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Addressing Parental Mental Health Within Interventions for Children: A Review

Mary C. Acri[1] and **Kimberly Eaton Hoagwood**[1]

[1]New York University School of Medicine, New York, NY, USA

Abstract

Purpose—Untreated parent mental health problems have deleterious effects upon the family, yet caregivers are unlikely to receive services for their emotional health. We conducted a review of treatments and services for children and adolescents that also offered services to parents.

Methods—Child treatment and service studies were included in the present study if they analyzed parent symptoms or diagnoses over time, and the intervention contained a parent component.

Results—Of 200 studies reviewed, 20 contained a component for the parent and assessed the parent's emotional health at multiple time points. Depression and anxiety were the most commonly studied parental mental health problem; most parent components consisted of behavioral strategies in service of the child's psychological health.

Conclusion—Major shifts in health care policy affecting mental health services provide an opportunity to create integrated and coordinated health and behavioral health systems. Attention must be given to ensure that the workforce of providers, the administrative structures, and the reimbursement strategies are strengthened and connected to serve the needs of parents/caregivers and children in order to enhance family outcomes.

Keywords

parent mental health; child mental health services; parent support; service fragmentation; parent outcomes

Parents of children with psychiatric disorders are more likely to evidence mental health problems than the general population (Gopalan, Dean-Assael, Klingstein, Chacko, & McKay, 2011). Their parenting responsibilities are compounded by challenges associated with navigating mental health, school, and other systems to meet their child's needs (Bailey, Golden, Roberts, & Ford, 2007; Yatchmenoff, Koren, Friesen, Gordon, & Kinney, 1998). They experience stigma and blame by family, friends, and their child's school and providers because of their child's difficulties (Oruche, Gerkensmeyer, Stephan, Wheeler, & Hanna,

Corresponding Author: Mary C. Acri, Department of Child and Adolescent Psychiatry, New York University School of Medicine, One Park Avenue at East 33rd, 8th Floor, New York, NY 10016, USA. mary.acri@nyumc.org.

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2012; Scharer, 2002, 2005). Many lack needed social support and experience considerable social isolation (Lee, Anderson, Horowitz, & August, 2009; Oruche et al., 2012; Rishel et al., 2006). Parents who are impacted by poverty, and experience social/environmental stressors such as child welfare involvement, community, and interpersonal violence, are particularly at risk for mental health problems (Marcenko, Lyons, & Courtney, 2011).

A robust mental health literature suggests many mental health disorders experienced in adulthood are treatable. For example, depression and anxiety, which are two of the most common mental health disorders among adults (Anxiety and Depression Association of America, 2013), are effectively treated by cognitive–behavioral therapy (CBT) and interpersonal psychotherapy, and pharmacologic agents, such as selective serotonin reuptake inhibitors (Miranda et al., 2003). Yet most adults, and especially female caregivers, do not receive mental health services (Glied, Newfield, & McCormack, 2003; Grote, Bledsoe, Swartz, & Frank, 2004; Swartz et al., 2002). Lack of child care, insurance, and transportation are substantial impediments to receipt of services, especially among caregivers living in poverty due to their lack of financial resources (Miranda & Bruce, 2002; Miranda & Green, 1999; Rosen, Tolman, & Warner, 2004). Stigma (Glied et al., 2003; Grote et al., 2004; Swartz et al., 2002) and concerns that service use will result in a loss of their parental rights are also powerful dissuaders from service use among caregivers (Mauthner, 1999; McIntosh, 1993; Miranda & Bruce, 2002; Shakespeare, Blake, & Garcia, 2003; Templeton, Velleman, Persaud, & Milner, 2003). Parents living in poverty, especially those who identify as belonging to an ethnic minority group, are particularly unlikely to seek mental health treatment because of these perceptual impediments.

Mental health disorders in parents influence their child's mental health. For example, depression and anxiety increase the risk of both disorders among their offspring in comparison to children of parents without a mood or anxiety disorder (Weissman et al., 1996). Similar findings have been shown for bipolar disorder (Birmaher et al., 2009), schizophrenia (Asar-now et al., 2001), and attention-deficit hyperactivity disorder (Biederman et al., 1995).

