Case Study 1: An Evidence-Based Practice Review Report

Theme: Interventions involving Parents as the agents of change

How effective are cognitive-behavioural approaches delivered by parents in helping their children to overcome anxiety, in comparison to therapist led treatment or no treatment at all?

1. Summary

There is a growing body of research which indicates that cognitive-behavioural therapy (CBT) is an effective form of treatment for children and adolescents with anxiety disorders. As a therapeutic approach CBT involves helping the child or adolescent recognise maladaptive processes and alter these for more adaptive ones. However, access to such therapeutic approaches are restricted. Therefore, the current review synthesised the available research in order to look at the effectiveness of parent-delivered cognitive-behavioural approaches, in comparison to either therapist-delivered CBT or no treatment at all. For the five studies evaluated, effect sizes for the difference between pre-and post-treatment measures of clinical severity and child and parent reported anxiety associated symptoms and behaviours were compared. The findings revealed that compared to therapist-delivered CBT, parent-delivered approaches were not as effective. However, therapy delivered by a parent was found to be more effective than being on a waiting list. These findings indicate that manualised programmes delivered by a parent are a viable, therapeutic method which would be available with minimal delay potentially reducing the demands on CBT providers.

2. Introduction

Childhood and Adolescent Anxiety

Anxiety is a natural emotion that serves to both protect an individual from harm and motivate them to achieve certain goals (Velting, Setzer, & Albano, 2004). However, high levels of anxiety can have a detrimental effect on development through interfering with cognition, behaviour and physiology. For example, manifestations of heightened anxiety are varied but include children and adolescents who have problem-solving difficulties, attention problems, erratic behaviour, or an inability to complete tasks (Huberty, 2012). These characteristics of anxiety disorders can consequently impair functioning in areas related to friendships, family life and school (Ezpeleta, Keeler, Erkanli, Costello, & Angold, 2001; Strauss, Frame, & Forehand, 1987; Van Ameringen, Mancini, & Farvolden, 2003). Many of these characteristics mean schools are well placed to intervene early, which inevitably places a greater focus on the type of advice and input schools may seek from educational psychologists (Rait, Monsen, & Squires, 2010).

On occasions specialised forms of support are needed because of the high levels of comorbidity between anxiety disorders and other psychological disorders. For example, children and adolescents diagnosed with a form of anxiety are suggested to be at a heightened risk of other psychological disorders such as depression, which has been suggested to place young people at the highest risk of adverse consequences such as suicidal attempts and ideation (James, Soler, & Weatherall, 2005; Lewinsohn, Rohde, & Seeley, 1995; Pine, 1997). If left untreated, anxiety

disorders in young people have also been found to be a strong predictor of a range of a of psychiatric disorders in later adolescence (Bittner et al., 2007). This is all of great concern when it is considered that anxiety disorders are one of the most commonly reported psychological disorders affecting between 15 – 20% of children and adolescents during their lifetime (Beesdo, Knappe, & Pine, 2009). Therefore, the difficulties a large proportion of young people may face highlight the need for effective and easily accessible treatment.

Cognitive-Behavioural Approaches – Basis in Psychological Theory

CBT is a form of treatment that is commonly available to children and adolescents with anxiety disorders. As a therapeutic approach, CBT is conceptualised as an amalgamation of different psychological approaches, including rational-emotive behaviour therapy (Ellis, 1993), cognitive therapy (Beck, 1987; Ellis & Grieger, 1986) and cognitive-behavioural modification (Meichenbaum, 1977). In essence, these approaches assume that it is not necessarily the situations per se, but an individual's maladaptive interpretation of the situation which can cause negative emotions and behaviours to be exhibited (Pugh, 2010). Therefore, this therapeutic approach helps an individual identify this dysfunction and then works to provide the necessary coping skills and opportunities to develop new or modify existing cognitive paths for more appropriately interpreting information (Malchiodi & Rozum, 2012; Southam-Gerow & Kendall, 2000).

Mode of Delivery

While CBT is a therapeutic approach that is becoming more common within educational psychology practice (Pugh, 2010; Rait et al., 2010), it is typically a type of therapy that is delivered by therapists or counsellors from the child and adolescent mental health services (CAHMS, Squires, 2010). The format of delivery for CBT varies, but generally takes the form of individual, group or family/parent sessions, which have been found to have similar anxiety remission rates (James, James, Cowdrey, Soler, & Choke, 2013). CBT for childhood and adolescent anxiety disorders generally focuses around six main components. These include psychoeducation (self-monitoring), somatic management (breathing retraining), cognitive restructuring (monitoring of thought processes), problem solving (generating alternative solutions), exposure (imaginal, symbolic or genuine exposure to feared situations) and relapse prevention (reduction in sessions and generalising treatment gains) (Velting et al., 2004).

Rationale of Review

Studies that have explored the efficacy of child-and adolescent-focused CBT for clinical anxiety disorders have found promising results, with the average remission rate being around 56% (James et al., 2005). However, getting access to CBT through services such as CAMHS is not an easy endeavour.

As the number of referrals and demands on CAMHS are suggested to be rising sharply, consultants within the service have reported this as having an impact on the provision they are able to deliver. Specifically, certain services are having to provide provisions to those in urgent need with little to no capacity for early intervention being available (O'Dowd, 2014). While shorter wait times for those young people most in

need is appropriate, many individuals who are in need of a new or alternative form of therapy have to wait and face the adverse consequences such as exacerbated problems (Kowalewski, McLennan, & McGrath, 2011). If these services continue to be stretched and children and young people are unable to receive the help they need, there difficulties may have to be dealt with by other professionals. For example, since manifestations of heightened anxiety have been found to be related to such difficulties as attention problems or an inability to complete tasks (Huberty, 2012), educational psychologists may see an increase in their caseloads, which may also have a potential impact on the provision they are then able to offer.

One potential way to overcome the difficulty of accessing treatment through services such as CAMHS and avoid the subsequent impact on other services, may be possible through looking at similar approaches without the need of a therapist, such as self-help guides (Williams, 2001). While the involvement of a therapist in CBT with anxious children and adolescents is invaluable in increasing the effectiveness of such programmes (Rapee, Wignall, Spence, Lyneham, & Cobham, 2000), recent research has questioned whether or not a therapist is necessary for all sessions (James et al., 2013). Others have gone as far to suggest that the effectiveness of such treatments for anxiety disorders are largely down to the techniques and not the overly simplistic reduction of therapy to a 'curative relationship' between therapist and client (Newman, Erickson, Przeworski, & Dzus, 2003).

While this review focuses on childhood and adolescent anxiety disorders, research suggests that parents play a big part in the severity of this disorder, with the parent-

child bond and certain parenting behaviours being linked to higher levels of anxiety (Drake & Ginsburg, 2012). Due to a link between parenting behaviours and child and adolescent anxiety disorders, self-help guides have been published to help parents understand their child's fears and worries and provide practical strategies to help their children overcome them. For example, such self-help guides as "Overcoming Your Child's Fears and Worries: A self-help guide using Cognitive Behavioural Techniques" (Creswell & Willetts, 2007), contains information that explores how to question whether thoughts are helpful, how to help your child face their fears and how to problem solve. These sections provide information around areas that are considered to be in line with the psychological basis of CBT. For example, questioning whether thoughts are helpful or not, links in with the notion that an individual's maladaptive interpretation of the situation causes negative emotions and behaviours to be exhibited (Pugh, 2010). Likewise, sections of the self-help guides which provide the parents with the knowledge of how to encourage their children to be independent and have a go, links with the importance of CBT and providing the anxious individual with opportunities to develop new or modify existing cognitive paths for more appropriately interpreting information (Malchiodi & Rozum, 2012; Southam-Gerow & Kendall, 2000). Therefore, this review will attempt to explore how effective cognitive-behavioural approaches delivered by parents through the use of self-help guides/manuals are in comparison to therapist led treatment or no treatment at all.

3. Critical Review

Search of Databases

To address the current review question a comprehensive search of the most appropriate online databases (PsychINFO and PubMed) was carried out on the 31st January 2015. For each database a combination of search terms[1] in the title or abstract was used to locate the relevant studies for review:

Intervention	Target population	Area of concern
- Cognitive Behav*, **OR**	- Parent*, **AND**	- Anx*
- CBT, **AND**	- Child*, **AND**	
	- Therapist, **AND**	

A filter was imposed on the online databases before the search was run which excluded any results which were not in the English language or from a peer reviewed journal (see Table 1 rationale). The search terms used generated 43 results between both databases, of which 15 were duplicates and excluded from the review. The titles and abstracts of the remaining 28 articles were screened adhering to the inclusion criteria (Table 1). After this initial screening 23 articles did not meet the inclusion criteria through either their title and/or abstract. The remaining 5 articles were read in full to see if they still complied with the inclusion criteria and consequently 2 articles were excluded (see appendix A for reasons of exclusion). The 3 articles that remained then underwent an ancestral search in order to ensure that no articles that were relevant to the review were missed. A further 5 articles were found and read in full, of which 2 were deemed relevant to the current review based on the inclusion criteria. Figure 1 shows a graphical representation of this process.

[1] The asterisk represents a wildcard term such as "behav*" which will search for a range of different associated terms e.g. ""behaviours", "behaviour" and "behavioural".

