Forældretræning for behandling af børn og unge med ADHD

Review information

Authors

Sundhedsstyrelsen[1]

[1][Empty affiliation]

Citation example: S. Forældretræning for behandling af børn og unge med ADHD. Cochrane Database of Systematic Reviews [Year], Issue [Issue].

Characteristics of studies

Characteristics of included studies

Abikoff 2015

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Intervention1: NFPP ● *Children age (mean (SD))*: 3.57 (0.50) ● *Gender (% boys)*: 73.0% ● *Care givers age (Mean(SD))*: NS WL ● *Children age (mean (SD))*: 3.56 (0.5) ● *Gender (% boys)*: 70.6% ● *Care givers age (Mean(SD))*: NS Overall ● *Children age (mean (SD))*: 3.57 (0.50) ● *Gender (% boys)*: 73.8% ● *Care givers age (Mean(SD))*: NS

	Included criteria: Participants were 3.0-to 4.11-year-old boys and girls attending a preschool, daycare or nursery school at least 2 and-a-half days a week. Inclusion required that the primary caretaker be fluent in English and that the child have an IQ ≥ 70 on the Wechsler Preschool Primary Scale of Intelligence, 3rd edition (WPPSI-III; Wechsler, 2002); elevated scores above age and gender norms on the DSM-IV Total, DSMIV Hyperactive/Impulsive, or DSM-IV Inattentive subscales on both the Revised Conners Teacher (CTRS-R) (T-score ≥ 65) and Parent (CPRS-R) Rating Scales (T-score ≥ 60), (Conners, Sitarenios, Parker, & Epstein, 1998a,b); a Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-IV; American Psychiatric Association, 1994) diagnosis of ADHD (any type) on the Diagnostic Interview Schedule for ChildrenParent Report Version 4, (Shaffer, Fisher, & Lucas, 1998),modified Young Child Version (DISC-IV-YC) (Lucas, Fisher, & Luby, 1998), confirmed by clinical evaluation conducted by apsychologist with child and parent; standard score ≥ 7 on the Concepts and Following Directions subscale of the ClinicalEvaluation of Language Fundamentals (CELF-2, Semel, Wiig, & Secord, 2004).Recruitment relied on referrals from preschools, daycares, nursery schools, community resources (clinics, physicians, and agencies), parent mailings, newspaper ads, and website postings. **Excluded criteria:** Reasons for exclusion included current medication or behavioral treatment for ADHD; a diagnosis of pervasive developmental disorder, psychosis, or post-traumatic stress disorder; history of sexual or physical abuse; or any other psychiatric or medical condition judged to contraindicate participation. Children with common mental health diagnoses were not excluded **Pretreatment:**
Interventions	**Intervention Characteristics** Intervention1: NFPP ● *Description*: New forest parenting package.NFPP, a manualizedintervention for preschoolers with ADHD, involves 8 weekly1-to-1.5-hour sessions, delivered in the family home bytrained clinicians (see Appendix S1 for detailed description).NFPP focuses on key issues related to ADHD children'sfunctioning, and relies on the parent as the primary agent ofchange. While it shares a number of features with standardBPT (i.e., management of problematic behavior using behav-ioral techniques; promotion of authoritative parenting;increasing the quality and quantity of positive and reciprocalparent–child interaction; reduction of parental negative reac-tivity; and between-session 'homework tasks' to facilitateimprovement in specific parenting techniques), it has anumber of distinctive features. First, its home-based natureenables the therapist to model play and behavioral strategiesfor the parent in the setting where the behaviors areproblematic. It also enables the therapist to address natu-rally occurring instances of problematic child behaviors (e.g.,difficulty waiting, inattention, dysregulation, etc.) that callfor the use of the parenting (and child) skills being taught.Sensitizing parents to the importance of these 'teachablemoments' and of identifying and exposing their child torelevant real-world situations where skills can be usedprovides numerous opportunities for skills development andgeneralization.Second, NFPP directly aims to improve four elements

	ofconstructive parenting: (a)Scoping–learning how to observetheir child's current level of competencies so as to promoterealistic expectations and performance goals for their childregarding self-control, attention, and memory, (b)Extending–establishing new goals based on their child's performanceand progress, (c)Scaffolding–using game-like activities tofacilitate their child's skills development and goal achieve-ment, and (d)Consolidation—promoting their child's skill useacross settings and situations to facilitate generalization.Third, NFPP educates parents to alter their views of ADHD,avoid blaming their child for ADHD symptoms, and increaseparental tolerance with the ultimate goal of improving thequality of the parent–child relationship. ● *Duration*: 8 sessions WL ● *Description*: WL ● *Duration*: 8 uge
Outcomes	*ADHD kernesymptomer kliniker/observatør (lower better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (Lower better)* ● **Outcome type**: ContinuousOutcome *Skadevirkninger* ● **Outcome type**: DichotomousOutcome
Identification	**Sponsorship source:** This research was supported by National Institute of Mental Health Grant 5R01MH074556 to H.B.A. **Country:** USA **Setting:** clinic **Comments:** **Authors name:** Howard B Abikoff **Institution:** The Child Study Center at NYU Langone Medical Center **Email:** howard.abikoff@nyumc.org

	Address: One Park Avenue, New York, NY 10016, USA
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	The randomization was stratified by age (3 or 4 years old) and gender. Block randomization to the three treatment conditions (NFPP, HNC, WL) was in a ratio (2:2:1) and was carried out in blocks of random sizes (5 or 10). The randomization assignment was computer generated and automatically linked to a subject when the subject's data for eligibility were entered into the database and it was established that s/he met the study entry criteria. The randomization sequence was generated by the research organization responsible for data management.
Allocation concealment (selection bias)	Low risk	Block randomization to the three treatment conditions (NFPP, HNC, WL) was in a ratio (2:2:1) and was carried out in blocks of random sizes (5 or 10). The randomization assignment was computer generated and automatically linked to a subject when the subject's data for eligibilitywere entered into the database and it was established that s/he met the study entry criteria.
Blinding of participants and personnel (performance bias)	High risk	No blinding possible for this kind of intervention
Blinding of outcome assessment (detection bias)	High risk	High for parents as blinding is not possible
Incomplete outcome data (attrition bias)	Low risk	No serious dropout rates and authors perform ITT analyses
Selective reporting (reporting bias)	Low risk	Trial registry: Home-Based Parent Training in ADHD Preschoolers; Registration ID, ClinicalTrials.gov Identifier: NCT01320098; URL: http://www/clinicaltrials.gov/ct2/show/NCT01320098
Other bias	Low risk	Study seems free of other types of bias

Au 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Triple-P ● *Children age (mean (SD))*: 7.81 (0.75) ● *Gender (% boys)*: 100% ● *Care givers age (Mean(SD))*: 39.00 (6.16) WL ● *Children age (mean (SD))*: 7.56 (1.26) ● *Gender (% boys)*: 88.9% ● *Care givers age (Mean(SD))*: 39.11 (4.26) **Included criteria:** Inclusion criteria were the following: (a) children aged 5–10years; (b) children were diagnosed to have ADHD upon medicaldiagnosis according to theDSM-IV-TR; (c) children scored at orabove an estimated IQ of 80 on the Test of Nonverbal Intelli-gence, which is a language-free intelligence test measuringabstract problem-solving ability (Test Of Nonverbal Intelligence,Third Edition; Brown, Sherbenou, & Johnsen, 1997); (d)parents were Chinese Cantonese speaking; (e) parents were themain caregivers of the child; (f) parents were living with theirchild; (g) parents did not have intellectual impairment or psy-chosis; and (h) parents did not receive formal behavioural treat-ment in the past **Excluded criteria:** NS **Pretreatment:**
Interventions	**Intervention Characteristics** Triple-P ● *Description*: Triple-P ● *Duration*: 9 sessions Triple P parent training WL ● *Description*: WL ● *Duration*: 8 weeks

Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** NS **Country:** Hong Kong **Setting:** Clinic **Comments:** **Authors name:** Alma Au **Institution:** Department of Applied Social Sciences, The Hong Kong Polytechnic University, **Email:** Correspondence email: kammy-km.lau@polyu.edu.h **Address:** Kam-Mei Lau, Department of Applied Social Sciences, The Hong Kong Polytechnic University, Hung Hom, Kowloon, Hong Kong.
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	They completed pre-intervention assessment and gave written informed consent prior to being randomly allo- cated into either the intervention group (Triple P) or control group. There were eight and nine participants in the interven- tion and control groups, respectively. The randomisation was conducted by a research assistant who was not involved in this project.
Allocation concealment (selection bias)	Unclear risk	No information on allocation concealment
Blinding of participants and personnel (performance bias)	Unclear risk	Insufficient information on blinding of participants and personnel

Blinding of outcome assessment (detection bias)	Unclear risk	Insufficient information on blinding of outcome assessors
Incomplete outcome data (attrition bias)	Low risk	No major dropouts
Selective reporting (reporting bias)	Unclear risk	No information to determine whether selective outcome reporting
Other bias	Low risk	The study appears to be free of other sources of bias

Bor 2002

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Enhanced Behavioral Family Intervention (EBFI) ● *Children age (mean (SD))*: 40.41 (3.80) Months ● *Gender (% boys)*: 73% ● *Care givers age (Mean(SD))*: 28.41 (4.21) Years WL ● *Children age (mean (SD))*: 42.81 (3.81) Months ● *Gender (% boys)*: 74% ● *Care givers age (Mean(SD))*: 29.72 (4.57) Years Intervention 2: ● *Children age (mean (SD))*: 39.86 (3.34) Months ● *Gender (% boys)*: 57% ● *Care givers age (Mean(SD))*: 30.21 (4.69) Years **Included criteria:** (a) the target child was aged between 36 and 48 months;(b) mothers rated their child's behavior as being in the elevated range on the Eyberg Child Behavior Inventory (ECBI; Intensity score ≥ 127 or Problem score ≥ 11; Eyberg & Ross, 1978); (c) the child showed no evidence of developmental disorder (e.g., language disorder, autism) or significant health impairment; (d) the child was not currently having regular contact with another professional or agency or taking medication for behavioral problems; and(e) the parents were not currently receiving therapy for psychological problems, were not intellectually disabled, and reported they were able to read the newspaper without assistance.