Untreated parental mental health issues are also associated with less optimal therapeutic progress and poorer outcomes among youth in treatment (Beauchaine, Webster-Stratton, & Reid, 2005; Pilowsky et al., 2008; Rishel et al., 2006). Studies of therapeutic outcomes for children with disruptive behavioral disorders, for example, suggest parent depression inhibits uptake of behavioral parenting strategies and undermines therapeutic outcomes (Chronis, Chacko, Fabiano, Wymbs, & Pel-ham, 2004). Yet when the parent's issues resolve, child symptoms and impairment abate (Brent et al., 1998; Coiro, Riley, Broitman, & Miranda, 2012; Foster et al., 2009; Gordon, Antshel, & Lewandowski, 2012; Pilowsky et al., 2008).

Because of this connection, there have been calls to attend to the emotional health of parents within the context of their child's treatment. This premise is concordant with a growing movement to address parental mental health in settings that caregivers, and primarily mothers, naturally frequent, such as pediatric clinics (Earls, 2010), obstetric and gynecological offices (Committee on Obstetric Practice, 2010), and even supermarkets

(Swartz et al., 2002). Considerable barriers to linking child and parent mental health services have been cited, particularly in real-world settings. The existence of separate sectors to address children's issues, along with separate funding streams, lack of training in the workforce, and biases toward parents about their presumed contribution to their child's problems results in a fragmented and uncoordinated set of systems for children and their parents (Blanch, Nicholson, & Purcell, 1994; Mason & Subedi, 2006). There have been few studies specifically addressing parental mental health within the context of child treatments (Silverman, Kurtines, Jaccard, & Pina, 2009). The extent to which it is a component of child treatment and how has not been systematically examined.

The current study aims to answer these questions. The interventions reviewed in this project were analyzed as part of a larger study of outcome domains in child mental health treatments and services. This review focuses specifically on services offered to parents within the context of child mental health treatments and services. It is likely that interventions addressing both child and parent mental health can reduce logistical obstacles associated with navigating multiple services, potentially enhance youth outcomes, and serve as a model for service integration among providers working with families with complex needs.

Method

This review is an analysis of a data set that was compiled for a prior review. Briefly, the initial project examined outcome domains that were investigated within studies of mental health treatments and services for children between birth and 18 years of age. Inclusion criteria consisted of articles that were published between 1996 and 2011, used a randomized experimental design, and had either a 6-month or longer posttreatment follow-up assessment for treatment studies or a 6-month or longer postbaseline data point for service studies. In total, 200 studies described in 224 articles were included.

The authors used the same descriptive categories to classify treatment and service studies and the same outcome domains as in the prior review. Specifically, treatment and service studies were grouped separately, and treatment studies were further categorized by symptom or diagnosis, comorbid conditions, or other, yielding 12 categories: (1) attention-deficit hyperactivity disorder, (2) anxiety, (3) autism, (4) conduct, (5) bipolar, (6) comorbid disorders, (7) depression, (8) eating disorders, (9) other (a general category for studies that did not fit in any of the other categories), (10) personality disorder, (11) posttraumatic stress disorder, and (12) services for emotional/behavioral problems.

Outcome domains were coded according to a typology referred to as SISYPHUS: (1) symptoms and diagnoses, (2) functioning/impairment, (3) consumer-oriented perspectives, (4) interpersonal–environmental contexts, (5) services/systems, (6) parent symptoms and diagnoses, and (7) health. *Parent symptoms and diagnoses* was defined as emotions or behaviors that the child's parent or caregiver exhibits, often leading to a formal psychiatric diagnosis according to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth edition (American Psychiatric Association and American Psychiatric Association Task Force on DSM-IV, 1994). See Hoagwood et al. (2012) for a fuller explanation and definition of each construct.