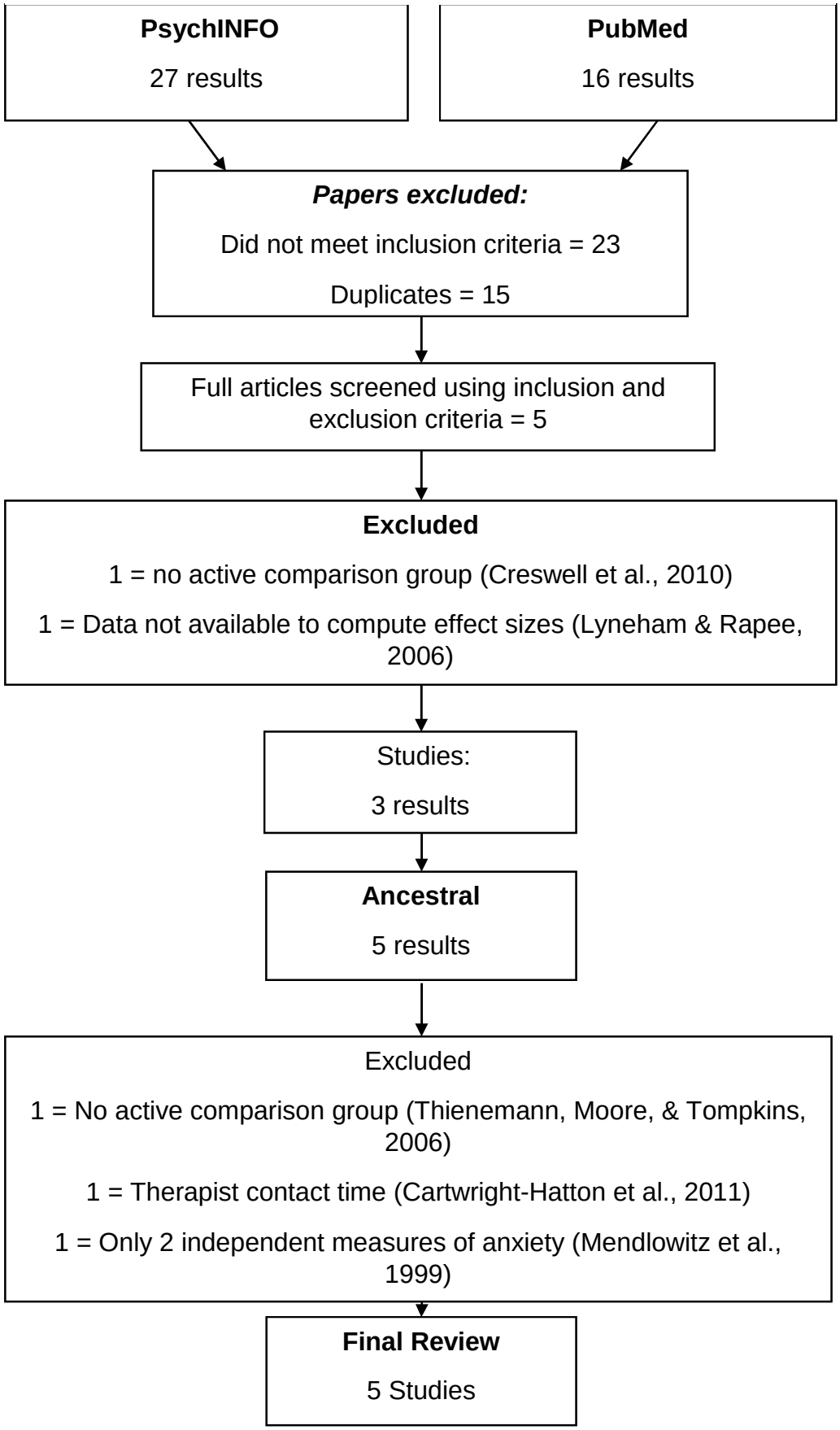
Table 1. Inclusion and exclusion criteria

	Inclusion Criteria	Exclusion Criteria	Rationale
1. Type of Publication	Peer reviewed journal	Material in a non-peer reviewed journal	To ensure high methodological rigour
2. Language	Published in English	Not available in the English Language	Translation services not available
3. Type of Study	An experimental design that involves the collection and analysis of primary data with an experimental group and a comparison group (i.e. waitlist, alternative/delayed treatment)	A study that does not have an experimental design (i.e. at least two independent groups)	To ensure originality of findings and measure the effectiveness of treatment compared to alternative/no treatment
4. Methodology	a. Provides descriptive/raw data in order to calculate effect sizes or provides information to acquire them (i.e. contact details of the author/s)	a. Information or data not available	a. The availability of descriptive/raw data ensures that findings are original and that effect sizes can be generated for analysis and comparison.
	b. A process of triangulation is available as the study has used measures from three independent sources (i.e., a child-self report, a parent report and a clinician report)	b. Does not have measures from three independent sources	b. Enables the review to produce a richer picture of effect through a method of triangulation

Table 1 Continued. Inclusion and exclusion criteria

	Inclusion Criteria	Exclusion Criteria	Rationale
5. Intervention	a. Must be a cognitive-behavioural type of intervention targeted at reducing symptoms associated with anxiety completely implemented by the parent	a. Not a cognitive-behavioural type of intervention or one which involves the therapist having contact with the child	a. Current interest of this review is to explore the effectiveness of cognitive-behavioural approaches to reducing anxiety symptoms through parenting interventions
	b. The parent or carer who implemented the intervention should receive no more than 15 hours contact (e.g. training or support) with a therapist	b. More than 15 hours contact with a therapist	b. More than 15 hours contact with a therapist is more than the average full course of individual CBT commonly reported in previous studies (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004)
5. Participants	a. CYP aged 5-25	a. Children and young people aged younger or older than 5- or 25-years-old, respectively	a. This is the current population of interest in line with the SEND code of practice. (Department for Education, 2014). Children younger than 5 are not believed to benefit from such an approach.
	b. Meet criteria for a diagnosis of an anxiety disorder according to a standardised diagnostic tool	b. Do not meet criteria for a diagnosis of an anxiety disorder according a standardised diagnostic tool	b. Ensures appropriate population is being targeted
6. Date	Published before 31st January 2015	Published after 31st January 2015	Final search date before transcription of the final review

Figure 1. Search flow chart



Weight of Evidence (WoE)

The five studies which met the inclusion criteria are summarised in the appendices (appendix B). As they met the inclusion criteria they were evaluated using a WoE framework (Gough, 2007). The WoE framework used provided a generic judgement of each studies methodological quality (WoE A); a review-specific judgement of the methodological relevance (WoE B); a review-specific judgment of the relevance of the studies focus (WoE C); and an overall judgment of the extent to which the study contributed evidence to answering the review question (WoE D). For an overview of the WoE and numerical rating each study received, see Table 2 (with a more in-depth explanation of the WoE ratings and corresponding rationales, in appendix C).

Table 2. Summary of WoE judgements

Author	WoE A	WoE B	WoE C	WoE D
Chavira et al. (2014)	High (2.50)	Medium (1.67)	High (2.67)	Medium (2.28)
(Cobham, 2012)	High (2.50)	Medium (2.33)	Medium (2.33)	Medium (2.39)
(Leong, Cobham, de Groot, & McDermott, 2009)	High (2.50)	Medium (2.33)	Medium (2.33)	Medium (2.39)
(Rapee, Abbott, & Lyneham, 2006)	High (2.50)	Medium (2.00)	Medium (1.67)	Medium (2.06)
(Thirlwall et al., 2013)	High (2.50)	Medium (2.33)	High (3.00)	High (2.61)

Participants

In total, 591 participants were included in this review who were aged between 6- 14-years-old. The most common types of anxiety disorders participants were diagnosed

with were generalised anxiety disorder (30%), social anxiety (26%) and separation anxiety (23%) which made up 79% of all the diagnoses made. There was a slight gender imbalance with 60% of participants being male, which is surprising considering research typically states that anxiety disorders are more prevalent in females than males (Bekker & van Mens-Verhulst, 2007; McLean, Asnaani, Litz, & Hofmann, 2011). However, the small gender difference between the reviewed studies was not perceived to be a factor that would have a significant impact on the generalisability of the findings.

In addition to meeting the diagnosis for an anxiety disorder to be eligible for inclusion into each study, there was a difference around whether participants were included if they were receiving an alternative form of treatment (in this instance psychotropic medication). Chavira et al. (2014), Rapee et al. (2006) and Thirlwall et al. (2013) all included participants who were receiving medication into their interventions. Whereas, Cobham (2012) and Leong et al. (2009) excluded participants for the same reason. While two of the studies only included participants if medication was stable (Chavira et al., 2014; Thirlwall et al., 2013), it is hard to determine whether or not the parent delivered therapeutic approach used was solely responsible for a change in anxiety severity, or if it was a combination of the two (therapy and medication). Given that the current review aimed to explore how effective cognitive-behavioural approaches delivered by parents were, those studies which included children who were receiving medication were rated lower in WoE B (appendix C).

Design

Randomisation

Three of the studies included in this review completely randomised participants to each condition (Leong et al., 2009; Rapee et al., 2006; Thirlwall et al., 2013). Chavira et al. (2014) used a block randomisation procedure to minimise imbalances in assignment to the treatment condition. Whereas, Cobham (2012) used a modified randomisation procedure to ensure three participants with unusual anxiety disorders were allocated to the individual therapy and waitlist control conditions. As many of these studies were coded as model/demonstration programmes within the procedural coding manual used (see appendix D), it was considered important that they used the most rigorous method possible (Kratochwill, 2003). Therefore, studies which did not completely randomise participants to each condition were unable to receive a high rating on this dimension within WoE B.

