information (stated as principles) needed to develop practice-based skills. Although empirical evidence may be available to support certain principles, principles are primarily based on clinical consensus. This Parameter is a [ ]-oriented Parameter.**

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

**The authors acknowledge the following experts for their contributions to this Parameter: [experts' names].**

**[name] served as the AACAP staff liaison for the CQI.**

**This Practice Parameter was made available for review to the entire AACAP membership on the AACAP Web site from [month, year] to [month, year].**

**From [month, year] to [month, year], this Parameter was reviewed by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were [co-chair's name, shepherd's name, members' names]**

(CQI); [names] (topic experts); [names] (AACAP [name of committee]); [names] (AACAP Assembly of Regional Organizations); and [names] (AACAP Council).

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

**This Practice Parameter is available on the internet ([www.aacap.org](http://www.aacap.org)).**

**Disclosures: [inserted for principal authors and CQI co-chairs].**

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

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## **INTRODUCTION**

The following information should be included in the Introduction section of the parameter:

- The purpose of the parameter
- The rationale for the parameter (Example: “Because the process of evaluating child custody disputes is complex and requires special expertise and unique approaches, this Parameter can be of help for clinicians and ultimately, for the families they evaluate”)
- The patient population for whom the parameter is appropriate (Example: “Recommendations [principles] in this Parameter 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 parameter (Example: “This Parameter assumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment.”)
- Clarification of terminology (Example: “In this Parameter, 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.”)

The Introduction section should approximate 200 words.

## **METHODOLOGY**

AACAP practice parameters 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 searches:

1. For each of the potential issues under study in the parameter, 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 parameter’s bibliography without documenting the winnowing process.
6. Finally, the entire search process summarized above should be documented in the Methodology section of the parameter, including the following specific information:
  - An explicit statement that the parameter 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 assessment, treatment, or 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 approximate 400 words.

The following sections are appropriate for parameters pertaining to specific disorders. (If the parameter addresses a specific disorder, the author should refer the reader to the DSM-5 for a review of the diagnostic criteria for the disorder). These five sections combined should approximate 1800 words.

#### **CLINICAL PRESENTATION AND COURSE**

#### **EPIDEMIOLOGY**

#### **ETIOLOGY OF RISK AND PROTECTIVE FACTORS**

#### **DIFFERENTIAL DIAGNOSIS**

#### **COMORBIDITIES**

## **DESCRIPTION OF PROCEDURE**

This section is appropriate for parameters pertaining to specific tests or procedures (e.g., neuropsychological testing, psychotherapy).

## **EVIDENCE BASE FOR PRACTICE PARAMETERS**

For patient-oriented (treatment) parameters, the following boilerplate (adapted from Zarin DA, Seigle L, Pincus HA, McIntyre JS, Evidence-based practice guidelines. *Psychopharmacology Bulletin* 33: 641-646, 1997) is added:

**In this parameter, recommendations for best assessment and treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:**

- **Clinical Standard [CS] is applied to recommendations that are based on rigorous empirical evidence (e.g., meta-analyses, systematic reviews, multiple consistent randomized controlled trials)**
- **Clinical Option [OP] is applied to recommendations that are based on emerging empirical evidence (e.g., observational studies, uncontrolled trials or case series/reports), or on clinical opinion**
- **Not Endorsed [NE] is applied to practices that are known to be ineffective or contraindicated**

**The strength of the empirical evidence is rated in descending order as follows:**

- **[rct] Randomized, controlled trial is applied to studies in which subjects are randomly assigned to two or more treatment conditions**
- **[ct] Controlled trial is applied to studies in which subjects are non-randomly assigned to two or more treatment conditions**
- **[ut] Uncontrolled trial is applied to studies in which subjects are assigned to one treatment condition**
- **[ob] Observational study is applied to studies in which subjects are followed without assignment to treatment condition**
- **[cs] Case series/report is applied to a case series or a case report**

## **RECOMMENDATIONS/PRINCIPLES**

Authors should think of this section as the most important practical “do’s and don’ts” regarding this topic (approximately 8-12). Recommendations/principles should be a

single declarative statement; any modifying or additional information should be placed in the text following the recommendation/principle. Recommendations/principles should be clustered by topic area and sequenced in a logical order. For example, all recommendations/principles pertaining to screening and assessment should be grouped together under an *Assessment* heading; all recommendations/principles pertaining to treatment should be grouped together under a *Treatment* heading.

The following are examples of recommendations from a patient-oriented parameter:

- The psychiatric assessment of children and adolescents should routinely include screening questions about depressive symptomatology.
- During all treatment phases, for a child or adolescent who is not responding to appropriate pharmacological and/or psychotherapeutic treatments, consider factors associated with poor response.
- Children with risk factors associated with development of depressive disorders should have access to early intervention services.

The following are examples of principles from a clinician-oriented parameter:

- 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, and participate in comprehensive treatment planning with clinical, school, home, and community components as indicated.

For recommendations designated as CS for “clinical standard” that are supported by rigorous empirical evidence (e.g., systematic reviews/meta-analyses, multiple consistent randomized controlled trials), the empirical evidence supporting the recommendation is reviewed in the text immediately below the recommendations, or alternatively, in a table. An example of an evidence table is presented in Appendix III. Concluding the presentation of the empirical support, a summary of the empirical evidence is presented which links the overall body of evidence to the recommendation. An example of a summary is presented in Appendix IV. The summary should conclude with a statement regarding relative benefits and harms of the action stated in the recommendation, based upon the evidence.