Inclusion and Exclusion Criteria

Child treatment and service studies were included in the present study if they analyzed parent symptoms or diagnoses over time, and the intervention contained a parent component, which was broadly defined as involving the parent in some way (e.g., providing information about the child's mental health difficulty, family therapy, parenting skills training).

Coding and Analysis

To code the parent component, the two authors (Acri and Hoag-wood) systematically reviewed the 200 original studies in biweekly meetings over 6 months. The two authors developed a coding typology for treatments and services ranging from 0, which was defined as *not containing a parent component*, to 3, defined as *providing a parent component explicitly for the parent's own psychological health*. Any discrepancies were discussed among the authors until consensus was reached. The coding system was refined until no additional codes were needed. Table 1 presents the coding typology.

Results

Of the pool of 200 studies, 20 (10%) met criteria for inclusion in the current review, meaning they contained a component for the parent and assessed the parent's emotional health at multiple time points. The 20 studies were grouped within the following four treatment/services categories for children: (1) conduct (n = 15, 75%), (2) anxiety (n = 3, 15%), (3) services (n = 1, 4.5%), and (4) posttraumatic stress (n = 1, 4.5%). In addition to their focus on parental emotional health, over a third of the studies (n = 7, 35%) recruited families that evidenced risk factors for child health and well-being. Specifically, five (71.4%) were recruited from poverty-impacted communities or purposely enrolled families who were of low socioeconomic status, and the other two (n = 2, 28.6%) were recruited from families that experienced domestic violence. See Table 2 for a list of included studies.

Parent Symptoms and Diagnoses

Depression and anxiety were the most commonly assessed mental health problems among parents. All but one study measured depression (n = 19, 95%), which was typically assessed via a structured interview or standardized measure such as the Beck Depression Inventory (Beck, Steer, & Carbin, 1988) or the Depression Anxiety Stress Scale (DASS; Antony, Bieling, Cox, Enns, & Swinson, 1998). The prevailing rationale for measuring parental depression was to prevent the inhibition of behavioral parenting strategies critical to enhancing therapeutic outcomes (Chronis et al., 2004). The sole study that did not measure parental depression was a treatment for child anxiety (Silverman et al., 2009); only symptoms of anxiety were measured among parents.

Parental anxiety was assessed in almost three quarters of studies (n = 14, 70%), usually by a standardized assessment instrument such as the DASS, the General Health Questionnaire (Goldberg & Williams, 2000), or the anxiety subscale of the Symptom Checklist-90–Revised (Derogatis & Unger, 2010). Anxiety among caregivers was measured (and addressed) in order to reduce the maintenance of anxiety among their children, as parental

distress was viewed as transmissible to the child and interfered with treatment gains (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008).

Additional mental health problems among parents that were assessed included emotional distress over their child's sexual abuse (n = 1, 5%; Deblinger, Mannarino, Cohen, & Steer, 2006) and symptoms of trauma (Jouriles et al., 2009); however, these were studied substantially less frequently.

Parent Component and Outcomes

Parent component in service of the child's psychological health—The parent component in 14 (70%) of the 20 studies was in service of the child's psychological health. Of the 14 studies, 10 (71.4%) offered parents parenting skills or programs such as Triple P (e.g., Sanders, Bor, & Morawska, 2007; Turner & Sanders, 2006) and The Incredible Years (e.g., Bywater et al., 2009; Hutchings et al., 2007; Patterson et al., 2002). An 11th study, by Barrett, Healy-Farrell, and March (2004), offered parenting skills in conjunction with psychoeducation and cognitive–behavioral strategies for parents to reduce their child's anxiety.

The other three (21.4%) studies offered parents cognitive–behavioral strategies to manage their child's anxiety or distress after sexual abuse (Deblinger et al., 2006), Multisystemic Therapy, a family-based treatment to reduce severe conduct problems among youth (Borduin et al., 1995), and Child/Parent Psychotherapy (Lieberman, Ippen, & Van Horn, 2006), a parent/child psychotherapy that draws from multiple theories (e.g., attachment, social learning, cognitive behavior, and trauma) to improve child behavior through the parent–child relationship.