Comparison Conditions

As per the inclusion criteria (Table 1) all studies included in this review incorporated at least one active comparison group as part of their experimental design. The presence of an active comparison condition enabled this review to determine that it was not only the extra attention participants were receiving that would cause a change in symptoms associated with anxiety. In line with the WoE B criteria (appendix C) only one study (Cobham, 2012) included an individual therapy condition as well as a waitlist control and was coded the highest as it provided the most appropriate evidence in answering the review question. While two studies did include an active comparison group and a waitlist control (Rapee et al., 2006; Thirlwall et al., 2013), the programme delivered to the comparison group was not done in an individual format. Therefore,

these studies were coded slightly lower as they were not equivalent to the parent-delivered programme, which would have been delivered in a 1:1 setting. That is, the amount of attention that each child may have received would have been different when comparing a 1:1 therapy to group therapy and perhaps have an impact on the effectiveness of the approach taken (e.g. more attention being related to a greater reduction in the severity of anxiety symptoms). While still relevant to the review the last two studies (Chavira et al., 2014; Leong et al., 2009) only included an active comparison group. Consequently, these were coded the lowest as they did not enable the parent-delivered programme to be compared to a group that did not receive any treatment.

Group equivalence

All studies found no pre-treatment differences on several demographic and clinical variables across conditions, which included children's age and pre-treatment measures of type and severity of anxiety disorders. While child's gender significantly differed between groups in one study (Rapee et al., 2006), further analyses (with gender as a covariate) indicated that it was not a variable that affected the relationship between the independent variable and dependent variables of interest. Therefore, these findings suggest that the efficacy of such programmes are not affected by gender. Where applicable studies also found that there was no difference in other demographic variables of interest, such as parents' education (Chavira et al., 2014; Leong et al., 2009; Thirlwall et al., 2013). As a certain level of education is often assumed in using self-help CBT materials (Williams, 2001), it is suggested that this is a crucial factor that would have affected the parents' access to and usability of materials. Therefore, studies which provided information of parent education were

rated higher in WoE C, as it enables the findings to be more confidently generalised to the right population (i.e education level).

Measures

All of the studies reviewed utilised at least 3 measures from 3 different sources (specific measures described in appendix E). Anxiety measures provided by the therapist and those from the participants (children) were generally anxiety specific in their focus in all studies. However, parent reports differed considerably between studies, with some having the desired focus on anxiety symptoms (Chavira et al., 2014; Rapee et al., 2006; Thirlwall et al., 2013) and others focusing more on behaviours associated with anxiety (Cobham, 2012; Leong et al., 2009). Therefore, as the relevance of the measure used differed between studies, those which contained measures that all had an explicit focus on quantifying anxiety symptoms were rated the highest in WoE C (appendix C).

Interventions.

Fidelity in implementing a manualised cognitive-behavioural approach was considered to be an essential part of WoE A. However, all five studies were unable to receive a high rating for this dimension. Nevertheless, treatment fidelity was considered to be closely related to the amount of time therapists spent training and/or supporting the parents. While all of the studies reviewed here did not exceed the 'typical' amount of therapist time used for individual therapy, it was believed that any time therapists did spend with the parents could be suggested to be closely linked to fidelity of the programme. That is, the more time therapists spent with parents, the more likely parents were to stick to the process described in the manual. Consequently, the

duration of training and/or support parents received was related to WoE C, with the more time being related to a higher weighting.

Findings: Outcomes and Effect sizes

Effect sizes for each study and measure were calculated based on the mean pre-post change in the treatment condition minus the mean pre-post change in the comparison condition, divided by the pooled pre-test standard deviation. The aforementioned method of calculating effect sizes was used as it has been found to be favourable on measures of bias, precision and robustness (Morris, 2007). Effect sizes were computed and then interpreted using Cohen's (1992) interpretation of small (.2), medium (.5) and large (.8).

Tables 3, 4 and 5 display the effect sizes for how effective the cognitive-behavioural approaches delivered by parents were in comparison to individual therapist led treatment (Table 3), a waitlist control condition (Table 4) and two alternative forms of treatment (Table 5). A negative effect size indicates that the difference between a pre- and post-treatment measure was greater for children from the parent delivered therapy condition. However, a positive effect size indicates that the difference between a pre- and post-treatment measure was greater for the comparison group.

Clinical severity rating

The effect sizes reported from the comparison between parent delivered therapy and therapy led by a therapist (i.e. Table 3 and Table 5[a]) are varied. The effect sizes range from small, to medium, to large. However, they are all positive which indicates that

reductions seen between pre-treament and post-treatment clinical severity ratings (CSR) favour the children who received therapy from a therapist, compared to those who received it from a parent.

When compared to a waitlist control condition, parent delivered therapy reported medium to large effect sizes which were all negative. These negative effect sizes indicate that the difference between pre-and post-treatment CSR were moderately to largely greater for children from the parent delivered condition, compared to those from the waitlist control condition.

The amount of guidance parents received from a therapist, such as face-to-face contact or telephone support was also found to be a contributing factor in a reduction in CSR. Thirlwall et al. (2013) reported a large negative effect size, indicating that the difference between pre-and post-treatment CSR of children from the parents who received full support, was greater than those who received less support.

Child Self-Report

Similarly, the effect sizes reported for child self-reports of anxiety symptoms are also varied and range from small, to medium, to large. However, these effect sizes are also positive and negative, indicating that sometimes the effect favoured the parent delivered approach and other times favoured the comparison condition. Of the eight reported effect sizes six of them are small, with the others being medium and large. The medium effect size from Leong et al. (2009) and the large effect size from Cobham (2012) are both negative, indicating that when compared to individual therapy and a

waitlist control, respectively, children in the parent delivered approach reported a greater reduction in anxiety symptoms.

Parent reports

The majority of the parent reports were generally found to have small effect sizes, with a great proportion favouring the parent delivered therapeutic approach. While the rest of the effect sizes were large and in favour of the parent delivered condition as well, they were from a single study (Cobham, 2012) and were not concerned with measuring a reduction in anxiety symptoms but behaviours associated with anxiety disorders.

Table 3. Effect sizes for parent-delivered therapy vs. individual therapy

Author	Measures	Parent delivered			Individual therapy			Pretest-Posttest effect size	Effect size descriptor	Overall WoE
		N	Pre M (SD)	Post M	N	Pre M (SD)	Post M	Parent delivered vs. Individual therapy		
Chavira et al. (2014)	Clinical Severity	24	5.54 (0.66)	2	24	5.46 (0.78)	1.5	0.58	Medium	Medium
Cobham (2012)		20	5.55 (1.36)	0.2	23	6 (0.6)	6	0.03	Small	Medium
Leong et al. (2009)		13	6.53 (1.35)	1.46	14	6.93 (0.99)	1.69	0.14	Small	Medium
Chavira et al. (2014)	Child Report	24	27.5 (14.01)	14.71	24	25.2 (16.23)	8.59	0.25	Small	Medium
Cobham (2012)		20	32.75 (16.88)	17	12	36.48 (16.63)	24.13	-0.20	Small	Medium
Leong et al. (2009)		13	16.6 (6.84)	9.33	14	14.86 (7.85)	11.78	-0.57	Medium	Medium
Chavira et al. (2014)	Parent report	24	32.13 (9.66)	12.6	24	33.03 (11.19)	12.5	0.10	Small	Medium
Cobham (2012) - Mothers		20	66.05 (10.10)	58	23	65.53 (7.27)	58.26	-0.23	Small	Medium
Cobham (2012) - Fathers		20	70.75 (8.84)	61	23	67 (7.98)	59.21	-0.09	Small	Medium
Leong et al. (2009)		13	6 (2.33)	3.92	14	6.28 (2.58)	4.78	-0.24	Small	Medium

Table 4. Effect sizes for parent delivered therapy vs. waitlist control

Author	Measures	Parent delivered			Waitlist			Pretest-Posttest effect size	Effect size descriptor	Overall WoE
		N	Pre M (SD)	Post M	N	Pre M (SD)	Post M	Parent delivered vs. Waitlist		
Cobham (2012)	Clinical Severity	20	5.55 (1.36)	0.2	12	6 (0.6)	6	-4.69	Large	Medium
Rapee et al. (2006)		90	6.4 (1)	5.2	87	6.5 (0.9)	5.8	-0.53	Medium	Medium
Thirlwal et al. (2013)		64	5.52 (0.85)	3.58	69	5.7 (0.85)	4.9	-1.34	Large	High
Cobham (2012)	Child Report	20	32.75 (16.88)	17	12	37.92 (8.45)	39.67	-1.22	Large	Medium
Rapee et al. (2006)		90	34.2 (18.2)	28.1	87	33.2 (18)	25.5	0.09	Small	Medium
Thirlwal et al. (2013)		60	35.47 (16.6)	28.47	66	39.83(19.83)	29.4	0.19	Small	High
Cobham (2012) - Mother	Parent report	20	70.75 (8.84)	61	12	66.33 (7.11)	69	-1.15	Large	Medium
Cobham (2012) - Father		20	66.05 (10.1)	58	12	69.5 (7.01)	71.16	-1.07	Large	Medium
Rapee et al. (2006)		90	31.1 (14.2)	27.2	87	30.1 (13.4)	27.7	-0.11	Small	Medium
Thirlwal et al. (2013)		59	35.56 (15.62)	20.45	63	37.81 (17.09)	24.15	-0.09	Small	High

Table 5. Effect sizes for parent delivered therapy vs. other

Author	Measures	Parent delivered			Other			Pretest-Posttest effect size	Effect size descriptor	Overall WoE
		N	Pre M (SD)	Post M	N	Pre M (SD)	Post M	Parent delivered vs. Other		
Rapee et al. (2006)	Clinical Severity	90	6.4 (1)	5.2	90	6.5 (1)	3.4	1.90[a]	Large	Medium
Thirlwal et al. (2013)		64	5.52 (0.85)	3.58	61	5.61 (0.92)	4.35	-0.77[b]	Large	High
Rapee et al. (2006)	Child Report	90	34.2 (18.2)	28.1	90	32 (13)	23.7	0.14[a]	Small	Medium
Thirlwal et al. (2013)		60	35.47 (16.6)	28.47	57	39.7 (17.54)	30	0.16[b]	Small	High
Rapee et al. (2006)	Parent Report	90	31.1 (14.2)	27.2	90	55.2 (9.8)	50.9	0.03[a]	Small	Medium
Thirlwal et al. (2013)		59	35.56 (15.62)	20.45	56	40.21 (17.44)	24.16	0.06[b]	Small	High

[a] = Children received therapy as part of a group, [b]= Brief guided parent-delivered therapy

4. Conclusion and Recommendations

This review aimed to identify the effectiveness of cognitive-behavioural approaches delivered by parents in comparison to treatment delivered by a therapist or no treatment at all. Through the use of various guides and manuals parents were directed through a cognitive-behavioural approach to help their children overcome their anxiety. In addition to the guides and manuals parents were given, the parents within some of studies also received support from therapists through the form of scheduled telephone contact. While all of the studies stated that the parent-delivered therapy took a cognitive-behavioural approach, the details of what exactly parents did was not always readily available. Nevertheless, effect sizes generally suggested that therapy delivered by a parent was not as effective as that delivered by a therapist, but was more effective than being on a waiting list. The rationale for this conclusion, implications for implementing such programmes and recommendations for future research are outlined below.