	Excluded criteria: **Pretreatment:**
Interventions	**Intervention Characteristics** Enhanced Behavioral Family Intervention (EBFI) ● *Description*: Enhanced Triple-P parent program ● *Duration*: 14 sessions WL ● *Description*: WL ● *Duration*: Intervention 2: ● *Description*: Standart Triple P program ● *Duration*:
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** The study is supported by grants from Queensland Healthand the National Health and Medical Research Council(941044, 971099 **Country:** Australia **Setting:** clinic **Comments:** The Triple P project is an ongoing study conducted at the School of Psychology, The University of Queensland

	Authors name: William Bor **Institution:** South Brisbane Child and Youth Mental Health Service, Brisbane, Australia. **Email:** e-mail: matts@psy.uq.edu.au **Address:** Address all correspondence to Matthew R. Sanders, PhD, Parenting and Family Support Centre, School of Psychology, University of Queensland, Brisbane QLD 4072, Australia; e-mail:
Notes	*NKR01 ADHD børn og unge* on 27/10/2020 20:44 **Select** OBS diagnose

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Method not described. Participants in this study were 87 families that had previously been randomly assigned to one of three treatment groups, EBFI, SBFI, or a WL control group
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	No blinding possible
Blinding of outcome assessment (detection bias)	High risk	No blinding possible
Incomplete outcome data (attrition bias)	High risk	Drop out rates are 42% (EBFI), 27% (SBFI) og 15% (control, WL). So for IV groups a relative high drop out
Selective reporting (reporting bias)	Low risk	All relevant outcomes apppear reported
Other bias	Low risk	Study seems free of other sources of bias

Dose 2017

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** TASH + TAU ● *Children age (mean (SD))*: 9.84(1.54) ● *Gender (% boys)*: 75% ● *Care givers age (Mean(SD))*: 40.24(6.45) TAU ● *Children age (mean (SD))*: 9.72(1.65) ● *Gender (% boys)*: 88% ● *Care givers age (Mean(SD))*: 39.37(6.37) **Included criteria:** Participants were parents, mostly mothers, of school-aged children with ADHD. Parents were eligible for the study if their child was aged 6–12 years, attending school, had been diagnosed with ADHD by a pediatrician or child psychiatrist, was on methylphenidate with a stable dose for at least the previous 2 months, and no change of medication or dose was planned.Ref fig 1 **Excluded criteria:** NS **Pretreatment:** In the intention-to-treat sample, no significant group differences between the EG and CG regarding demographic characteristics, functional impairment, and symptoms were seen at baseline
Interventions	**Intervention Characteristics** TASH + TAU (RCC) ● *Description*: Individual telephone assisted self-help (TASH) as adjunct to routine clinical care (RCC) including continued daily medication. Parents also received 10 telephone consultations of about 30 min each during the first 6 months and four booster telephone consultations during the second 6-month period to help them applying the advice given to the specific problem behaviors of their child ● *Duration*: 12 months TAU ● *Description*: The Control Group received only routine clinical care, including continued daily medication. ● *Duration*: 12 months

Outcomes	*Funktionsniveau hos barnet/den unge, forældrerapporteret (WFIRS-P total) (lower better)* ● **Outcome type**: Continuous outcome *ADHD kernesymptomer, forældrebedømt FBB-ADHS total symptom score (lower better)* ● **Outcome type**: Continuous outcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: Continuous outcome
Identification	**Sponsorship source:** The study was supported by a grant from ShirePharmaceuticals Development Ltd. (unrestricted grant). **Country:** Germany **Setting:** clinic **Comments:** **Authors name:** Christina Dose **Institution:** Department for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, Medical Faculty of theUniversity of Cologne, Cologne **Email:** Correspondence: manfred.doepfner@uk-koeln.de **Address:** Correspondence: Manfred Doepfner, Department for Child and Adolescent Psychiatry, Psychosomatics and Psychotherapy, University of Cologne, Robert-Koch-Str. 10, 50931 Cologne, Germany;
Notes	*Christina Mohr Jensen* on 28/10/2020 00:35 Det er lidt en outlier ift. design men pt. taget med videre ITT analysis

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Participating families were randomly assigned to either an enhancement group (EG; n = 51) or a CG (n = 52; see Figure 1). The randomization process was carried out using computerized block-randomization (blocks of four families)
Allocation concealment (selection bias)	Unclear risk	No information provided

Blinding of participants and personnel (performance bias)	High risk	Blinding not possible
Blinding of outcome assessment (detection bias)	High risk	Blinding not possible
Incomplete outcome data (attrition bias)	Low risk	Both intention-to-treat and per-protocol analyses were conducted, the intention-to-treat analyses forming the primary analytic approach. The intention-to-treat sample consisted of all families which had been randomized. For" Quote: "Missing values for dosages at postassessment were replaced using the EM procedure with dosages at baseline and available information on dosages at postassessment as predictors (intention-to-treat sample: 17 cases with missing values in the EG and 16 cases with missing values in the CG; per-protocol sample: two cases with missing values in the EG and five cases with missing values in the CG)." Judgement Comment: Missing data have been imputed using appropiate methods.However, there were a higher rate of non-completers in the intervention group (18 versus 11)
Selective reporting (reporting bias)	Low risk	The RCT was registered at ClinicalTrials.gov (identifier: NCT01660425; URL: https://clinicaltrials.gov/ct2/show/ NCT01660425) and approved by the Medical Ethical Committee of the University Hospital of Cologne, Germany
Other bias	Low risk	The study appears to be free of other sources of bias

DuPaul 2018

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Behavioral Parent Treatment Group Home (BPTH@HOME) ● *Children age (mean (SD))*: 4.51 (0.63) ● *Gender (% boys)*: 8 (50.0) ● *Care givers age (Mean(SD))*:NS Care as usual ● *Children age (mean (SD))*: 4.27 (0.68) ● *Gender (% boys)*: 13 (81.25) ● *Care givers age (Mean(SD))*: NS

	Online BPT ● *Children age (mean (SD))*: 4.52 (0.55) ● *Gender (% boys)*: 9 (60.0) ● *Care givers age (Mean(SD))*: NS Overall ● *Children age (mean (SD))*: 4.43 (0.63) ● *Gender (% boys)*: 30 (63.8) ● *Care givers age (Mean(SD))*: NS **Included criteria:** Children eligible for inclusion were between the ages of 3 years 0 months (3;0) and 5 years11 months (5;11); enrolled in a preschool or day care settingat least 2 days a week unless otherwise unable to enroll(e.g., behavioral problems, lack of services for unrelateddisability); and have no diagnoses of autism spectrum dis-order (ASD), pervasive developmental disorder, intellectualdisability, neurological damage, or significant motor or phy-sical impairments. In addition, parents had to have an elec-tronic device with Internet access and be willing to attendF2F meetings or complete online sessions. Children musthave metDiagnostic and Statistical Manual of MentalDisorders(5th ed.;DSM-5; American PsychiatricAssociation,2013) criteria for one of the three presentationsof ADHD based on graduate research assistant–adminis-tered clinical interview and parent behavior ratings includ-ing parent report of elevated levels of impairment at home(i.e., score greater than 90th percentile on one or moreConners Early Childhood Rating Scale subscales relevantto ADHD). **Excluded criteria:** Children who obtained a Differential Ability Scale globalcognitive ability score lower than 80 were excluded **Pretreatment:** There were no significantbetween-group differences in demographic and diagnostic char-acteristics or cognitive ability prior to treatment
Interventions	**Intervention Characteristics** Behavioral Parent Treatment Group Home (BPTH@HOME) ● *Description*: Face-to-face BPT: Families enrolled in the F2F sessions were expectedto attend all 10 sessions,which were held at a localschool that was accessible to families and the instructor.These sessions occurred across consecutive weeks unlessbad weather prohibited driving. At each session childcare and food were provided to the families.Graduate student therapists met with the research teamon a weekly basis, and each week’ssessionswerereviewed in detail regarding delivery of manualized con-tent, participation of parents in group discussions, andany questions that therapistshad about treatment proce-dures. In addition, the second author provided feedbackto therapists based onfidelity checks of parent trainingsessions. ● *Duration*: 10 sessions