For recommendations/principles designated as CO for “clinical option” that are unsupported by rigorous empirical evidence, the rationale for the recommendation/principle is presented in the text immediately below the recommendation/principle (e.g., “This recommendation is supported by emerging empirical evidence”, “This recommendation represents the consensus of the authors and expert reviewers of these Practice Parameter”, or “This recommendation represents the consensus of expert opinion as presented in current clinical practice guidelines and clinical algorithms”). A discussion of the rationale for the recommendation then follows.

## **ALGORITHMS/TABLES/FIGURES**

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

## **PARAMETER LIMITATIONS**

The following disclaimer is included as boilerplate:

**AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or 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 parameters is to present literature that is compelling, relevant, and integral to the parameter 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 Committee, 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, recommendations/principles, tables and references. All drafts should have an accurate word count on the first page. Some practice parameters 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, because 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 parameter to the authors. Please use this copy to make revisions for the next draft.**

### **FIRST PAGE**

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

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 parameters are as follows:

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

Example:

**PRACTICE PARAMETER FOR THE ASSESSMENT AND TREATMENT  
OF CHILDREN AND ADOLESCENTS WITH SCHIZOPHRENIA**

-----

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

Example:

**TREATMENT**

-----

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

Example:

STIMULANT MEDICATION

-----

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

Example:  
Uses of Stimulants in Children

-----

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

Example:  
*Medication efficacy and side effects.*

-----

## **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 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 parameter has an appropriate entry in the References, and 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:

<http://www.effectivehealthcare.ahrq.gov/ehc/products/555/2133/disruptive-behavior-disorder-report-151201.pdf>

## APPENDIX I

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

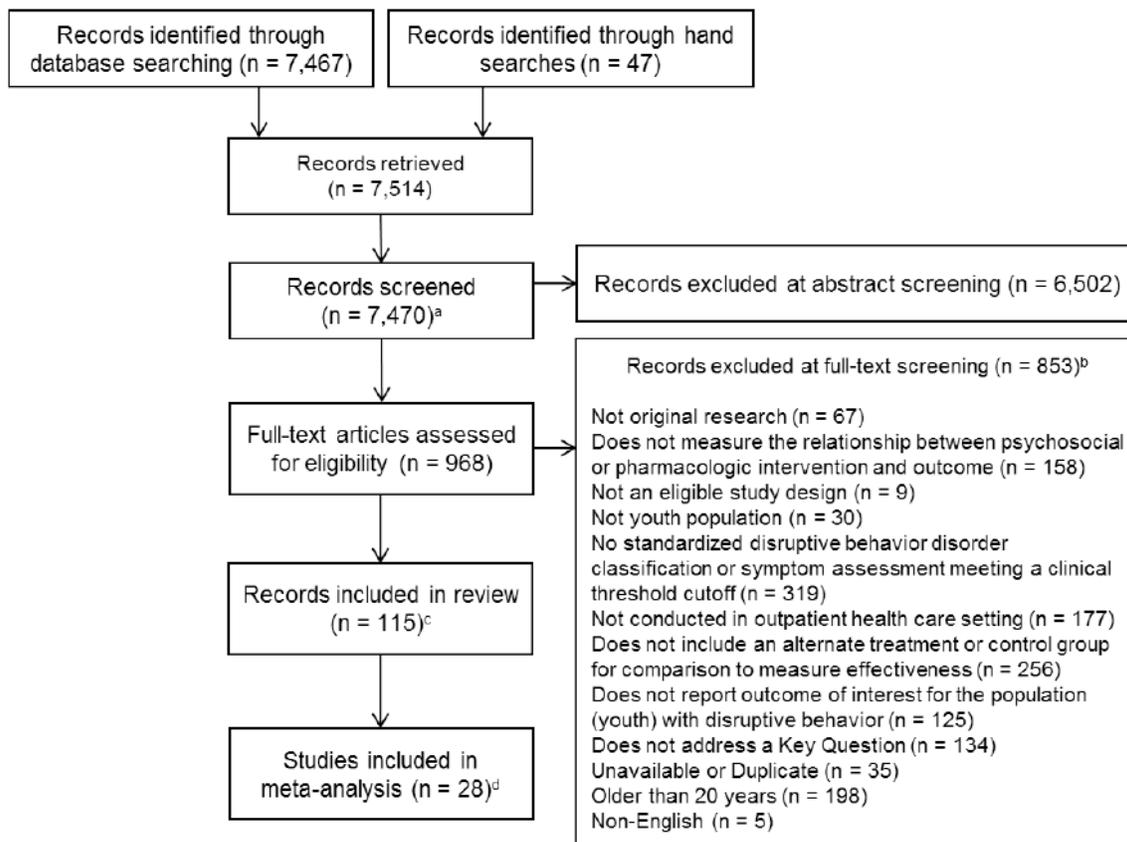
Search terms	Results
Psychosocial interventions	
#1 attention deficit and disruptive behavior disorders[mh:noexp] OR conduct disorder[mh] OR (mental disorders[mh] AND aggression[mh]) OR externalizing behavior*[tiab] OR externalizing behaviour*[tiab] OR oppositional defiant*[tiab] OR conduct disorder*[tiab] 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 II

Figure B. Literature flow diagram



<sup>a</sup>Excluding discarded duplicates (n = 44).

<sup>b</sup>Records could be excluded for more than one reason.

<sup>c</sup>115 publications representing 84 unique studies.

<sup>d</sup>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**

Author, Year Design (Risk of Bias) Country: N Randomized	Groups	Behavior Measure	Between-Group Difference <sup>a</sup>
Perrin et al., 2013 <sup>93</sup> 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 <sup>87</sup> 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 <sup>102</sup> 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 <sup>129</sup> 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 <sup>138</sup> and 2014 <sup>163</sup> 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

<sup>a</sup>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.

## 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.