While therapy delivered by a therapist was consistently found to be more effective than therapy delivered by a parent on measures of clinical severity, the magnitude of effectiveness varied between studies. It is suggested that the effectiveness of parent delivered therapeutic approaches such as those reviewed here, are largely moderated by the amount of training or support that is provided to the parents. That is, the studies which found a small effect gave parents training in how to implement the programme (Cobham, 2012; Leong et al., 2009), whereas those which provided parents with telephone support or neither forms of guidance reported moderate to large effects, respectively (Chavira et al., 2014; Rapee et al., 2006). Therefore, it is assumed that perhaps the fidelity and/or efficacy of the programme implemented by parents that did

receive training, was similar to that implemented by the therapist resulting in a smaller effect. This assumption is further reinforced when the amount of support between two identical cognitive-behavioural approaches delivered by parents were compared (Thirlwall et al., 2013). The large effect size that was calculated further supported the concept that more support gives way to superior diagnostic outcomes.

Nevertheless, when parents received no training or support, greater reductions in clinical severity were still found in comparison to those receiving no therapy at all (Rapee et al., 2006). While these reductions were greater when therapist contact was increased (Cobham, 2012; Leong et al., 2009), the results do paint a positive picture of 'true' self-help guides. However, given the range of aforementioned symptoms and behaviours that are associated with anxiety disorders, it is suggested that all programmes should have some form of professional guidance and/or monitoring in place. Not only will this increase the effectiveness of such approaches, but will ensure maladaptive behaviours that put the child or young person at risk are dealt with effectively and efficiently.

Parent and child self-reports were gathered and analysed to triangulate the reported effectiveness of different approaches. However, this comparison was approached with caution, as while the majority of child self-reports were specifically concerned with anxiety symptoms, some parent reports were concerned with behaviours associated with anxiety. Nevertheless, the two studies that did use anxiety specific measures found small effect sizes. These small effects indicate that the difference reported by the children and parents was not considerably different between the modes of delivery that were being explored (e.g. individual therapy vs. parent delivered therapy).

In conclusion, based on the available research it is believed that parent delivered CBT can be an effective way of delivering treatment for individuals that would otherwise be placed on a waiting list. This mode of delivery provides an answer to the growing demands placed on services such as CAMHS, as it is an approach that can be accessed with minimal delay and one which is considered to more cost effective than the typical individual therapy of around 15-hours. Furthermore, parent delivered therapeutic approaches may also be more accepted by individuals that may otherwise reject therapy due to a stigma around mental illness or accepting help from others. However, this would require further exploration and is therefore a potential area of interest for future research.

Limitations of the current review

It is important to note some of the limitations of the current review. Firstly, only one individual was able to code the articles reviewed, which does mean a degree of subjectivity may have been applied. Secondly, while self-help guides/manuals were an important part of the programmes that parents implemented, they were not reviewed here due to the lack of available information that was provided from the majority of studies. Lastly, this review imposed a strict inclusion criteria which may have eliminated some studies that could have built a richer picture of the effectiveness of parent-delivered therapeutic approaches.

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Appendix A: Excluded studies with rationale

Excluded studies

Study	Reason for exclusion (criterion number
Cartwright-Hatton, S., McNally, D., Field, A. P., Rust, S., Gallagher, B., Harrington, R., Miller, C., Pemberton, K., Symes, W., White, C., & Woodham, A. (2011). A new parenting-based group intervention for young anxious children: Results of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*(3), 242-251.	Over 15 hours therapist time **(criteria 5c)**
Creswell, C., Hentges, F., Parkinson, M., Sheffield, P., Willetts, L., & Cooper, P. (2010). Feasibility of guided cognitive behaviour therapy (CBT) self-help for childhood anxiety disorders in primary care. *Mental Health in Family Medicine, 7,* 49-57.	No active comparison group **(criteria 3b)**
Lyneham, H. J., Rapee, R. M. (2006). Evaluation of therapist-supported parent-implemented CBT for anxiety disorders in rural children. *Behaviour Research and Therapy, (44),* 1287-1300.	Relevant raw/ descriptive data not available **(criteria 4a)**
Mendlowitz, S. L., Manassis, K., Bradley, S., Scapillato, D., Miezitis, S., Shaw, B. F. (1999). Cognitive-Behavioral Group Treatments in Childhood Anxiety Disorders: The Role of Parental Involvement. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1223-1229.	3 independent measures of anxiety not used **(criteria 4b)**
Thienemann, M., Moore, P., Tompkins, K. (2006). A parent-only group intervention for children with anxiety disorders: Pilot study. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(1), 37-46.	No active comparison group **(criteria 3b)**

Appendix B: Summary of Included Studies

Author	N	Study Design	Age, gender presenting difficulties	Parent led therapeutic method	Therapist support	Outcome	Follow up
Chavira et al. (2014)	48	Experimental design with random allocation of participants to either the face-to-face or therapist-supported bibliotherapy groups	8- 13-year-old boys and girls who spoke English and had a primary diagnosis of social anxiety disorder, separation anxiety disorder, obsessive compulsive disorder, specific phobia, and/or generalised anxiety disorder based on the ADIS	Families received a parent and child work book based on the book, *Helping Your Anxious Child, 2nd Edition.* Each week parents read a chapter on a given CBT skill, completed activities designed to help them apply what they learned to their child's fear. The children also had specific worksheets and activities to complete	Telephone sessions occurred exclusively with the parent and typically lasted 35-45 minutes	There was no statistically significant cross-level Time x Intervention Group interactions for the measure of anxiety severity. There was, however, statistically significant time effects for the anxiety severity outcome, suggesting a significant decrease in severity over time for both active treatment groups. Parent and child reports of anxiety and overall functioning were within normative levels by the end of treatment for both the face-to-face and therapist-supported bibliotherapy groups	A 3 month follow up was conducted showing a slight increase in anxiety severity rating in the parent led therapeutic group (mean increase of 0.15) and the individual therapy group (mean increase of 0.45)
Cobham (2012)	55	Experimental design with random allocation of participants to treatment condition	7- 14-year-old boys and girls who met the criteria for a clinically significant anxiety disorder according to the ADIS	Parents were provided with a brief 2-hr group training session in which rationale for and contents of the materials provided was reviewed. Parents worked through the '*Do as I Do'* and *'Facing your Fears'* programme with their children at a rate of one session per week over a 12-week period	Therapists spoke to parents fortnightly for no longer than 20 minutes. Therapists reviewed progress, answered any questions and checked that parents understood the content of what they were due to cover with their children	There were significant difference between conditions. Post hoc analyses indicated significantly more children in the parent led therapy group were anxiety diagnosis free at post-treatment compared with the waitlist condition. Likewise, significantly more children in the individual therapy group were anxiety diagnosis free at the post-treatment compared to the waitlist group. There was, however, no significant difference between the parent led and individual therapy groups. Child self-report data and parent reported internalising behaviour problems showed that relative to the waitlist group children and parents in both active treatment groups reported significantly reduced anxiety and internalising symptoms from pre- to post-treatment	A 3 month and 6 month follow up was conducted. Within the two active treatment conditions there was no further change beyond post-treatment – by way of either deterioration or improvement

Appendix B Continued: Summary of Included Studies

Author	N	Study Design	Age, gender presenting difficulties	Parent led therapeutic method	Therapist support	Outcome	Follow up
Leong et al. (2009)	27	A pilot study with random allocation to treatment condition	7- 14-year-old boys and girls who met the criteria for a clinically significant anxiety disorder according to the ADIS	Parents attended an initial 2-hour training session with a trained therapist, whereby an overview of the treatment materials was presented. Parents were required to cover one chapter of the workbooks per week over a 12-week period	Therapist support was provided via the phone at a pre-arranged time each fortnight	The severity of primary diagnosis was significantly diminished in both the treatment groups. However, there was no significant difference between treatment groups. Child and parent reported measures of anxiety were also shown to significantly improve post treatment for both treatment groups with no significant difference between the two conditions being found	Symptom reduction was maintained at 3- and 6- month follow up
Rapee et al. (2006)	267	A randomised control trial. Participants were randomly allocated to one of three groups; bibliotherapy, group treatment or a waitlist control group	6- 12-year old boys and girls who met the criteria for an anxiety disorder according to the ADIS	Each parent was provided with a copy of the book *Helping Your Anxious Child: A Step by Step Guide which described anxiety management skills and ways of introducing them to and implementing them with their children*	After receiving a schedule with a suggested programme of completing the intervention no further contact with a therapist was initiated	The clinical severity ratings using the intention-to-treat sample showed that children receiving bibliotherapy treatment improved compared to the waitlist condition but not group treatment. Similarly, parent reports of child anxiety for the intention-to-treat analyses showed that bibliotherapy did not differ to those from the waitlist condition but was significantly different from group treatment. Children's self-report of anxious symptoms did not show a significant difference between the three groups	Severity ratings and parent rating of anxiety did not significant differ from post treatment to 3-month follow up. However, Children's report of anxiety symptoms did show a significant effect of time
Thirlwal et al. (2013)	194	A randomised control trial. Participants were randomly allocated to one of three groups; full guided parent-delivered CBT, brief guided parent-delivered CBT or a waitlist control group	7- 12-year old boys and girls who met the criteria for an anxiety disorder, social phobia, separation anxiety disorder, panic disorder/agrophobia or specific phobia according to the DSM-IV	Parents were given a self-help book called *Overcoming your child's fears and worries: A self-help guide using cognitive behavioural Techniques*	The groups were provided with weekly therapist contact (either face-to-face or telephone contact) totalling approximately 5 hours and 20 minutes for the full guidance group or 2 hours 40 minutes for the brief guidance group	50% of children from the full guidance CBT group and 39% from the brief guidance CBT group had recovered from their primary diagnosis at post-treatment assessment compared to 25% in the wait-list group. Child self-report measures showed no difference between any of the groups. A significant difference in Parent reports of their children's anxiety was only found between the full guidance group and waitlist condition	At the 6 month follow up 53% of those who received full guidance CBT and 55% of those who received brief guidance CBT no longer met the criteria for any anxiety disorder