Under a third of studies (n = 6, 30%) offered a service to the parents for their own emotional health (Barrington, Prior, Richardson, & Allen et al., 2005; Jouriles et al., 2009; Sanders & McFarland, 2000; Sanders et al., 2007; Silverman et al., 2009; Verduyn, Barrowclough, Roberts, Tarrier, & Harrington, 2003). Of them, the common component offered to parents was cognitive–behavioral strategies, which were either provided alone (Barrington et al., 2005; Silverman et al., 2009) or provided in addition to psychoeducation and/or parenting skills (Sanders & McFarland, 2000; Sanders et al., 2007; Verduyn et al., 2003) to reduce anxiety and/or depression. Jouriles et al.'s (2009) Project Support was an exception, in that it primarily offered instrumental and emotional support by a trained therapist, in addition to parenting skills to parents who were leaving a shelter for women impacted by domestic violence and psychiatric symptoms as measured by the Symptom Checklist-90 (Derogatis & Unger, 2010; e.g., depression, anxiety, somatization, and psychoticism) and trauma.

Six (42.9%) of the 14 studies that offered a parent component in service of the child's treatment compared the intervention to a wait-list control group (Bradley et al., 2003; Bywater et al., 2009; Gardner, Burton, & Klimes, 2006; Hutchings et al., 2007; Patterson et al., 2002; Turner & Sanders, 2006), 4 (28.6%) tested the active intervention against a comparison condition (Borduin et al., 1995; Deblinger et al., 2006; Lieber-man et al., 2006; Morawska, Haslam, Mile, & Sanders, 2010), and 3 (21.4%) compared the intervention to

one or more comparison groups and a wait-list control group (Barrett, Healy-Farrell, & March, 2004; Markie-Dadds & Sanders, 2006; Reid, Webster-Stratton, & Hammond, 2003).

Outcomes

Parental component in service of the child's psychological health—The 14 studies that offered a component in service of the child's treatment were largely mixed with respect to parental outcomes. Four (28.6%) studies found significant reductions in parental mental health symptoms in comparison to a wait-list control or comparison group at posttest (Borduin et al., 1995; Hutchings et al., 2007) and over time (Bywater et al., 2009; Lieberman et al., 2006). An additional four (28.5%) studies showed partial benefits to parents (e.g., Deblinger et al., 2006; Patterson et al., 2002). For example, parents who received 1-2-3 Magic evidenced improvement in the hostility subscale of the Brief Symptom Inventory only (Bradley et al., 2003), while in a second study, parents who received Triple P evidenced significant improvements in anxiety in comparison to the wait-list control group, although there was no significant improvement in symptoms of depression (Turner & Sanders, 2006).

Two (14.3%) studies did not find any discernible change in depression (Gardner et al., 2006) or depression or anxiety over time (Morawska et al., 2010). Finally, in the remaining four (28.5%) studies, either parental mental health symptoms fell below clinical levels at baseline (Barrett et al., 2004; Markie-Dadds & Sanders, 2006) or predictors of child outcomes were studied (Harrington et al., 2000; Reid et al., 2003).

Parental component in service of the parent's psychological health—Six (30%) studies offered a parent component in service of their psychological health. Half (n = 3, 50%) tested the standard treatment versus a treatment that was augmented with the component that addressed the parent's emotional health (e.g., standard vs. enhanced parent training that addressed one or more adverse familial factors, including parental mental health, Sanders et al., 2007; parenting skills vs. parenting skills plus a cognitive piece to address parent depression, Sanders & McFarland, 2000; and cognitive–behavioral treatment for the child vs. the child's treatment plus an active parent component, Silverman et al., 2009).

Results were mixed. Sanders and McFarland (2000) found that the added parent component was more effective in addressing parental depression at follow-up than the standard condition. The other two studies found parental mental health improved in both the active treatment and comparison conditions, with no significant difference between groups (Sanders et al., 2007; Silverman et al., 2009).