	Care as usual ● *Description*: WLC ● *Duration*: 10 sessions Online BPT ● *Description*: Online BTP: Families enrolled in the online program were expected tocomplete all 10 sessions. Unlike in the F2F program,families in the online program had someflexibility inwhen the sessions were completed. Online sessions weredesigned through the university's course site, and familieswere given unique and confidential login credentials. Toensure that families could successfully log in to the pro-gram, thefirst session was completed in person, along withthe F2F families from the same cohort. Families from bothgroups received a brief introductory overview of the pro-gram together before separating to complete Session 1.Online families were provided technical assistance to login to the program prior to accessing Session 1. Subsequentsessions were released weekly and remained open for theremainder of the program. Parents in the online programreceived weekly calls from a research assistant to check onintervention implementation and answer any questionsregarding intervention procedures. Parent completion ofeach session was tracked electronically through theprogram. ● *Duration*: 10 sessions
Outcomes	*ADHD kernesymptomer, forældrebedømt (ADHD-RS) (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** The research reported here was supported by the Institute ofEducation Sciences, U.S. Department of Education, throughGrant R324A120284 to Lehigh University **Country:** California, USA **Setting:** **Comments:** ADHD pre-Kindergartners (PEAK) **Authors name:** George J. DuPaul **Institution:** Departmentof Education and Human Services, Lehigh University, 111 Research Drive,Bethlehem, PA 18015 **Email:** E-mail:gjd3@lehigh.edu

	Address: 111 Research Drive, Bethlehem, PA 18015
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Sequence generation not described in details Quote: "After eligibility was determined and parent written consent was obtained, families were randomly assigned to participate in the F2F program (n = 16), participate in the online program (n = 15), or be placed in the WLC group (n = 16) to receive the online program at the conclusion of 15 weeks, after posttreatment assessment phase."
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	No blinding possible
Blinding of outcome assessment (detection bias)	High risk	Self-reported outcomes
Incomplete outcome data (attrition bias)	Unclear risk	Some dropouts in each group, with different reason
Selective reporting (reporting bias)	Low risk	No protocol registration, but all relevant outcomes appear reported
Other bias	Low risk	"Range of intervention targets. FUNDING The research reported here was supported by the Institute of Education Sciences, U.S. Department of Education, through Grant R324A120284 to Lehigh University. The opinions expressed are those of the authors and do not represent views of the Institute or the U.S. Department of Education. REFERENCES Abidin, R. R. (1995)." The study seems free of other types of bias

Franke 2020

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Behavioral Parent Treatment Group Home (BPTG@HOME) Overall ● *Children age (mean (SD))*: 4.0 ● *Gender (% boys)*: 71.7 ● *Care givers age (Mean(SD))*: NS **Included criteria:** Participants were 53 parents with a 3- to 4-year-old child (M = 4.0 years) with elevated and impairing levels of ADHD symptoms. Mothers had a mean age of 35.4 years (SD = 4.87), and the 43 fathers who contributed study data had a mean age of 38.8 years (SD = 6.65). A third of all families had an annual income below NZ$75,000 (approxi-mately US$50,000), another third more than NZ$100,000 (approximately US$67,000), and just over half of the moth-ers had a university degree (55.7%). Seventeen families had a parent with clinically elevated levels of ADHD symp-toms. The majority of the children were male (71.7%) and of New Zealand European ethnicity (79.2%).Recruitment took place throughout New Zealand, between January 2013 and August 2014, through commu-nity outreach in early childhood education centers, child care centers, organizations that work with young families, and media outlets. After initial contact, parents completed a 45-min telephone screening interview to inform parents and assess eligibility. Families were included if their child met the cutoff criteria on the Werry–Weiss–Peters (WWP) activity rating scale (≥ 14; Routh, 1978) and the Parental Account of Child Symptoms (PACS; ≥ 16; Taylor, Sandberg, Thorley, & Giles, 1991), and if their child was perceived to have impaired functioning due to hyperac-tive/inattentive behaviors **Excluded criteria:** Reasons for exclusion included being below the cutoff score for ADHD symptoms (n = 22), no perceived impairment in functioning (n = 13), child outside the age range (n = 9), parent or child already receiving sup-port for parenting and/or child behavior (n = 9), no interest in participating (n = 9), presence of a developmental disor-der (n = 4), lack of time (n = 4), no Internet access (n = 2), and interested in face-to-face support only (n = 2). Another 13 families failed to complete T1 assessment, leaving 53 participants in the study (see Figure 1) **Pretreatment:**
Interventions	**Intervention Characteristics** Intervention1: Behavioral Parent Treatment Group Home (BPTG@HOME) ● *Description*: Online Parenting Program ● *Duration*: 16 weeks

	Kontrol 1: Care as usual ● *Description*: Delayed intervention: The delayed intervention group families received theintervention after T3 assessment. ● *Duration*: 16 weeks
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt, min 3 mdr FU (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (min 3 mdr FU) (lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This research was supported by grants from the New Zealand Federation of Graduate Women and the University of Auckland **Country:** New Zealand **Setting:** **Comments:** **Authors name:** Nike Franke **Institution:** Faculty of Education and Social Work, The University of Auckland **Email:** n.franke@auckland.ac.nz **Address:** Private Bag 92601, Symonds St., Auckland 1150, New Zealand

Notes	*Christina Mohr Jensen* on 28/10/2020 17:19 **Select** Der er blot to tlf. opkald til støtte - er det mon nok? Jeg har lukket med for nu, men det bør diskuteres hvad omfang af terapeutstøtte til e-programmer bør være

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Quote: "After T1 assessment, families were randomly allocated to the intervention or delayed intervention group." Sequence generation not described in details
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	Not possible to blind intervention group and personnel
Blinding of outcome assessment (detection bias)	High risk	Self-reported outcomes
Incomplete outcome data (attrition bias)	Low risk	At post-intervention (T2), five families did not complete all questionnaires. Of these five families, two could not be contacted, one family was too busy, one mother suffered a prolonged illness, and one family in the delayed intervention group started another parenting program. At 6-month follow-up (T3), another three families failed to complete the questionnaires, two of whom could not be contacted and one family was too busy. They perform ITT analyses
Selective reporting (reporting bias)	Low risk	Quote: "ACTRN12613000480785)." Quote: "Ethics approval was obtained, and the trial was registered on the Australian New Zealand Clinical Trials Registry (ANZCTR; registration code: ACTRN12613000480785)." Judgement Comment: A decrease in hyperactive/ inattentive child behaviour.- Measured by the Conners Early Childhood Behaviour questionnaire (Conners EC-BEH) Inattention/ Hyperactivity subscale, completed by the primary caregiver.Timepoint [1]Pre-intervention, post-intervention and at 6-month follow-up (i.e. 6 months after completion of treatment).Primary outcome [2]A decrease in hyperactive/ inattentive child behaviour.- Measured by the Conners EC-BEH short form Inattention/ Hyperactivity subscale, completed by

		the secondary caregiver.Timepoint [2]Pre-intervention, post-intervention and at 6-month follow-up (i.e. 6 months after completion of treatment).Secondary outcome [1]Reduction of less optimal parenting practices as measured by the Parenting Scale (PS).Timepoint [1]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [2]Increase in self-reported authoritative parenting as measured by the Parenting Styles and Dimensions Questionnaires (PSDQ) authoritative parenting scale.Timepoint [2]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [3]Increase in parent satisfaction and efficacy. Measured by the Parenting Sense of Competence Scale (PSOC).Timepoint [3]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [4]Decrease in symptoms of depression, anxiety and stress reported by parents. Measured by the Depression Anxiety Stress Scales (DASS-21).Timepoint [4]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [5]A decrease in teacher reported hyperactive/ inattentive child behaviour.- Measured by the Strengths and Difficulties Questionnaire-Hyperactivity scale (SDQ).Timepoint [5]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [6]An improvement in the child's social functioning measured by preschool teacher ratings on the Child Behaviour Scale (CBS).Timepoint [6]Pre-intervention, post-intervention, and at 6-month follow-up.Secondary outcome [7]Client satisfaction as measured by the Client Satisfaction Questionnaire, completed by the primary caregiver.Timepoint [7]6-month follow-up.
Other bias	Low risk	The study seems from other sources of bias.

Herbert 2013

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Parenting Your Hyperactive Preschooler (PYHP) Overall ● *Children age (mean (SD))*: 54.92 (10.79) Months ● *Gender (% boys)*: 74.2% ● *Care givers age (Mean(SD))*: **Included criteria:** (a) Behavior Assessment System for Children 2–Parent Report Scale (BASC 2-PRS; Reynolds & Kamphaus, 2004) hyperactivity scores of 65 or higher, or (b) at least six hyperactive/impulsive symptoms based on the Diagnostic Interview Schedule of Children, Fourth Edition (DISC-IV; Shaffer, Fisher, Lucas, Dulcan, & Schwab-Stone,