Appendix C: Weight of Evidence

Weight of Evidence A: Methodological quality
Through the use of a procedural and coding manual for reviewing evidence-based interventions (Kratochwill, 2003) a generic and thus non review specific judgment about the coherence and integrity of the evidence that each study provided was able to be gathered.

Weight of Evidence A: *Measure reliability*

Focus	Weighting High (3), Medium (2) or Low (1) evidence	Summary of weighting criteria
Measurement	High	Studies must report the type of reliability statistic used and measures must have a reliability coefficient of .85 or higher. Data must have been collected from multiple methods and sources.
	Medium	Measures must have a reliability coefficient of .75 or higher. Data must be collected from either multiple methods or multiple sources.
	Low	Measures must have a reliability coefficient of at least .50. Multiple methods/sources not a criteria for this rating.

Weight of Evidence A: *Comparison Group*

Focus	Weighting High (3), Medium (2) or Low (1) evidence	Summary of weighting criteria
Comparison Group	High	Studies must use at least one "active" comparison group. Group equivalence must be established (through random assignment), evidence that change agents were counterbalanced must have been provided and low attrition at post must be reported.
	Medium	Studies must use at least a "no intervention" comparison group. At least two of the following must also be present: (1) counterbalancing of change agents, (2) group equivalence established or (3) equivalent mortality with low attrition.
	Low	Studies must use a comparison group and at least one of the following (1) counterbalancing of change agents, (2) group equivalence established or (3) equivalent mortality with low attrition.

Weight of Evidence A: *Fidelity*

Focus	Weighting High (3), Medium (2) or Low (1) evidence	Summary of weighting criteria
Fidelity	High	Evidence should be measured through at least two of the following: ongoing supervision/consultation, coding sessions or audio/video tapes and use of a manual.
	Medium	Evidence should be measured through at least one of the criteria and use of a manual.
	Low	Evidence of acceptable adherence measured through at least one of the above criteria or use of a manual.

Weight of Evidence A: *Follow up assessment*

Focus	Weighting High (3), Medium (2) or Low (1) evidence	Summary of weighting criteria
Follow up assessment	High	The study must have conducted follow up assessment over multiple intervals (e.g. 3 months and 6 months) with all participants that were included in the original sample.
	Medium	The study must have conducted follow up assessments at least once (e.g. 3 months) with the majority of participants that were included in the original sample.
	Low	Follow up conducted at least once (e.g. 3 months) with some participants from the original sample.

Overall WoE A scoring criteria

- **High =** 2.40 – 3.00
- **Medium =** 1.70 – 2.30
- **Low =** 1.00 – 1.60

Overall WoE A

Author	Dimensions				Overall WoE A
	Measure	Comparison	Fidelity	Follow up assessment	
Chavira et al., 2014	3	3	2	2	**High (2.50)**
Cobham 2012	2	3	2	3	**High (2.50)**
Leong et al., 2009	2	3	2	3	**High (2.50)**
Rapee et al., 2006	3	3	2	2	**High (2.50)**
Thirlwall et al., 2013	3	3	2	2	**High (2.50)**

Weight of Evidence B: Methodological relevance

WoE B provided a judgement about the appropriateness of that form of evidence for answering the review question, that it the fitness for purpose of that form of evidence.

Rationale for ratings

- To receive a high rating for randomisation, studies needed to completely randomise participants to treatment and alternative conditions. Complete randomisation was required for a high rating as this would minimise the risk of confounding variables and provide the most reliable evidence of the effectiveness of an intervention.

- To receive a high rating for comparison group, studies needed to contain a parent led therapy, individual therapy and waitlist control condition. Having these three groups would enable the study to accurately determine how effective one approach was compared to another and be able to identify that any difference was not just due to increase in the amount of attention the child was getting.

- To receive a high rating for alternative treatment, studies needed to ensure that no other treatment was being received by the participants. Ensuring that the participants were not in receipt of alternative treatments such as psychotropic drugs would enable the study to more accurately conclude that any changes in anxiety severity were a direct consequence of the therapeutic approach and not a combination of therapy and medication.

Weight of Evidence B: *Randomisation*

Weighting	Descriptive
High	Complete randomisation of all participants to treatment and alternative conditions
Medium	Randomisation block design
Low	Not all participants were randomised (specify)

Weight of Evidence B: *Comparison group*

Weighting	Descriptive
High	The study contained parent led therapy, individual therapy and waitlist control condition
Medium	The study contained Parent led therapy, an active comparison and waitlist
Low	The study contained Parent led therapy, an active comparison

Weight of Evidence B: *Alternative treatment*

Weighting	Descriptive
High	No alternative treatments were received by Children during the treatment phase
Medium	Children who were receiving psychotropic drugs which were explicitly stated to be stable prior to and while the treatment phase was taking place
Low	Children were receiving psychotropic drugs which were not stated to be stable prior to or while the treatment phase was taking place

Overall WoE B scoring criteria

- **High =** 2.40 – 3.00
- **Medium =** 1.70 – 2.30
- **Low =** 1.00 – 1.60

Overall WoE B

Author	Dimensions			Overall WoE B
	Randomisation	Comparison group	Alternative treatment	
Chavira et al. (2014)	2	1	2	Medium (1.67)
Cobham (2012)	1	3	3	Medium (2.33)
Leong et al. (2009)	3	1	3	Medium (2.33)
Rapee et al. (2006)	3	2	1	Medium (2.00)
Thirlwall et al. (2013)	3	2	2	Medium (2.33)

Weight of Evidence C

WoE C provided a judgement about the relevance of the focus of the evidence for the review question.

Rationale for ratings

- To receive a high rating for demographics, studies needed to provide information about the participants' ages, parents' education and ethnicity. This information was seen as important as it would allow for generalisability of the effectiveness of the intervention for other children who were of a similar age, background and parental education.

- To receive a high rating for anxiety measures, all of the relevant measures analysed within the study needed to be directly used to measure actual or felt anxiety symptoms. Measures that aim to measure similar aspects of anxiety enables the review to be able to compare the perceived/felt change in anxiety severity between the three individuals (e.g., child, parent and therapist).

- To receive a high rating for training/Therapist support, studies needed to provide parents with a training programme and regular support from a therapist. It was believed that any time therapists did spend with the parents through training and support would be related to higher levels of fidelity. That is, the more time therapists spent with parents, the more likely parents were to stick to the process described in the manual.

Weight of Evidence C: Demographics

Weighting	Descriptive
High (Met all of the following)	Descriptive demographic information is provided for children's age, parents education and ethnicity of sample
Medium (Met two of the following)	Descriptive demographic information is provided for children's age, parents education and ethnicity of sample
Low (Met one of the following)	Descriptive demographic information is provided for children's age, parents education and ethnicity of sample

Weight of Evidence C: Anxiety Measures

Weighting	Descriptive
High	All three anxiety measures used were directly related to measuring actual or felt anxiety symptoms
Medium	Two of the three anxiety measures were directly related to measuring actual or felt anxiety symptoms
Low	Only one of the three anxiety measures were directly related to measuring actual or felt anxiety symptoms

Weight of Evidence C: Training/Therapist support

Weighting	Descriptive
High	A training programme was given and regular therapist support was provided
Medium	A training programme was given or contact with a therapist was provided
Low	No training or contact with a therapist was provided

Overall WoE C scoring criteria

- **High =** 2.40 – 3.00
- **Medium =** 1.70 – 2.30
- **Low =** 1.00 – 1.60

Overall WoE C

Author	Dimensions			Overall WoE C
	Demographics	Anxiety Measures	Training/Therapist support	
Chavira et al. (2014)	3	3	2	High (2.67)
Cobham (2012)	2	2	3	Medium (2.33)
Leong et al. (2009)	2	2	3	Medium (2.33)
Rapee et al. (2006)	1	3	1	Medium (1.67)
Thirlwall et al. (2013)	3	3	3	High (3.00)

Weight of Evidence D

Using the criteria explained above, each study was given a weighting of between 1 and 3 for A, B and C. These scores were then averaged to correspond to an overall weight (WoE D) for each study.