The other three studies contrasted the intervention with a comparison or control condition. Families in Jouriles et al.'s (2009) study were randomized to Project Support, which consisted of parenting skills, instrumental and emotional support, or monthly phone or in person contacts in which caregivers received instrumental and emotional support in addition to other services they might receive outside of the study. Barrington, Prior, Richardson, and Allen (2005) tested the impact of CBT compared to treatment as usual, which could include individual treatment and family therapy among other services. Verduyn, Barrowclough,

Roberts, Tarrier, and Harrington (2003) compared CBT for mothers to parent/child groups to a no treatment condition. Similar to the previous findings, one of the three studies found greater benefits to parental mental health among the active treatment group (Jouriles et al., 2009), while the other two showed improvements in both conditions, and no significant differences between groups (Barrington et al., 2005; Verduyn et al., 2003).

Discussion and Applications to Practice

The purpose of this review was to investigate whether parent mental health is addressed within child treatments and services, the services offered to parents, and the results of these efforts. The large majority of studies that focused on parent mental health symptoms or diagnoses were among studies examining treatments for child conduct problems. Eight treatment categories in the original review, such as attention-deficit hyperac-tivity disorder, eating disorders, and bipolar disorder, did not include any study that addressed parent mental health. One interpretation of this finding is that evidence-based treatments for certain disorders, such as anorexia, are relatively newer in development and testing than treatments for conduct problems; thus, these therapies may be focused on demonstrating their efficacy and effectiveness at improving child symptoms and functioning before moving onto caregiver outcomes. Although the prior review showed a growing focus upon parental symptoms and diagnoses (Hoagwood et al., 2012), only a fraction of interventions identified and offered the parent a service. Given the increased risk of mental health problems among parents of children with psychological disorders and the possibility that improving parent mental health may strengthen youth outcomes, it is important to understand the extent to which addressing the psychological well-being of caregivers within the context of children's treatment does make a difference.

Another notable finding was that most studies offered a parent component in service of the child's psychological health and, most commonly, parenting skills. Again, this finding may be a reflection of the prevalence of treatments for child conduct problems (n = 15, 75%) and that parenting skills is a well-established treatment for behavioral problems among youth. While debatable whether parenting skills is also primarily for the parent (e.g., to maintain control and reduce stress), nonetheless, only six of the interventions offered a service that was focused on the parent. This result reflects a tension as to how much of an impact child mental health interventions can feasibly have on parent well-being and the level of effort required with respect to training clinicians, administrative burden, and staff time. An additional concern is reimbursement, as parental mental health treatment in the context of child treatment may not be reimbursable in all systems. The advent of the Affordable Care Act (ACA; Patient Protection and Affordable Care Act, 2010; Rak & Coffin, 2012) requiring health insurance coverage for all adults and the Wellston-Domenici Parity Act (2013), which mandates parity for substance abuse and mental health treatments, may have a positive effect on treatment access for parents.

Another approach to the problem of providing services to both parents and children maybe the model of co-location. Offering services for children and their parents in one setting reduces logistical barriers to access and would remedy problems associated with reimbursement and training child therapists to address parental well-being.

The number of studies that compared the impact of a parent-augmented intervention to the standard treatment is too few for drawing any firm conclusions. This gap suggests a need for more research to examine the impact of parent-focused services on youth outcomes beyond that offered as part of the child's treatment. Nonetheless, it is encouraging that all six studies that offered a parent component in service of the parent's psychological health found some benefit. These results are stronger than parent outcomes in the 14 studies that offered a parent component for the sake of the child's psychological health. Indeed, several studies found a partial benefit, or no benefit beyond the wait-list control group. Future research needs to be done in order to add clarity to what is currently an incomplete finding.

Implications

This review points to a systemic problem involving a narrow focus in research and practice on children's mental health treatments and services. While a huge body of literature now substantiates the existence of effective treatments and services for children and adolescents, only a small number of these studies have also examined the combined effect of adding treatments and services targeting parent's mental health. Child mental health providers are typically not trained to work with parents, nor even to identify caregivers who are at risk for mental health problems and refer them to services. Training for child therapists should include assessment of risk including screening for depression and other mental health symptoms or factors likely to influence both their need and their child's need. These include domestic violence and low socioeconomic status.