	2000). **Excluded criteria:** Children who showed evidence of mental retardation, autism, Asperger's syndrome, or cerebral palsy were excluded. **Pretreatment:**
Interventions	**Intervention Characteristics** Parenting Your Hyperactive Preschooler (PYHP) ● *Description*: Parent training and social emotion coaching ● *Duration*: 14 sessions, 1,5 h. WL ● *Description*: WL ● *Duration*: 14 uger
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** NS **Country:** USA **Setting:** Clinic **Comments:** **Authors name:** Sharonne D herbert **Institution:** University of Massachusetts Amherst **Email:** eharvey@psych.umass.edu **Address:** Address correspondence to Elizabeth Harvey, Ph.D., Department of Psychology, Tobin Hall, 135 Hicks Way, University of Massachusetts, Amherst, MA 01003; USA
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	After the pretest session, children were randomly assigned to one of two groups (PT and WL). Each child was matched with another child based on gender and hyperactivity severity. The second author used an online random number generator to assign one member of the pair to the PT group. If there were an odd number of children, a trio was formed, and 2 of the 3 children were randomly assigned to the PT group.
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	No blinding possible
Blinding of outcome assessment (detection bias)	High risk	No blinding possible
Incomplete outcome data (attrition bias)	Low risk	Using an intent-to-treat approach, pretest data were carried forward for missing posttest data, and posttest data were carried backward for missing pretest data. All 17 PT mothers completed posttest measures. One WL mother could not be reached to complete posttest data. One mother who partici- pated in the PT group completed posttest but was missing some pretest measures. Eleven PT mothers and 10 WL mothers had complete audiotape data at posttest (missing data was due to a combination of parents forgetting to complete the recording and technical failure of tapes). One PT mother com- pleted posttest but not pretest taping. Twelve PT fathers completed pretest or posttest measures. Two fathers completed pretest but not posttest, and one father completed posttest but not pretest.
Selective reporting (reporting bias)	Unclear risk	Not clear. Pretests indicate that both mothers and fathers are assigned IV and WL, but analyses present data from mothers only
Other bias	Low risk	Study seems free of other sources of bias

Lange 2018

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** New Forest Parent Training Programme (NFPP) Overall ● *Children age (mean (SD))*: 3-5 years: 57%, 6-7 years: 43% ● *Gender (% boys)*: 73% ● *Care givers age (Mean(SD))*: 35.4 (5.4) Mother 38.5 (5.6) Father **Included criteria:** Inclusion criteria were: age between 3-7 years; clinical ADHD diagnosis supportedbythe Development and Well-Being Assessment (DAWBA)29; Danish as a first language spoken athome. **Excluded criteria:** Exclusion criteria were: Intellectual disabilities (IQ < 70); autism spectrum disorder diagnosis; in receipt of pharmacological or psychosocial treatment for ADHD. Severe parental psychiatric disorder (i.e. untreated psychosis, bipolar or severe depressive disorder); severe social adversity inthe home (i.e. active child protection involvement). **Pretreatment:**
Interventions	**Intervention Characteristics** New Forest Parent Training Programme (NFPP) ● *Description*: ● *Duration*: 8 sessions 36 ugers FU TAU ● *Description*: ● *Duration*: 3-4 group sessions
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome

	ADHD kernesymptomer, forældrebedømt, min 3 mdr FU (lower better) ● **Outcome type**: ContinuousOutcome *Forældrestress (PSI) (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (min 3 mdr FU) (lower better)* ● **Outcome type**: ContinuousOutcome *Livskvalitet hos barnet (PedsQL) (higher better)* ● **Outcome type**: ContinuousOutcome ● **Scale**: PsS ● **Direction**: Higher is better ● **Data value**: Change from baseline
Identification	**Sponsorship source:** This study was supported by research grants from TrygFonden and Helse- fonden, Denmark, and was supported by the Central and Capital Regions of Denmark. **Country:** Denmark **Setting:** Clinic **Comments:** **Authors name:** Anne-Mette Lange **Institution:** Aarhus University Hospital, Research Department, Center for Child and Adolescent Psychiatry.Skovagervej 28240 RisskovDenmark **Email:** annelang@rm.dk **Address:** Skovagervej 2, 8240 Risskov, Denmark
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Participants were randomly assigned (1:1) to NFPP and TAU following T1 assessment.Randomization was conducted in blocks of four or six and in 12 strata defined by center, genderand age (3-5 and 6-7 year) using a web-based and logged randomization service within Trialpartner Participants were randomly assigned (1:1) to NFPP and TAU following T1 assessment.Randomization was conducted in blocks of four or six and in 12 strata defined by center, genderand age (3-5 and 6-7 year) using a web-based and logged randomization service within Trialpartner
Allocation concealment (selection bias)	Low risk	Research assistants were masked to treatment allocation and located separately to avoid contamination
Blinding of participants and personnel (performance bias)	High risk	Trial participants could not be masked. Parents were asked not to reveal treatment status of their children to teachers
Blinding of outcome assessment (detection bias)	High risk	Self-reported outcomes, blinding not possible
Incomplete outcome data (attrition bias)	Low risk	Allocation, drop out and fidelity In total,164 participants were randomized (Fig 1). Outcome measures were completed by mothers (n=139), fathers (n=15) and foster parents/other (n=9). Eighty-eight families were randomized to NFPP, and 83 completed all 8 sessions. (mean no. of hours/family = 12.07). Sessions were attended by both parents (58.8%), mother (29.5%), father (4.5%) (see Table S10, available online). Content fidelity was 95.3% (range: 83-100%). Seventy-six families were randomized to TAU (mean no. hours/family=8.8 hours). Patient records showed that 20 of these families did not receive any treatment between T1 & T3. Forty-six families attended parent groups and 32 families attended individual sessions instead of or in addition to group intervention across the three sites. FIG 1.
Selective reporting (reporting bias)	Low risk	Quote: "3 ClinicalTrial.gov identity no: NCT01684644. A Controlled Study of Parent Training in the Treatment of ADHD in Young Children (D'SNAPP) Introduction Behavioral parent training (PT)"
Other bias	Low risk	Study appears to be free of other types of bias

Leckey 2019

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** IYPT (Webster-Stratton, 2007) group-based intervention Intervention 1 ● *Children age (mean (SD))*: 57.1 (17.1) Month ● *Gender (% boys)*: 15 (79%) ● *Care givers age (Mean(SD))*: NS Kontrol 1 ● *Children age (mean (SD))*: 58.8 (16.5) Month ● *Gender (% boys)*: 10 (71%) ● *Care givers age (Mean(SD))*: NS **Included criteria:** Participants were included in the trial if: (a) the person wasthe primary caregiver of the child; (b) the child was aged 3–7 years;1(c) the primary refer-ral reason related to persistent hyperactivity, inattention and/or impulsive behaviours; (d)the child scored above the cut-off(>17) on the screening measure, the Werry–Weiss–Peters Activity Rating Scale (WWPARS; Werry,1968); (e) the child was not receivingany ADHD medication prior to, or for the duration of, the research; and (f) the parentor child had not previously attended any IY programmes. **Excluded criteria:** **Pretreatment:** No significant differences between groups
Interventions	**Intervention Characteristics** Intervention 1 ● *Description*: Parent training: The IYPT (Webster-Stratton, 2007) is a group-based intervention guided by the principlesof behavioural and social learning theory and comprising 20 weekly 2–2.5 hour sessions.Group discussions and role plays are used in combination with DVD material to illustratevarious parenting and discipline strategies. The programme promotes positive parentingtechniques, such as child-directed play and encouragement to foster child cooperation andto strengthen parent–child relationships. Child problem behaviours are addressed byencouraging parents to reinforce positive pro-social behaviour and manage inappropriate6 Y. LECKEY ET AL.behaviour using non-aversive discipline strategies. For the purposes of this study, thestructure and methods of the programme were slightly enhanced to address the highlevels of hyperactivity and inattention; these included

	more role-plays and group activitiesto model and practise skills to promote positive behaviour. While programme modifications are not recommended, especially as fidelity is a key component for effectiveimplementation, modifications have been made when treating children with ADHD(Webster-Stratton & Reid, 2014). Parents were also encouraged to establish moreregular and consistent routines and to set clear limits and boundaries. Facilitators madeweekly phone calls to problem-solve and encourage the application of skills in the home ● *Duration*: 20 sessions/ 6 months Kontrol 1 ● *Description*: WL ● *Duration*: 6 months
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** The Incredible Years Ireland Study was funded by Archways with support from The AtlanticPhilanthropies. **Country:** Ireland **Setting:** **Comments:** **Authors name:** Yvonne Leckey **Institution:** Department of Psychology, Maynooth University, Maynooth, Ireland **Email:** yvonne.leckey@mu.ie **Address:** Maynooth University, Maynooth, Ireland
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Randomisation was carried out on a 2:1 basis by an independent statistician using a computer-generated random number sequence. This allowed for the inclusion of a larger interventiongroup (i.e. PT + CT or PT), which is ethically desirable in evaluations within a communitysetting, whilst also ensuring that fewer people were placed on a waiting list. The unit ofrandomisation was the parent–child dyad and participants were block randomised byarea to ensure that parents attended the programme in their locality.
Allocation concealment (selection bias)	Unclear risk	An administrator subsequently informed participants of their treatment allocation. While the administratorwas also a researcher on the study, all other researchers were unaware of group allocation and parents were asked not to inform researchers at follow-up assessment as to their allocated group to minimise potential basis (where possible).
Blinding of participants and personnel (performance bias)	High risk	Participants were aware of allocation. However, all other researchers were unaware of group allocation
Blinding of outcome assessment (detection bias)	High risk	Parent-reported outcomes. Blinding not possible
Incomplete outcome data (attrition bias)	Unclear risk	Per-protocol analysis was not conducted as only three participants were lost to follow-up, no account of why participants were lost
Selective reporting (reporting bias)	Low risk	Quote: "ISRCTN82596506." Report outcome as presented in protocol
Other bias	Low risk	The study seems free of other sources of bias.Note1. One child, aged 2.9 years, was slightly outside of the eligibility criteria but was included in the study.Disclosure Statement No potential conflict of interest was reported by the authors.