The scores were as follows:
High overall WoE: Average score between 2.40 – 3.00
Medium overall WoE: Average score between 1.70 and 2.30
Low overall WoE: Average score between 1.00 – 1.70

WoE D

Author	WoE A	WoE B	WoE C	WoE D
Chavira et al. (2014)	High (2.50)	Medium (1.67)	High (2.67)	Medium (2.28)
(Cobham, 2012)	High (2.50)	Medium (2.33)	Medium (2.33)	Medium (2.39)
(Leong, Cobham, de Groot, & McDermott, 2009)	High (2.50)	Medium (2.33)	Medium (2.33)	Medium (2.39)
(Rapee, Abbott, & Lyneham, 2006)	High (2.50)	Medium (2.00)	Medium (1.67)	Medium (2.06)
(Thirlwall et al., 2013)	High (2.50) High (2.50)	Medium (2.33) Medium (1.67)	High (3.00) High (2.67)	High (2.61) Medium (2.28)

Appendix D: Coding protocol

Section excluded	Rationale
C. Primary/Secondary Outcomes Are Statistically Significant	Only a selection of outcomes were being analysed and effect sizes were being calculated
D. Educational/Clinical Significance	This section relates to outcomes which are dealt with separately in this review.
E. Evidence for primary outcomes (rate from previous code)	Relates to primary/secondary outcome section previously excluded
G. Replication	Not relevant to current review
H. Site of Implementation	Coding relates to school based interventions
A 1-5. Participant Characteristics Specified for Treatment and Control group	Information already gathered and provided in summary of study table
B Length of intervention	No numerical rating – interventions that were too long already excluded due to strict criteria
C. Intensity/dosage of intervention & D. Dosage Response	Not relevant to current review question
I. Characteristics of the intervener & E. Program implementer	All intervention implemented by parent as per inclusion criteria
G. Intervention Style or Orientation	All studies took a cognitive-behavioural approach as per inclusion criteria
H. Cost Analysis data	Not relevant to current review question
I. Training and Support Resources	Information already gathered and provided in summary of study table
J. Feasibility	Not relevant to current review

Appendix D cont. Example protocol

Coding Protocol: Group-Based Design

Domain:

- ☐ School- and community-based intervention programs for social and behavioral problems
- ☐ Academic intervention programs
- ☑ Family and parent intervention programs
- ☐ School-wide and classroom-based programs
- ☐ Comprehensive and coordinated school health services

Name of Coder(s): _____ **Date:** 12/28/2014 (M / D / Y)

Full Study Reference in APA format: Chavira, D. A., Drahora, A., Roesch, S., Garcia, M., & Stein, M. B. (2014). Feasibility of two models of treatment delivery for child anxiety in primary care. Behaviour Research and Therapy, 60, 60-66

Intervention Name (description from study): Cool kids outreach-therapist-supported bibliotherapy (TSB)

Study ID Number (Unique Identifier): 1

Type of Publication: (Check one)

- ☐ Book/Monograph
- ☑ Journal article
- ☐ Book chapter
- ☐ Other (specify):

I. General Characteristics

A. General Design Characteristics

A1. Random assignment designs (if random assignment design, select one of the following)

A1.1 ☐ Completely randomized design
A1.2 ■ Randomized block design (between-subjects variation)
A1.3 ☐ Randomized block design (within-subjects variation)
A1.4 ☐ Randomized hierarchical design

A2. Nonrandomized designs (if nonrandom assignment design, select one of the following)

A2.1 ☐ Nonrandomized design
A2.2 ☐ Nonrandomized block design (between-participants variation)
A2.3 ☐ Nonrandomized block design (within-participants variation)
A2.4 ☐ Nonrandomized hierarchical design
A2.5 ☐ Optional coding of Quasi-experimental designs (see Appendix C)

A3. Overall confidence of judgment on how participants were assigned (select one of the following)

A3.1 ☐ Very low (little basis)
A3.2 ☐ Low (guess)
A3.3 ☐ Moderate (weak inference)
A3.4 ☐ High (strong inference)
A3.5 ■ Very high (explicitly stated)
A3.6 ☐ N/A
A3.7 ☐ Unknown/unable to code

B. Statistical Treatment/Data Analysis (answer B1 through B6)

B1. Appropriate unit of analysis ■ yes ☐ no
B2. Familywise error rate controlled ☐ yes ■ no ☐ N/A
B3. Sufficiently large *N* ☐ yes ■ no
Statistical Test: Multilevel model
_ level: .05
ES: large
N required: 52 in each group

B4. Total size of sample (start of the study): 48 N
B5. Intervention group sample size: 24 N
B6. Control group sample size: 24 N

~~**For studies using qualitative research methods, code B7 and B8**~~

~~B7. Coding~~

~~B7.1 Coding scheme linked to study's theoretical empirical basis (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~B7.2 Procedures for ensuring consistency of coding are used (select one)~~ ☐ ~~yes~~ ☐ ~~no~~
~~Describe procedures:~~

~~B7.3 Progression from abstract concepts to empirical exemplars is clearly articulated (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~B8. Interactive process followed (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~Describe process:~~ _____

C. Type of Program (select one)

C1. ☐ Universal prevention program
C2. ☐ Selective prevention program
C3. ☐ Targeted prevention program
C4. ☒ Intervention/Treatment
C5. ☐ Unknown

D. Stage of the Program (select one)

D1. ☒ Model/demonstration programs
D2. ☐ Early stage programs
D3. ☐ Established/institutionalized programs
D4. ☐ Unknown

E. Concurrent or Historical Intervention Exposure (select one)

E1. ☒ Current exposure
E2. ☐ Prior exposure
E3. ☐ Unknown

II. Key Features for Coding Studies and Rating Level of Evidence/ Support

(3=Strong Evidence 2=Promising Evidence 1=Weak Evidence 0=No Evidence)

A. Measurement (answer A1 through A4)

A1. Use of outcome measures that produce reliable scores for the majority of primary outcomes. The table for Primary/Secondary Outcomes Statistically Significant allows for listing separate outcomes and will facilitate decision making regarding measurement (select one of the following)

A1.1 ■ Yes
A1.2 ☐ No
A1.3 ☐ Unknown/unable to code

A2. Multi-method (select one of the following)

A2.1 ■ Yes
A2.2 ☐ No
A2.3 ☐ N/A
A2.4 ☐ Unknown/unable to code

A3. Multi-source (select one of the following)

A3.1 ■ Yes
A3.2 ☐ No
A3.3 ☐ N/A
A3.4 ☐ Unknown/unable to code

A4. Validity of measures reported (select one of the following)

A5.1 ■ Yes validated with specific target group
A5.2 ☐ In part, validated for general population only
A5.3 ☐ No
A5.4 ☐ Unknown/unable to code

Rating for Measurement (select 0, 1, 2, or 3): ■ **3** ☐ **2** ☐ **1** ☐ **0**

B. Comparison Group

B1. Type of Comparison Group (select one of the following)

B1.1 ☐ Typical contact
B1.2 ■ Typical contact (other) specify:
B1.3 ☐ Attention placebo
B1.4 ☐ Intervention elements placebo
B1.5 ☐ Alternative intervention
B1.6 ☐ PharmacotherapyB1.1
B1.7 ☐ No intervention
B1.8 ☐ Wait list/delayed intervention
B1.9 ☐ Minimal contact
B1.10 ☐ Unable to identify comparison group

Rating for Comparison Group (select 0, 1, 2, or 3): ■ **3** ☐ **2** ☐ **1** ☐ **0**

B2. Overall confidence rating in judgment of type of comparison group (select one of the following)

B2.1 ☐ Very low (little basis)
B2.2 ☐ Low (guess)
B2.3 ☐ Moderate (weak inference)
B2.4 ☐ High (strong inference)
B2.5 ■ Very high (explicitly stated)
B2.6 ☐ Unknown/Unable to code

B3. Counterbalancing of Change Agents (answer B3.1 to B3.3)

B3.1 ■ By change agent
B3.2 ☐ Statistical
B3.3. ☐ Other

B4. Group Equivalence Established (select one of the following)

B4.1 ■ Random assignment
B4.2 ☐ Posthoc matched set
B4.3 ☐ Statistical matching
B4.4 ☐ Post hoc test for group equivalence

B5. Equivalent Mortality (answer B5.1 through B5.3)
B5.1 ■ Low Attrition (less than 20% for Post)
B5.2 ☐ Low Attrition (less than 30% for follow-up)
B5.3 ■ Intent to intervene analysis carried out
Findings_____

C. ~~**Primary/Secondary Outcomes Are Statistically Significant**~~

~~C1. Evidence of appropriate statistical analysis for **primary outcomes** (answer C1.1 through C1.3)~~

~~C1.1 ☐ Appropriate unit of analysis (rate from previous code)~~
~~C1.2 ☐ Familywise/experimenterwise error rate controlled when applicable (rate from previous code)~~
~~C1.3 ☐ Sufficiently large *N* (rate from previous code)~~

~~C2. Percentage of **primary outcomes** that are significant (select one of the following)~~

~~C2.1 ☐ Significant primary outcomes for at least 75% of the total primary outcome measures for each key construct~~

~~C2.2 ☐ Significant primary outcomes for between 50% and 74% of the total primary outcome measures for each key construct~~

~~C2.3 ☐ Significant primary outcomes for between 25% and 49% of the total primary outcome measures for any key construct~~

~~**Rating for Primary Outcomes Statistically Significant** (select 0, 1, 2, or 3): ☐ **3** ☐ **2** ☐ **1** ☐ **0**~~

~~C3. Evidence of appropriate statistical analysis for **secondary outcomes** (answer C3.1 through C3.3)~~

~~C3.1 ☐ Appropriate unit of analysis~~
~~C3.2 ☐ Familywise/experimenterwise error rate controlled when applicable (rate from previous code)~~

C3.3 ☐ Sufficiently large *N* (rate from previous code)

C4. Percentage of **secondary outcomes** that are significant (select one of the following)

C4.1 ☐ Significant secondary outcomes for at least 75% of the total secondary outcome measures for each key construct

C4.2 ☐ Significant secondary outcomes for between 50% and 74% of the total secondary outcome measures for each key construct