As passive referrals have been shown to be largely ineffective, providers need to develop a community network of adult providers who are available to provide both a comprehensive assessment and treatment for parents. A growing number of health professionals, for example, have moved to an open-access scheduling system. In contrast to fixed appointments, which are usually made weeks or even months in advance, open-access scheduling allows patients to book same-day appointments. The rationale behind open-access scheduling is that it reduces long wait-lists for new patients, decreases missed appointments, increases patient satisfaction with services, and facilitates continuity of care, provider efficiency, and reduced costs (Qu & Shi, 2009). And for families who are identified as experiencing severe stressors, the provision of additional supports, which include both tangible assistance and addressing misperceptions about treatment and its implications, can enhance service use and family outcomes.

The absence of well-designed studies that examine the impact of treating parent mental health on children leaves many unanswered questions. When is parent treatment really likely to benefit the child and when is it not? If it does, what is the mechanism by which it does so? When is parent education and support effective on its own versus specific and targeted treatment for the parent? How can systems be created to ensure that the needs of parents as well as their children are addressed? This review points to a huge deficit in the literature on children's treatments, which have to date been focused narrowly on a set of symptom and functioning outcomes only (Hoag-wood et al., 2012). Research targeted at issues of family mental health and system redesign to support families are greatly needed.

This review also points to the fact that not every parent will be in need of mental health care. However, standardizing detection efforts and using that information to inform treatment planning for the entire family may have a significant impact upon both parent and child outcomes.

Limitations

Some interventions were not captured because the original inclusion criteria stipulated that studies had either a 6-month or longer posttreatment follow-up assessment for treatment studies or a 6-month or longer postbaseline data point for service studies. Studies that assessed outcomes any earlier were not included in the review.

A second limitation is the generalizability of these interventions to real-world settings. Very few were conducted in community-based clinics; the large majority were grant-funded studies conducted in academic laboratories instead of community settings. Thus, it may be that child mental health providers working in the public mental health system are using different strategies to enhance parental mental health and this was not reflected in our review.

Finally, studies were coded based upon their analysis of parental emotional health and what they stated about the intervention. It is possible that some studies omitted this information and thus we were unable to capture it.

Conclusion

The ACA and restructuring of the health system provide for the first time in decades the opportunity to create integrated and coordinated health and behavioral health systems for everyone. This includes families, parents with behavioral health needs, and their children. In order to take advantage of this, it is important to have solid research findings about the services, treatments, strategies, and practices that will enable parents' behavioral health needs and those of their children to be addressed seamlessly and continuously. The research base on treatments and services for parents in the context of children's mental health treatments is very thin and weak. This should be a major focus for research in the future. The issues extend beyond merely providing treatments and services to parents who need them. Rather, they include attention to system redesign, to ensure that the workforce of providers, the administrative structures, and the reimbursement strategies are strengthened and connected to serve the needs of parents/caregivers and children. No other approach will suffice.

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Table 1

Coding Typology.

Code	Definition	Example
0	No parent component offered	Child-focused treatment with no parent contact aside from updates regarding the child's progress.
1	Minimal parent component	Pamphlets, informational handouts
2	Active parent component in service of the child	Family therapy, parenting skills training
3	Active parent component for the parent's emotional health	Cognitive–behavioral therapy, provision of emotional support

Table 2

List of studies.