Matos 2009

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group

Participants	**Baseline Characteristics** Behavioral Parent Treatment Group Home (BPTG@HOME) ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Care as usual ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS **Included criteria:** The sample consisted of 32 families. Children met the following criteria: were 4–6years of age attending a preschool program, parents reported hyperactivity and be-havior problems; had an ADHD diagnosis, combined or hyperactive-impulsive (HIT)type, according to theNIMH Diagnostic Interview Schedule for Children IVFParentVersion (NIMH-DISC IV, 1997); had an IQ80 on the Peabody Picture VocabularyTest (PPVT); showed no evidence of significant sensory, language, neurological, orpervasive developmental difficulties; their mothers were Puerto Rican and lived with their children; were not receiving treatment with stimulant or other psychotropicmedication; and their parents agreed not to participate in any other form of childpsychotherapy and/or pharmacotherapy until completion of study participation. Otherinclusion criteria included: absence of domestic violence, severe major depression,substance abuse, psychopathology, or severe mental retardation in participatingparents. None of the parents were excluded for any of these criteria. All parents wereoriented on other treatment options and informed of their right to leave the treatmentat any time. Their primary language was Spanish **Excluded criteria:** This study targeted the combined (CT) and HIT types of ADHD and excluded the predominantly inattentive type (IT) for three reasons.
Interventions	**Intervention Characteristics** Behavioral Parent Treatment Group Home (BPTG@HOME) ● *Description*: PCIT: PCIT sessions were conducted on a weekly basis and lasted 1.5 hours. Treatment was delivered in Spanish following the adapted treatment manual (Matos et al., 2006).Each family was seen individually by a therapist and a cotherapist. Therapists wereadvanced graduate clinical psychology students with an average of 3 years of clinicalexperience. Cotherapists were also graduate clinical students but with less experience.All sessions were videotaped and 60% were observed by the first author who alsoprovided group and individual supervision sessions on a weekly basis.PCIT phases were conducted in the standard order, beginning with CDI andfollowing with PDI. The major goal of the CDI phase is to create or strengthen apositive and mutually rewarding parent-child relationship. During the first session,parents were taught CDI skills through instruction, modeling, and

	role-playing.They were instructed to describe, imitate, and praise the child's appropriate behavior,reflect appropriate child speech, ignore inappropriate behavior, and allow theirchild to lead play activity. Parents were also taught not to criticize the child and notto use commands and questions. Handouts were given to them summarizing thematerial, and they were instructed to practice CDI skills at home, in daily 5-minutesessions. ● *Duration*: 17 sessions /3,5 months Care as usual ● *Description*: WL: WL group were contacted by phone on a monthly basis by the research staff. Each family received pretreatment and post-treatment assessments after 3.5 months of waiting. ● *Duration*: 3.5 months
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: Continuous Outcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: Continuous Outcome
Identification	**Sponsorship source:** This research was supported by NIH Research Grant 5R24-MH-49368-12 funded by the National Instituteof Mental Health and by the Division of Mental Disorders, Behavioral Research & Aids to Guillermo Bernal. **Country:** Puerto Rico **Setting:** **Comments:** **Authors name:** Maribel Matos, Ph.D **Institution:** Department of Psychology, University Center for Psychological Services and Research, Universityof Puerto Rico, Rio Piedras, Puerto Rico, PO Box 23174, San Juan, PR 00931-3174. **Email:** m-matos@uprrp.edu **Address:** Rio Piedras, Puerto Rico, PO Box 23174, San Juan, PR 00931-3174
Notes	*Christina Mohr Jensen* on 30/10/2020 17:53 **Select** Jeg kan simpelthen ikke greje hvad jeg skal gøre med de her PCIT studier - jeg synes jo ikke det sådan rammer helt spot on - medtaget for nu og så må vi diskutere det

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Quote: "Of these, 32 cases were randomized to either PCIT (n ¼ 20) or the WL (n ¼ 12) conditions." Quote: "Following this module, recruited families were organized in six groups of five. In each of these groups, three families were randomly assigned to the PCIT and two to the WL group. The last group only had two families that were randomly assigned to the PCIT." Quote: "After the pretreatment assessment, each family participated in a two-session psy- choeducational module about ADHD and its relationship with behavior problems, associated difficulties, risks and protective factors, possible etiologies, and treatment options. Following this module, recruited families were organized in six groups of five. In each of these groups, three families were randomly assigned to the PCIT and two to the WL group. The last group only had two families that were randomly assigned to the PCIT. Because of the pilot nature of this study, we opted for a randomization allocation of 3:2 because of budget and ethical considerations."
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	Not possible to blind intervention group
Blinding of outcome assessment (detection bias)	High risk	Self-reported measurements, no blinding possible
Incomplete outcome data (attrition bias)	Unclear risk	Of these, 32 cases were randomized to either PCIT (n ¼ 20) or the WL (n ¼ 12) conditions. Only one case dropped out immediately from the PCIT; 19 families completed posttreatment measures and 17 the follow-up assessment. Nine fathers from the PCIT attended treatment sessions. All mothers from the WL completed the assessment after a 3.5-month waiting period. See Figure 1. No account of why the participant dropped out or why post assessment was not collected for 3 out of 20 participants 1 family started medication in the invention group but were included in analysis.
Selective reporting (reporting bias)	Unclear risk	Not referring to a protocol registration, but seems to report on relevant outcomes

Other bias	Low risk	Quote: "This research was supported by NIH Research Grant 5R24-MH-49368-12 funded by the National Institute of Mental Health and by the Division of Mental Disorders, Behavioral Research & Aids to Guillermo Bernal. The content is solely the responsibility of the authors and does not represent the official views of the NIMH or the National Institute of Health. The research also received support from the Institutional Funds for Research from the Dean of Graduate Studies and Research at the University of Puerto Rico, Rio Piedras Campus." The study seems to be free of other types of bias

Nobel 2020

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Intervention1: Behavioral Parent Treatment Group Home (BPTG@HOME) ● *Children age (mean (SD))*: 8.2 (1.5) ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Kontrol 1: Care as usual ● *Children age (mean (SD))*: 9.0 (1.3) ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Kontrol 2 ● *Children age (mean (SD))*: 9.4 (1.4) ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Intervention 2: ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Overall ● *Children age (mean (SD))*: 8.8 (1.5)

	● *Gender (% boys)*: 52 ● *Care givers age (Mean(SD))*: NS **Included criteria:** Children had to meet the following inclusion criteria: (1) at time of referral a diagnosis of ADHD (all comorbid disorders allowed) as obtained from medical records (based on clinical interviews with the parents and teacher); (2) a Global Assessment of Functioning score of <55, according to the DSM-IV-TR; (3) current Eyberg Child Behavior Inventory (ECBI) ratings in the clinical range (i.e., intensity scale >131 and problem scale>3); (4) a full scale, verbal, and performance IQ >70 as established within the previous 2 years (in 94.5% of the cases based on Wechsler Intelligence Scale for Children-III-NL);(5) had previously been offered and/or received routine treatments including ADHD medication and/or clinic-based behavioral parent training; (6) attending primary school and aged 6–13 at time of inclusion in the trial. **Excluded criteria:** Children were excluded from the study if (1) they had a medical condition that prohibited participation in the study; (2) their parents were unable to understand or follow instructions, e.g., due to intellectual disability of the parents; (3) their family had received home-based treatment in the previous year **Pretreatment:** Table 3 shows basic demographic features (child's age, total IQ, and educational level of the primary caregiver), treat-ment characteristics (duration of treatment and number of sessions), and change of extra care during trial (medication and other care) of the three study arms. There were no sig-nificant differences between BPTG@HOME and the other study arms on the baseline ratings of the outcome measures. In addition, there were no differences in medication use dur-ing treatment between the three study arms and in extra care received at T1, T2, and T3. However, the care-as-usual treat-ment lasted significantly longer than BPTG@HOME and consisted of significantly more sessions, and the BPTG@HOME condition had younger children (see Table 3
Interventions	**Intervention Characteristics** Intervention1: Behavioral Parent Treatment Group Home (BPTG@HOME) ● *Description*: ● *Duration*: 5.3 (1.7) Months / 13.1(5.1) sessioner Kontrol 1: Care as usual ● *Description*: ● *Duration*: 13.9 (5.4) Months / 29.8 (18.0) sessioner
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: Continuous Outcome ● **Direction**: Lower is better

	ADHD kernesymptomer, forældrebedømt, min 3 mdr FU (lower better) ● **Outcome type**: Continuous Outcome ● **Scale**: ADHD-RS / SNAP ADHD SCALE ● **Direction**: Lower is better *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: Continuous Outcome ● **Direction**: Lower is better *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (min 3 mdr FU) (lower better)* ● **Outcome type**: Continuous Outcome ● **Scale**: ECBI-intensity / PACS conduct ● **Direction**: Lower is better
Identification	**Sponsorship source:** This study has been financially supported by the Netherlands Organization for Health Research and Development (ZonMw, nr 15700.3010). **Country:** The Netherlands **Setting:** clinic **Comments:** - **Authors name:** Ellen Nobel **Institution:** Department of Child and Adolescent Psychiatry, University Medical Center Groningen, University of Groningen, **Email:** e.nobel@me.com **Address:** Hanzeplein 1 XA10, NL-9713 GZ Groningen, The Netherlands
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Computergenerated randomization
Allocation concealment (selection bias)	Low risk	Containing a letter stating either the randomization outcome active home treatment (but not which treatment) or waiting list. Parents who were randomized to our home-based parent training or to the care-as-usual treatment were not explicitly informed about the nature of the allocated home-based treatment. Furthermore, no information about the differences between the treatments was publicized on a website and the thera- pists who performed the care-as-usual treatment were not informed about the content of the other home-based treat- ment. Moreover, when parents had questions about the randomization and the other treatment, all therapists were instructed not to answer the question, but to refer to the research team. The flow of subjects from initial recruitment through the final analysis is presented in Fig. 1. Table 1 contains child and family characteristics.
Blinding of participants and personnel (performance bias)	High risk	No blinding possible
Blinding of outcome assessment (detection bias)	High risk	Parent reported outcomes. No blinding possible
Incomplete outcome data (attrition bias)	Low risk	The Medical Ethical Committee of the University Medical Center in Groningen provided ethical approval for the study (METC nr 2010.289). The trial has been registered at https ://www.trial regis ter.nl: Home-based behavioral treatment for ADHD; NTR3021.
Selective reporting (reporting bias)	Low risk	Quote: "tains child and family characteristics. The Medical Ethical Committee of the University Medi- cal Center in Groningen provided ethical approval for the study (METC nr 2010.289). The trial has been registered at https ://www.trial regis ter.nl: Home-based behavioral treat- ment for ADHD; NTR3021. Because of the slow recruit- ment, we changed from a single-center to a multi-center studies. Measures The primary outcome"
Other bias	Low risk	Judgement Comment: No other apparent bias