C4.3 ☐ Significant secondary outcomes for between 25% and 49% of the total secondary outcome measures for any key construct

Rating for Secondary Outcomes Statistically Significant (select 0, 1, 2, or 3): ☐ **3** ☐ **2** ☐ **1** ☐ **0**

C5. Overall Summary of Questions Investigated

C5.1 Main effect analyses conducted	(select one)	☐ yes	☐ no
C5.2 Moderator effect analyses conducted	(select one)	☐ yes	☐ no
Specify results: _____			
C5.3. Mediator analyses conducted	(select one)	☐ yes	☐ no
Specify results: _____			

C. Primary/Secondary Outcomes Statistically Significant (only list $p \leq .05$)

(list primary outcomes first in alphabetical order, followed by secondary outcomes in alphabetical order)

Outcomes	Primary vs. Secondary	Who Changed	What Changed	Source	Treatment Information	Outcome Measure Used	Reliability	ES	(1-)
Outcome #1:	☐ Primary ☐ Secondary ☐ Unknown	☐ Child ☐ Teacher ☐ Parent/sign. adult ☐ Ecology ☐ Other ☐ Unknown	☐ Behavior ☐ Attitude ☐ Knowledge ☐ Other ☐ Unknown	☐ Self Report ☐ Parent Report ☐ Teacher Report ☐ Observation ☐ Test ☐ Other ☐ Unknown					
Outcome #2	☐ Primary ☐ Secondary ☐ Unknown	☐ Child ☐ Teacher ☐ Parent/sign. Adult ☐ Ecology ☐ Other ☐ Unknown	☐ Behavior ☐ Attitude ☐ Knowledge ☐ Other ☐ Unknown	☐ Self Report ☐ Parent Report ☐ Teacher Report ☐ Observation ☐ Test ☐ Other ☐ Unknown					
Outcome #3:	☐ Primary ☐ Secondary ☐ Unknown	☐ Child ☐ Teacher ☐ Parent/sign. Adult ☐ Ecology ☐ Other ☐ Unknown	☐ Behavior ☐ Attitude ☐ Knowledge ☐ Other ☐ Unknown	☐ Self Report ☐ Parent Report ☐ Teacher Report ☐ Observation ☐ Test ☐ Other ☐ Unknown					
Outcome #4:	☐ Primary ☐ Secondary ☐ Unknown	☐ Child ☐ Teacher ☐ Parent/sign. Adult ☐ Ecology ☐ Other ☐ Unknown	☐ Behavior ☐ Attitude ☐ Knowledge ☐ Other ☐ Unknown	☐ Self Report ☐ Parent Report ☐ Teacher Report ☐ Observation ☐ Test ☐ Other ☐ Unknown					
Outcome #5:	☐ Primary ☐ Secondary ☐ Unknown	☐ Child ☐ Teacher ☐ Parent/sign. Adult ☐ Ecology ☐ Other ☐ Unknown	☐ Behavior ☐ Attitude ☐ Knowledge ☐ Other ☐ Unknown	☐ Self Report ☐ Parent Report ☐ Teacher Report ☐ Observation ☐ Test ☐ Other ☐ Unknown					

~~Null Findings/Negative Outcomes Associated with the Intervention (listed alphabetically by outcome)~~

Outcomes	Primary vs. Secondary	Who Was Targeted for Change	What Was Targeted for Change	Source	Note null/negative outcomes	Outcome Measure Used	Reliability	ES
~~Outcome #1:~~	☐ ~~Primary~~ ☐ ~~Secondary~~ ☐ ~~Unknown~~	☐ ~~Child~~ ☐ ~~Teacher~~ ☐ ~~Parent/sign. Adult~~ ☐ ~~Ecology~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Behavior~~ ☐ ~~Attitude~~ ☐ ~~Knowledge~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Self Report~~ ☐ ~~Parent Report~~ ☐ ~~Teacher Report~~ ☐ ~~Observation~~ ☐ ~~Test~~ ☐ ~~Other~~ ☐ ~~Unknown~~				
~~Outcome #2~~	☐ ~~Primary~~ ☐ ~~Secondary~~ ☐ ~~Unknown~~	☐ ~~Child~~ ☐ ~~Teacher~~ ☐ ~~Parent/sign. Adult~~ ☐ ~~Ecology~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Behavior~~ ☐ ~~Attitude~~ ☐ ~~Knowledge~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Self Report~~ ☐ ~~Parent Report~~ ☐ ~~Teacher Report~~ ☐ ~~Observation~~ ☐ ~~Test~~ ☐ ~~Other~~ ☐ ~~Unknown~~				
~~Outcome #3:~~	☐ ~~Primary~~ ☐ ~~Secondary~~ ☐ ~~Unknown~~	☐ ~~Child~~ ☐ ~~Teacher~~ ☐ ~~Parent/sign. Adult~~ ☐ ~~Ecology~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Behavior~~ ☐ ~~Attitude~~ ☐ ~~Knowledge~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Self Report~~ ☐ ~~Parent Report~~ ☐ ~~Teacher Report~~ ☐ ~~Observation~~ ☐ ~~Test~~ ☐ ~~Other~~ ☐ ~~Unknown~~				
~~Outcome #4:~~	☐ ~~Primary~~ ☐ ~~Secondary~~ ☐ ~~Unknown~~	☐ ~~Child~~ ☐ ~~Teacher~~ ☐ ~~Parent/sign. Adult~~ ☐ ~~Ecology~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Behavior~~ ☐ ~~Attitude~~ ☐ ~~Knowledge~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Self Report~~ ☐ ~~Parent Report~~ ☐ ~~Teacher Report~~ ☐ ~~Observation~~ ☐ ~~Test~~ ☐ ~~Other~~ ☐ ~~Unknown~~				
~~Outcome #5:~~	☐ ~~Primary~~ ☐ ~~Secondary~~ ☐ ~~Unknown~~	☐ ~~Child~~ ☐ ~~Teacher~~ ☐ ~~Parent/sign. Adult~~ ☐ ~~Ecology~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Behavior~~ ☐ ~~Attitude~~ ☐ ~~Knowledge~~ ☐ ~~Other~~ ☐ ~~Unknown~~	☐ ~~Self Report~~ ☐ ~~Parent Report~~ ☐ ~~Teacher Report~~ ☐ ~~Observation~~ ☐ ~~Test~~ ☐ ~~Other~~ ☐ ~~Unknown~~				

Type of Data Effect Size is Based On	Confidence Rating in ES Computation
(check all that apply) ☐ Means and SDs ☐ *t*- value or *F* - value ☐ Chi square (*df* = 1) ☐ Frequencies or proportions (dichotomous) ☐ Frequencies or proportions (polytomous) ☐ Other (specify): ☐ Unknown	(select one of the following) ☐ Highly estimated (e.g., only have *N* p value) ☐ Moderate estimation (e.g., have complex but complete statistics) ☐ Some estimation (e.g., unconventional statistics that require conversion) ☐ Slight estimation (e.g., use significance testing statistics rather than descriptives) ☐ No estimation (e.g., all descriptive data is present)

D. Educational/Clinical Significance

Outcome Variables:	Pretest	Posttest	Follow Up
D1. Categorical Diagnosis Data	Diagnostic information regarding inclusion into the study presented: ☐ Yes ☐ No ☐ Unknown	Positive change in diagnostic criteria from pre to posttest: ☐ Yes ☐ No ☐ Unknown	Positive change in diagnostic criteria from posttest to follow up: ☐ Yes ☐ No ☐ Unknown
D2. Outcome Assessed via continuous Variables		Positive change in percentage of participants showing clinical improvement from pre to posttest: ☐ Yes ☐ No ☐ Unknown	Positive change in percentage of participants showing clinical improvement from posttest to follow up: ☐ Yes ☐ No ☐ Unknown
D3. Subjective Evaluation: The importance of behavior change is evaluated by individuals in direct contact with the participant.	Importance of behavior change is evaluated: ☐ Yes ☐ No ☐ Unknown	Importance of behavior change from pre to posttest is evaluated positively by individuals in direct contact with the participant: ☐ Yes ☐ No ☐ Unknown	Importance of behavior change from posttest to follow up is evaluated positively by individuals in direct contact with the participant: ☐ Yes ☐ No ☐ Unknown
D4. Social Comparison: Behavior of participant at pre, post, and follow up is compared to normative data (e.g., a typical peer).	Participant's behavior is compared to normative data ☐ Yes ☐ No ☐ Unknown	Participant's behavior has improved from pre to posttest when compared to normative data: ☐ Yes ☐ No ☐ Unknown	Participant's behavior has improved from posttest to follow up when compared to normative data: ☐ Yes ☐ No ☐ Unknown

Rating for Educational/Clinical Significance (select 0, 1, 2, or 3): ☐ **3** ☐ **2** ☐ **1** ☐ **0**

E. Identifiable Components (answer E1 through E7)

E1. Evidence for primary outcomes (rate from previous code): ☐ 3 ☐ 2 ☐ 1 ☐ 0
E2. Design allows for analysis of identifiable components (select one) ☐ yes ☐ no

E3. Total number of components:

N

~~E4. Number of components linked to primary outcomes:~~

~~N~~

~~Additional criteria to code descriptively:~~

~~E5. Clear documentation of essential components (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~E6. Procedures for adapting the intervention are described in detail (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~E7. Contextual features of the intervention are documented (select one)~~ ☐ ~~yes~~ ☐ ~~no~~

~~**Rating for Identifiable Components** (select 0, 1, 2, or 3):~~ ☐ ~~**3**~~ ☐ ~~**2**~~ ☐ ~~**1**~~ ☐ ~~**0**~~

F. Implementation Fidelity

F1. Evidence of Acceptable Adherence (answer F1.1 through F1.3)