Child Treatment/Service	Title	Authors	Active Intervention	Risk	Code
1. Conduct	Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence.	Borduin et al. (1995)	Multisystemic Therapy	No	2
2. Conduct	Brief psychoeducational parenting program: An evaluation and 1-year follow-up.	Bradley et al. (2003)	Brief Psychoeducational Parenting Program	No	2
3. Conduct	Long-term effectiveness of a parenting intervention for children at risk of developing conduct disorder.	Bywater et al. (2009)	The Incredible Years Basic Parenting Program	Yes	2
4. Conduct	Randomized controlled trial of a parenting intervention in the voluntary sector for reducing child conduct problems: Outcomes and mechanisms of change.	Gardner, Burton, & Klimes (2006)	The Incredible Years Parenting Program	Yes	2
5. Conduct	Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomized controlled trial.	Hutchings et al. (2007)	The Incredible Years Basic Parenting Program	Yes	2
6. Conduct	Reducing conduct problems among children exposed to intimate partner violence: A randomized clinical trial examining effects of project support.	Jouriles et al. (2009)	Project Support	Yes	3
7. Conduct	A pilot, controlled skills training study of schizotypal high school students.	Lieberman, Ippen, & Van Horn (2006)	Child-Parent Psychotherapy	Yes	2
8. Conduct	A controlled evaluation of an enhanced self-directed behavioral family inter- vention for parents of children with conduct problems in rural and remote areas.	Markie-Dadds & Sanders (2006)	Enhanced Self-Directed Family Intervention	No	2
9. Conduct	Evaluation of a brief parenting discussion group for parents of young children.	Morawska, Haslam, Mile, & Sanders (2010)	The Triple P-Positive Par- enting Program	No	2
10. Conduct	Improving mental health through parenting programs: Block randomized controlled trial.	Patterson et al. (2002)	Family Nurturing Network Parenting Program (Webster- Stratton's Parents and Children Series).	No	2
11. Conduct	Follow-up of children who received the Incredible Years intervention for oppositional-defiant disorder: Main- tenance and prediction of 2-year outcome.	Reid, Webster-Stratton, & Hammond (2003)	The Incredible Years Teacher and Child Training Programs	No	2
12. Conduct	Treatment of depressed mothers with disruptive children: A controlled evaluation of cognitive behavioral family intervention.	Sanders & McFarland (2000)	Cognitive Behavioral Family Intervention	Yes	3
13. Conduct	Maintenance of treatment gains: A comparison of enhanced, standard, and self-directed Triple P-Positive Parenting Program.	Sanders, Bor, & Morawska (2007)	Enhanced Triple P-Positive Parenting Program	No	3
14. Conduct	Help when it is needed first: A controlled evaluation of brief, behavioral family intervention in a primary care setting.	Turner & Sanders (2006)	Primary Care Triple P-Positive Parenting Program	No	2
15. Conduct	Maternal depression and child behavior problems: Randomized placebo- controlled trial of a cognitive- behavioral group intervention.	Verduyn, Barrowclough, Roberts, Tarrier, & Harrington (2003)	Cognitive Behavioral Therapy	Yes	3

Child Treatment/Service	Title	Authors	Active Intervention	Risk	Code
16. Anxiety	Cognitive–behavioral family treatment of childhood obsessive–compulsive disorder: A controlled trial	Barrett, Healy-Farrell, & March (2004)	Freedom From Obsessions and Compulsions Using Cognitive Behavioral Strategies (FOCUS)	No	2
17. Anxiety	Effectiveness of CBT versus standard treatment for childhood anxiety disorders in a community clinic setting	Barrington, Prior, Richardson, & Allen (2005)	Cognitive Behavioral Therapy	No	3
18. Anxiety	Directionality of change in youth anxiety treatment involving parents: An initial examination.	Silverman, Kurtines, Jaccard, & Pina (2009)	Cognitive Behavioral Therapy	No	3
19. Posttraumatic Stress	A follow-up study of a multisite, ran- domized, controlled trial for children with sexual abuse-related PTSD symptoms	Deblinger, Marrarino, Cohen, & Steer (2006)	Trauma-Focused CBT	No	2
20. Services	Randomized comparison of the effectiveness and costs of community and hospital-based mental health services for children with behavioral disorders.	Harrington et al. (2000)	Parent Education Group	No	2

Note. CBT = cognitive–behavioral therapy; PTSD = posttraumatic stress disorder.