Pfiffner 2014

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Parent-Focused Treatment (PFT) ● *Children age (mean (SD))*: 8.7 (1.2) ● *Gender (% boys)*: 64.9% ● *Care givers age (Mean(SD))*: NS Care as usual ● *Children age (mean (SD))*: 8.4 (1.1) ● *Gender (% boys)*: 58.8% ● *Care givers age (Mean(SD))*: NS **Included criteria:** Inclusion criteria specified a primary DSM-IV diagnosis of ADHD-I (confirmed by the KSADS-PL; see below), IQ > 80 (confirmed with the Wechsler Intelligence Scale for Children, version IV [WISC-IV, Wechsler, 2003]), living with at least one parent for the past year, child age between 7-11 years (and grades 2-5), attending school full time in a regular classroom, ability to participate in our groups on the days scheduled, school proximity within 45 minutes of study site to allow for the clinician to conduct school meetings, and teacher consent to participate in a school-based treatment **Excluded criteria:** Families of children who were taking non-stimulant psychoactive medication were excluded because of difficulty withholding medication to confirm ADHD-I symptoms, as were cases planning to initiate or change medication treatment (stimulant or otherwise) in the near term. Children with significant developmental disorders (e.g., pervasive developmental disorder) or neurological illnesses were also excluded **Pretreatment:** Only medication status at randomization differed across the treatment groups (p = .035), with significantly more CLAS children reporting medication use (9.5%) than PFT (1.4%), but not compared to TAU (2.0%).
Interventions	**Intervention Characteristics** Parent Focused Treatment (PFT) ● *Description*: PFT: Ten 90-minutes parent group meetings along with up to six 30-minutes family meeting (parent and therapist only). PFT included only the parent training group component described in the structure of CLAS IV. Thus, parent skills taught were identical to those in the CLAS parent group with the exception of PFT families not receiving specific training in how to work with teachers and were not informed about the child skills taught in the

	CLAS condition. PFT families received the same number of parent groups and individual family meetings as CLAS families, although children did not attend the individual family meetings. Childcare was offered to families while the parent group was held. The PFT condition did not include a child skills group or direct teacher consultation. Instead, teachers were contacted by mail regarding the study, given written information about ADHD-I and suggested classroom accommodations, and invited to call the therapists with any questions. Telephone contact with PFT teachers was limited to only a few teachers who had general questions about the study or related materials. Only 1 of 73 participants (1.4%) was on medication at randomization. ● *Duration*: 10-13 uger Care as usual ● *Description*: TAU: reatment as Usual (TAU)—TAU did not receive either study treatment. As with all other families, TAU families received a written diagnostic report based on the assessment conducted at baseline. Families in the TAU condition also received a list of community treatment providers but were not given specific treatment recommendations. After TAU families completed their follow-up treatment assessments in the fall, they were offered the opportunity to participate in a two-session parenting workshop focused on the strategies taught in the CLAS groups, with limited individual follow-up if needed. During the period between baseline and post-treatment, 14% received medication (all seven but one received stimulant medication), 33% received psychotherapy (family therapy, child therapy or parenting group), 51% received educational intervention (special education services at school, tutoring) and 53% received classroom accommodations (e.g., preferential seating modified homework, behavioral chart, extra time on tests). During the period between post-treatment and follow-up, 21% received medication (all nine but two received stimulant medication), 38% received psychotherapy, 52% received educational intervention, and 55% received classroom accommodations. ● *Duration*: 10-13 uger
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: Continuous outcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: Continuous outcome *Funktionsniveau hos barnet/den unge, forældrerapporteret (CGAS) (higher better)* ● **Outcome type**: Continuous outcome

Identification	**Sponsorship source:** This research was supported by a grant from the National Institute of Mental Health MH077671. **Country:** US **Setting:** Clinic **Comments:** **Authors name:** Linda J. Pfiffner **Institution:** Department of Psychiatry **Email:** lindap@lppi.ucsf.edu **Address:** 401 Parnassus Ave., Box 0984, University of California, San Francisco, San Francisco, CA 94143
Notes	*Henning Keinke Andersen* on 12/11/2020 02:29 Værdier er angivet som Mean (SE)!!

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Quote: "Children were randomized to CLAS (36 at site 1 and 38 at site 2), PFT (36 at site 1 and 38 at site 2), or TAU (24 at site 1 and 27 at site 2)." Judgement Comment: Insufficient information - 'Children were randomized to CLAS' p 6 Sequence generation not described
Allocation concealment (selection bias)	Unclear risk	No information provided to determine allocation concealment
Blinding of participants and personnel (performance bias)	High risk	Not possible to blind participants
Blinding of outcome assessment (detection bias)	High risk	Self-reported measurements. No blinding possible
Incomplete outcome data (attrition bias)	Unclear risk	Results 1.41% of data were missing at baseline, 3.78% of data were missing at post-treatment, and 7.87% of values were missing at follow-up. Missing values appeared to be related to attrition. Prior to post-assessment, four families discontinued their participation, and prior to follow-up, eight families ended their involvement. Mean scale substitution was used.

Selective reporting (reporting bias)	Unclear risk	It is not clear if this is posthoc analyse. Not referring to a protocol.Study refers to a previous study by Pfiffner 2014! Dropouts at baseline: 1,41% However 7.87 % of data values were missing at FU
Other bias	Low risk	This work was supported by the National Institute of Mental Health (grant MH077671; Principal Investigators: Linda J. Pfiffner, contact P.I., and Stephen P. Hinshaw). The study seems free from other sources of bias.

Shimabukuro 2020

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Well Parent Japan (NFPP) ● *Children age (mean (SD))*: 8.04 (1.61) ● *Gender (% boys)*: 77.8% ● *Care givers age (Mean(SD))*: 40.59 (4.06) WL ● *Children age (mean (SD))*: 8.86 (1.68) ● *Gender (% boys)*: 90.5% ● *Care givers age (Mean(SD))*: 42.10 (4.46) **Included criteria:** Fluency in Japanese language and parenting a child, aged 6–12 years, demonstrating 6 or more definite symptoms of inattention and/or hyperactivity/impulsivity on the parent completed SNAP **Excluded criteria:** Self-reported psychiatric symptomatology in the mother or other personal issues for which a group programme would be counter-indicated (e.g., delusions or paranoia, no parents were excluded); current or recent, i.e., within two months of screening, participation in another parenting programme; and the presence of moderate to severe Diagnostic and Statistical Manual ofMental Disorders (5th ed., DSM-5, APA 2013) symptoms of Autism Spectrum Disorder (ASD) in the target child, i.e., endorsement of symptoms equivalent to Level 3 on the GARS-3 **Pretreatment:**
Interventions	**Intervention Characteristics** Well Parent Japan (NFPP) ● *Description*: NFPP ● *Duration*: 13 uger (8 sessioner)

	WL ● *Description*: WL ● *Duration*: 13 uger
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** This work was supported by a KAKENHI (Grants-in-Aid forScientific Research) from the Japan Society for the Promotion ofScience to S.S. and internal subsidy funding from the OkinawaInstitute of Science and Technology Graduate University (OIST),Okinawa, Japan **Country:** Japan **Setting:** Clinic **Comments:** **Authors name:** Shizuka Shimabukuro **Institution:** Human Developmental Neurobiology Research Unit, Okinawa Institute of Science and Technology Graduate University, 1919-1 Tancha, Onna-son, Okinawa 904-0495, Japan **Email:** tripp@oist.jp **Address:** Human Developmental Neurobiology Research Unit, Okinawa Institute of Science and Technology Graduate University, 1919-1Tancha, Onna-son, Okinawa 904-0495, Japan
Notes	*Christina Mohr Jensen* on 28/10/2020 17:35 **Select** Kriterierne for ADHD er lidt løse, men da der er nogle kulturelle hensyn kan den måske alligevel overvejes - der er min 6 symp påAI/HI

	NKR01 ADHD børn og unge on 05/11/2020 18:11 **Included** Allerede inkluderet

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "they were randomized to immediate treatment or waitlist control groups by the first author using a simple random number generator."
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	Personnel are not blinded and not possible to blind intervention group. Four treatment groups were run by the same two female therapists, native Japanese speakers with graduate degrees in psychology. The principal therapist completed the standard NFPP training programme in English in the UK. During the course of the RCT she participated in regular supervision with two of the NFPP developers. The second therapist was trained and supervised by the principal therapist.
Blinding of outcome assessment (detection bias)	High risk	Some outcomes are self-reported.
Incomplete outcome data (attrition bias)	Unclear risk	Fifty-two mothers met inclusion criteria and agreed to participate in the study. Twenty-eight mothers were ran- domly assigned to the immediate treatment group and 24 to the wait-list control group. All mothers assigned to the treatment group participated in the intervention. In the control group, three mothers withdrew, two after complet- ing the pre-treatment questionnaires (one reported being too busy to participate, the other moved away from the area), another mother participated in the laboratory assessments but did not return the pre-treatment questionnaires and subsequently withdrew from the study. Reason for dropout and numbers are not balanced between groups.
Selective reporting (reporting bias)	Unclear risk	This study was approved by the Okinawa Institute of Science and Technology (OIST) Graduate University, Japan Human Subjects Research Review Committee. However, no reference to study protocol.