F1.1 ☒ Ongoing supervision/consultation
F1.2 ☐ Coding intervention sessions/lessons or procedures
F1.3 ☐ Audio/video tape implementation (select F1.3.1 or F1.3.2):

F1.3.1 ☐ Entire intervention
F1.3.2 ☐ Part of intervention

F2. Manualization (select all that apply)

F2.1 ☐ Written material involving a detailed account of the exact procedures and the sequence in which they are to be used

F2.2 ☐ Formal training session that includes a detailed account of the exact procedures and the sequence in which they are to be used

F2.3 ☒ Written material involving an overview of broad principles and a description of the intervention phases

F2.4 ☒ Formal or informal training session involving an overview of broad principles and a description of the intervention phases

F3. Adaptation procedures are specified (select one) ☐ yes ☒ no ☐ unknown

Rating for Implementation Fidelity (select 0, 1, 2, or 3): ☐ **3** ☒ **2** ☐ **1** ☐ **0**

~~**G. Replication** (answer G1, G2, G3, and G4)~~

~~G1.~~ ☐ ~~Same Intervention~~
~~G2.~~ ☐ ~~Same Target Problem~~
~~G3.~~ ☐ ~~Independent evaluation~~

~~**Rating for Replication** (select 0, 1, 2, or 3):~~ ☐ ~~**3**~~ ☐ ~~**2**~~ ☐ ~~**1**~~ ☐ ~~**0**~~

~~**H. Site of Implementation**~~

~~H1. School (if school is the site, select one of the following options)~~

~~H1.1~~ ☐ ~~Public~~

H1.2 ☐ Private
H1.3 ☐ Charter
H1.4 ☐ University Affiliated
H1.5 ☐ Alternative
H1.6 ☐ Not specified/unknown

H2. Non-School Site (if it is a non-school site, select one of the following options)

H2.1 ☐ Home
H2.2 ☐ University Clinic
H2.3 ☐ Summer Program
H2.4 ☐ Outpatient Hospital
H2.5 ☐ Partial inpatient/day Intervention Program
H2.6 ☐ Inpatient Hospital
H2.7 ☐ Private Practice
H2.8 ☐ Mental Health Center
H2.9 ☐ Residential Treatment Facility
H2.10 ☐ Other (specify):_____
H2.11 ☐ Unknown/insufficient information provided

Rating for Site of Implementation (select 0, 1, 2, or 3): ☐ **3** ☐ **2** ☐ **1** ☐ **0**

I. **Follow Up Assessment**

☒ Timing of follow up assessment: specify 3 months

☒ Number of participants included in the follow up assessment: specify 31

☒ Consistency of assessment method used: specify Same measures used

Rating for Follow Up Assessment (select 0, 1, 2, or 3): ☐ **3** ☒ **2** ☐ **1** ☐ **0**

III. Other Descriptive or Supplemental Criteria to Consider

A. External Validity Indicators

A1. Sampling procedures described in detail ☐ yes ☐ no

Specify rationale for selection: _____

Specify rationale for sample size: _____

A1.1Inclusion/exclusion criteria specified ☐ yes ☐ no

A1.2 Inclusion/exclusion criteria similar to school practice ☐ yes ☐ no

A1.3 Specified criteria related to concern ☐ yes ☐ no

A2. Participant Characteristics Specified for Treatment and Control Group

Participants from Treatment Group	Grade/age	Gender	Ethnicity or Multi-ethnic	Ethnic Identity	Race(s)	Acculturation	Pri-mary Lan-guage	SES	Family Struc-ture	Locale	Disability	Functional Descriptors
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												

Participants from Control Group	Grade/age	Gender	Ethnicity or Multi-ethnic	Ethnic Identity	Race(s)	Acculturation	Pri-mary Lan-guage	SES	Family Struc-ture	Locale	Disability	Functional Descriptors
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other												

A3. Details are provided regarding variables that:

A3.1 Have differential relevance for intended outcomes ☐yes ☐no

Specify: _____

A3.2 Have relevance to inclusion criteria ☐yes ☐no

Specify: _____

A4. Receptivity/acceptance by target participant population (treatment group)

Participants from Treatment Group	Results (What person reported to have gained from participation in program)	General Rating
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other		☐ Participants reported benefiting overall from the intervention ☐ Participants reported not benefiting overall from the intervention
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other		☐ Participants reported benefiting overall from the intervention ☐ Participants reported not benefiting overall from the intervention
☐ Child/Student ☐ Parent/caregiver ☐ Teacher ☐ School ☐ Other		☐ Participants reported benefiting overall from the intervention ☐ Participants reported not benefiting overall from the intervention

A5. Generalization of Effects:

A5.1 Generalization over time

A5.1.1 Evidence is provided regarding the sustainability of outcomes after intervention is terminated ☐yes ☐no

Specify: _____

A5.1.2 Procedures for maintaining outcomes are specified ☐yes ☐no

Specify: _____

A5.2 Generalization across settings

A5.2.1 Evidence is provided regarding the extent to which outcomes are manifested in contexts that are different from the intervention context ☐yes ☐no

Specify: _____

A5.2.2 Documentation of efforts to ensure application of intervention to other settings
☐yes ☐no

Specify: _____

A5.2.3 Impact on implementers or context is sustained ☐yes ☐no

Specify: _____

A5.3 Generalization across persons

Evidence is provided regarding the degree to which outcomes are manifested with participants who are different than the original group of participants for with the intervention was evaluated
☐yes ☐no

Specify: _____

B. Length of Intervention (select B1 or B2)

B1. ☐ Unknown/insufficient information provided

B2. ☐ Information provided (if information is provided, specify one of the following:)

B2.1 weeks _____ N

B2.2 months _____ N

B2.3 years _____ N

B2.4 other _____ N

C. Intensity/dosage of Intervention (select C1 or C2)

C1. ☐ Unknown/insufficient information provided

C2. ☐ Information provided (if information is provided, specify both of the following:)

C2.1 length of intervention session _____ N

C2.2 frequency of intervention session _____ N

D. Dosage Response (select D1 or D2)

D1. ☐ Unknown/insufficient information provided

D2. ☐ Information provided (if information is provided, answer D2.1)

D2.1 Describe positive outcomes associated with higher dosage: _____

E. Program Implementer (select all that apply)

E1. ☐ Research Staff
E2. ☐ School Specialty Staff
E3. ☐ Teachers
E4. ☐ Educational Assistants
E5. ☐ Parents
E6. ☐ College Students
E7. ☐ Peers
E8. ☐ Other
E9. ☐ Unknown/insufficient information provided

F. Characteristics of the Intervener

F1. ☐ Highly similar to target participants on key variables (e.g., race, gender, SES)
F2. ☐ Somewhat similar to target participants on key variables
F3. ☐ Different from target participants on key variables

G. Intervention Style or Orientation (select all that apply)

G1. ☐ Behavioral
G2. ☐ Cognitive-behavioral
G3. ☐ Experiential
G4. ☐ Humanistic/interpersonal
G5. ☐ Psychodynamic/insight oriented
G6. ☐ other (specify):_____
G7. ☐ Unknown/insufficient information provided

H. Cost Analysis Data (select G1 or G2)

H1. ☐ Unknown/insufficient information provided
H2. ☐ Information provided (if information is provided, answer H2.1)

H2.1 Estimated Cost of Implementation:_____

I. Training and Support Resources (select all that apply)

I1. ☐ Simple orientation given to change agents
I2. ☐ Training workshops conducted

# of Workshops provided _____

Average length of training _____

Who conducted training (select all that apply)

I2.1 ☐ Project Director
I2.2 ☐ Graduate/project assistants

~~I2.3~~ ☐ ~~Other (please specify):~~
~~I2.3~~ ☐ ~~Unknown~~

~~I3.~~ ☐ ~~Ongoing technical support~~
~~I4.~~ ☐ ~~Program materials obtained~~
~~I5.~~ ☐ ~~Special Facilities~~
~~I6.~~ ☐ ~~Other (specify):~~

~~J. Feasibility~~

~~J1. Level of difficulty in training intervention agents (select one of the following)~~

~~J1.1~~ ☐ ~~High~~
~~J1.2~~ ☐ ~~Moderate~~
~~J1.3~~ ☐ ~~Low~~
~~J1.4~~ ☐ ~~Unknown~~

~~J2. Cost to train intervention agents (specify if known):~~ _____

~~J3. Rating of cost to train intervention agents (select one of the following)~~

~~J3.1~~ ☐ ~~High~~
~~J3.2~~ ☐ ~~Moderate~~
~~J3.3~~ ☐ ~~Low~~
~~J3.4~~ ☐ ~~Unknown~~

Summary of Evidence for Group-Based Design Studies

Indicator	Overall Evidence Rating NNR = No numerical rating or 0 - 3	Description of Evidence Strong Promising Weak No/limited evidence or Descriptive ratings
General Characteristics		
General Design Characteristics	NNR	
Statistical Treatment	NNR	
Type of Program	NNR	
Stage of Program	NNR	
Concurrent/Historical Intervention Exposure	NNR	
Key Features		
Measurement	3	High
Comparison Group	3	High
~~Primary/Secondary Outcomes are Statistically Significant~~		
~~Educational/clinical significance~~		
~~Identifiable Components~~		
Implementation Fidelity	2	Medium
~~Replication~~		
~~Site of Implementation~~		
Follow Up Assessment Conducted	2	Medium

~~**Descriptive or Supplemental Criteria**~~		
~~External validity indicators~~		
~~Length of Intervention~~		
~~Intensity/dosage~~		
~~Dosage Response~~		
~~Program Implementer~~		
~~Characteristics of the Intervener~~		
~~Intervention Style/Orientation~~		
~~Cost Analysis Data Provided~~		
~~Training and Support Resources~~		
~~Feasibility~~		