Other bias	Low risk	Quote: "K.L. and G.T. have no interests to declare. S.S. has received a speaker fee from Shire. D.D. received fees from Eli Lilly, non-financial support from Eli Lilly, grants from Shire, personal fees from Shire, non-financial support from Shire, fees from Medice, non- financial support from HBPharma and royalties from the sale of the new Forest Parent Training Programme Self Help book. M.T. has received recent funding from Shire, a speaker fee from Jansen-Cilag, fees from training and supervision of the New Forest Parenting Programme and royalties from the sale of the new Forest Parent Training Programme Self Help book. C.L.-B. has received speaker fees from Janssen-Cilag and Shire, fees from training and supervision of the New Forest Parenting Programme and royalties from the sale of the New Forest Parent Training Programme Self Help book." The study appears to be free of other sources of bias

SonugaBarke 2001

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** New Forest Parenting Programme (NFPP) Overall ● *Children age (mean (SD))*: 2-9 years ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS **Included criteria:** Seventy-eight 3-year-old children (48 boys) entered the trial. Theywere identified at their 3-year developmental check from a populationof 3,051 children born between January 1992 and September 1993.There was an initial screening stage, and all children who scored morethan 20 on the Werry-Weiss-Peters Activity Scale (Routh, 1978) (n=286) were included in an initial sample. Only those children who metclinically validated cutoffs on the Parental Account of ChildhoodSymptoms (PACS) (Taylor et al., 1991) ADHD/Hyperkinesis scaleand whose parents reported that their condition was associated withimpairment significant enough to warrant clinical intervention (n=78) were included in the trial. **Excluded criteria:** Children were excluded from the trial if their parents had a serious mental illness, they had a serious learning disability, or they had a previous diagnosis for an unrelated mental health condition. **Pretreatment:**

Interventions	**Intervention Characteristics** New Forest Parenting Programme (NFPP) ● *Description*: Parents were educated about ADHD and introduced to a range ofbehavioral strategies for increasing attention and behavioral organiza-tion and reducing defiant and difficult behavior. In most sessions ther-apists worked with both mother and child. Progress was monitored ona weekly basis, and there were regular reviews of previously coveredissues and strategies. T ● *Duration*: 8 sessions WL ● *Description*: WL ● *Duration*: 8 uger
Outcomes	*Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) (higher better)* ● **Outcome type**: ContinuousOutcome *Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt, min 3 mdr FU (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (min 3 mdr FU) (lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** This research was supported by a grant from the NHS R&D Committee **Country:** UK **Setting:** Clinic **Comments:** **Authors name:** EDMUND J.S. SONUGA-BARKE **Institution:** Centre for Research into Psychological Development, Department of Psychology, University of

	Southampton, England **Email:** NS **Address:** Dr. Sonuga-Barke, Professor of Psychology, Department of Psychology, University of Southampton, SO17 1BJ England.
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Unclear risk	Not sufficient information. The present trial used a randomized, controlled design. Children who met the inclusion criteria were randomly assigned to either PT (n = 30), PC&S (n = 28), or a waiting-list control group (WLC; n = 20).
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	Insufficient information, but IVs PT/PCS are described so blinding of both participants and personal seems not possible
Blinding of outcome assessment (detection bias)	High risk	No blinding possible
Incomplete outcome data (attrition bias)	Low risk	Intention to treat was the basis for the inclusion of cases in the analysis. Attrition was low (seven children withdrew during the trial). Dropout was usually for personal or domestic reasons rather than dissatisfaction with treatment. Children whose parents dropped out were no different from those who remained in the program on any of the T 1 measures. Dropouts were handled in the most statistically conservative manner by replacing their scores at T 2 and T 3 with val- ues representing the poorest outcome for participants in their partic- ular condition. This approach to dropouts avoided overestimating potential effects of therapies on noncompleters while strengthening the study through an intention-to-treat analysis.
Selective reporting (reporting bias)	Unclear risk	No information to clarify selective outcome reporting. No trial registration, but all relevant outcomes appear to be reported
Other bias	Low risk	The study appears to be free of other sources of bias

SonugaBarke 2018

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** NEW FOREST PARENTING PROGRAMME (NFPP) ● *Children age (mean (SD))*: 43.4 (7.01) Months ● *Gender (% boys)*: 76% ● *Care givers age (Mean(SD))*: NS TAU ● *Children age (mean (SD))*: 42.3 (7.79) Months ● *Gender (% boys)*: 60% ● *Care givers age (Mean(SD))*: NS **Included criteria:** Children were included if: (i) they were between 2 years 9 months and 4 years 6 months old; (ii) had a parent/caregiver aged 18 years or over; (iii) screened positive for ADHD symptoms (score≥ 20) on the WerryWeiss-Peters Activity Rating Scale (WWP) and; (iv) were given an ADHD research diagnosis of any sub-type based on the parent DISC-IV-ADHD Scale **Excluded criteria:** Excluded if they had (i) a full clinical diagnosis of autismspectrum disorder; (ii) were severely delayed developmentally (18 months or more behind their chronologicalage on the Parent Involvement Project (PIP) Developmental Scales [20]; (iii) had a main caregiver with a seriousmental illness (e.g., psychosis). They were also excludedfor practical reasons including: (iv) if children were inshort- to medium-term foster care placements; (v) on theChild Protection Register or (vi) when their main carerhad insufcient English language **Pretreatment:**
Interventions	**Intervention Characteristics** NEW FOREST PARENTING PROGRAMME (NFPP) ● *Description*: Prior to the trial, we conducted a detailed analysis of the content of the NFPP programme. This led to its extension from an 8- to a 12-week version [22, 23], which meant it could be delivered at a slower pace with more emphasis on reinforcing messages to help parents with literacy or intel-lectual problems. New modules addressing: (a) child sleep problems, learning difficulties and language problems and (b) parental mental health problems and learning difficul-ties, were added and employed if needed. Two parent–child sessions were videoed to provide interactive feedback. Each session lasted approximately 1.5 h. Handouts, DVD/CDs and other resources were

	provided. Sessions were videoed for supervision purposes [12 ● *Duration*: 12 uger (12 sessioner) TAU ● *Description*: In the current trial, the content of TAU varied considerably. Many individuals received no treatment. Where they did receive some, it was typically of a non-specialised nature offered in child and adolescent clinics or in the community for families with a young child with ADHD. The use of health services during the trial was common but in most cases these were for general medical concerns and not for behavioural problems. Nine children visited child mental health services. Of these two children attended a special nursery and one a speech therapist. Two parents attended a general support group (Sure Start). In addition, six parents attending CAMHS received parent training for their chil-dren's behaviour problem. In five cases, this was Triple-P which was offered at one of the sites and in one site, it was non-specific behavioural advice. One child had an assess-ment by an educational psychologist. Parents of six children had respite support by family members. No children in the study received medication for ADHD ● *Duration*: 12 uger
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *ADHD kernesymptomer, forældrebedømt, min 3 mdr FU (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** This was an independent study funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research scheme (RP-PG-0108-10061 to Solent NHS Trust who were the grant holders and hosted the trial). **Country:** UK **Setting:** Clinic **Comments:** **Authors name:** Edmund J. S. Sonuga-Barke **Institution:** Academic Unit of Psychology, University of Southampton, Southampton SO17 IBJ, UK **Email:** edmund.sonuga-barke@kcl.ac.uk **Address:** Edmund J. S. Sonuga-Barke edmund.sonuga-barke@kcl.ac.uk

Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "After all baseline (T1) measures were completed, participants were block randomised into study arms by the Southampton Clinical Trials Unit using the TENALEA [see www. tenalea.com] system [3 (NFPP): 3 (IY): 1 (TAU) ratio] to ensure power for the comparison of the two treatment arms. Stratification was by site and tranche."
Allocation concealment (selection bias)	Low risk	Parents and therapists were not blinded to treatment allocation. However, to protect blinding for all other members of the team including statisticians and researchers collecting and coding direct observations, only site PIs and designated administrative staff liaised with the trials unit and participants, with regard to allocation. Families were informed of the need to maintain blindness. This meant that researchers who collected outcome measures at T2 and T3 (see below) were, as far as possible, blind to treatment allocation. Teachers were also potentially blind to allocation. The coding of the observation data (which was videoed) was done by a researcher who had not met the family and was unaware of the group allocation.
Blinding of participants and personnel (performance bias)	High risk	Parents and therapists were not blinded to treatment allocation
Blinding of outcome assessment (detection bias)	High risk	Parent reported outcomes - blinding not possible
Incomplete outcome data (attrition bias)	Low risk	ITT analyses - Drop out 1 of 134 reported for intervention group
Selective reporting (reporting bias)	Low risk	No protocol but all relevant outcomes appear reported
Other bias	Low risk	The study appears to be free of other sources of bias

Thompson 2009

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** NFPP ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS TAU ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Overall ● *Children age (mean (SD))*: 51.20 (11.30) Months ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS **Included criteria:** Inclusion into the trial was a score of 16 or over on the PACS ADHD symptom scale. Nine children did not meet clinical criteria according to the PACS interview. Because of limited resources IQ was not assessed during the trial. **Excluded criteria:** Families were excluded from the trial if they had previously or were currently attending the local child and adolescent services, if the mother was known to have a severe mental illness or if the child had a pervasive developmental disorder, severe receptive language impairment, neurological disorder or was on the social services register for a current history of child sexual or physical abuse **Pretreatment:**
Interventions	**Intervention Characteristics** NFPP ● *Description*: Two part-time nurses were employed to deliver the inter-vention and were trained in the revised NFPP program bythe first and second authors (MJJT and CL-B) who werecore members of the program development team. Weeklytelephone and email supervision was supported withmonthly visits to supervise the therapists on a face-to-facebasis for the first 6 months and then every 2 months for thelast 7 months during the intervention phase.

	All therapysessions were audio-taped and these tapes were used forsupervision sessions to ensure that the intervention wasdelivered as planned. The integrity of ongoing treatmentdelivery was reviewed using checklists completed by thetherapists and the clinical supervisors independently. Thetherapists also kept reflective diaries. The reflective diarieswere used by the therapists to review the sessions and givea view on whether the families were responding to th ● *Duration*: 9 weeks/ 8 sessions TAU ● *Description*: Treatment as usual was intended to control for the effectsof time in treatment and to compare NFPP treatmenteffects with the potential impact of interventions typicallyprovided by community-based practitioners on children'sand parents' functioning during the course of treatmentand follow-up. TAU participants received no treatmentfrom study staff, nor were they referred onto services, butwere given contact information for Health Visitors, gen-eral practitioners or school nurses which they could use asthey wished. No TAU cases received any interventions forADHD during the period of the trial, nor attended par-enting programs: given this the TAU group functioned asa no treatment control group to all intents and purposes.TAU scores between T1 and T2 were also used for test–retest reliability. All the families in the TAU group were offered therapy at the end of the study period if they wished ● *Duration*: 9 weeks
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (min 3 mdr FU) (lower better)* ● **Outcome type**: ContinuousOutcome
Identification	**Sponsorship source:** The project was funded by The Island of Guernsey Research Fund through Wessex Medical Trust HOPE to MT, ES-B, LP, PT **Country:** UK **Setting:** clinic **Comments:** **Authors name:** Margart J.J. Thompson **Institution:** Child and Adolescent Mental Health Service, Southampton City PCT, Southampton, UK

	Email: mt1@soton.ac.uk; ejb3@soton.ac.uk **Address:** School of Psychology, Institute for Disorders of Impulse and Attention, University of Southampton, Southampton SO17 1BJ, UK
Notes	*Henning Keinke Andersen* on 11/11/2020 01:49 **Included** Intervention 1: NFPP

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Participants were randomized (using random number tables) to receive either the revised NFPP (N = 21) or TAU (N = 20) condition.
Allocation concealment (selection bias)	Unclear risk	No allocation concealment procedures reported
Blinding of participants and personnel (performance bias)	Unclear risk	Every effort was made to keep the assessing psychologist blind to the treatment status of the children. The therapists and the families were told not to discuss their treatment status with the psychologist. The psychologist was not aware of the therapy content delivered to the families and worked in a different part of the building from the therapists. The videos were coded after collection at a later time. The psychologist collecting the data coded it from only T1 sessions, T2 and T3 sessions were recorded by independent observers. Measures of interrater reliability were calculated on the basis of 31% of tapes across all time points by two independent raters blind to treatment status.
Blinding of outcome assessment (detection bias)	High risk	No blinding of parents possible
Incomplete outcome data (attrition bias)	High risk	Ten families did not complete T2 assessments—four in NFPP including two that did not complete the intervention and six TAU families. Nine families did not complete T3 measures—two NFPP and seven TAU families. Two NFFP participants not assessed at T2 were assessed at T3. This meant that T1 to T3 data were unavailable for 11 children (four treatment and seven controls). Table 1 reports the child and parent symptom profiles of those children who remained in the study throughout and those that dropped out or did not have measures at all three time points. Drop outs had more severe ADHD as measured by both clinical interview and parent completed questionnaire. They were similar in other respects. It appears that the

		dropout families had children with more severe ADHD symptoms, compared to the completing families
Selective reporting (reporting bias)	Low risk	No trial protocol, but all relevant data seem to be reported
Other bias	Low risk	The study appears to be free of other sources of bias

vandenHoofdakker 2007

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** BPT+RCC ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS RCC alone ● *Children age (mean (SD))*: NS ● *Gender (% boys)*: NS ● *Care givers age (Mean(SD))*: NS Overall ● *Children age (mean (SD))*: 7.4 (1.9) ● *Gender (% boys)*: 80.9% ● *Care givers age (Mean(SD))*: **Included criteria:** Eligibility was determined by the following criteria: meetDSM-IVcriteria for ADHD; IQ >80 (Full Scale IQ of the WISC-III-R,for children under the age of 6 years; the Full Scale IQ of theWPPSI-R); age between 4 and 12 years; and both parents (ifpresent) were willing to participate in the BPT program. **Excluded criteria:** NS **Pretreatment:** OBS group differences for ADHD at baseline (CPRS ADHD INDEX!) samt på PSI (Parental Stress)
Interventions	**Intervention Characteristics** BPT+RCC ● *Description*: BPT.The manual-based BPT consisted of twelve 120-minute sessions of group parent training led by two psychologists. Sixchildren’s parents could participate in each group. Specific targetbehaviors were established

	for each child. The BPT program drewmost of its techniques from the programs of Barkley (1987) and Forehand and McMahon (1981). A brief description of our BPTmanual is available on theJournal'sWeb site atwww.jaacap.comthrough the Article Plus feature. The parenting skills dealt with inthe program were structuring the environment, setting rules,giving instructions, anticipating misbehaviors, communicating,reinforcing positive behavior, ignoring, employing punishment, and implementing token systems. Psychoeducation and cognitiverestructuring of parental cognitions were also important elements.Compared with other typical ADHD parent training programs,the first phase of the training focused strongly on teaching parentsto anticipate misbehaviors and to manipulate the antecedents.Homework assignments played a central role in the program. Foreach session, parents read a chapter of a book especially written forthis purpose (van der Veen-Mulders et al., 2001). In addition,parents practiced each week the parenting skill that was introducedin the preceding session. All of the exercises were tailored to thespecific target behaviors of each child. The parents wrote reportsafter the exercises. Each session started with a discussion of thehomework assignments and the parental reports. Then a new topicwas introduced. The sessions ended with the preparations for newhomework assignments ● *Duration*: 5 months (12 sessions) RCC alone ● *Description*: RCC.The psychiatrists were instructed to provide care as usual,including supportive counseling, psychoeducation, pharmacother-apy, and crisis management whenever necessary. Contact could takeplace by telephone or in a face-to-face appointment. Parents werefree to get in touch with their child and adolescent psychiatristwhenever necessary, in addition to the routine medication checkupsthat were usually scheduled every 3 to 6 month ● *Duration*: 5 months
Outcomes	*ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: ContinuousOutcome *Forældrestress (lower better)* ● **Outcome type**: ContinuousOutcome *Adfærdsvanskeligheder, forældrebedømt (ECBI, CBCL) (Lower better)* ● **Outcome type**: ContinuousOutcome

Identification	**Sponsorship source:** The study has been supported by the University Medical Center Groningen **Country:** The Netherlands **Setting:** clinic **Comments:** The study support is not necessarily financially **Authors name:** Barbara J. van den Hoofdakker, **Institution:** Department of Psychiatry, University Medical Center Groningen, University of Groningen, The Netherland **Email:** b.van.den.hoofdakker@accare.nl. **Address:** Barbara J. van den Hoofdakker, University Center of Child and Adolescent Psychiatry, P.O. Box 660, 9700 AR Groningen, TheNetherlands
Notes	

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Subjects were randomly assigned (randomized block design) to one of two treatment arms: 5 months of BPT (12 sessions in group format) plus uncontrolled RCC provided by a child and adolescent psychiatrist (n = 47) or 5 months of uncontrolled RCC alone (n = 47).
Allocation concealment (selection bias)	Unclear risk	No information on allocation concealment
Blinding of participants and personnel (performance bias)	High risk	Participants and those delivering intervention cannot be blinded.
Blinding of outcome assessment (detection bias)	High risk	Parent reported outcome measures
Incomplete outcome data (attrition bias)	Unclear risk	Only two drop outs, one in each group
Selective reporting (reporting bias)	High risk	All outcomes prospectively stated have been reported. However, Authors collected data from both parents separately but stated that: "In this study we analyzed the data from the mothers" (p 1266).
Other bias	Low risk	Study appears to be free from other sources of bias.

Yusuf 2019

Methods	**Study design:** Randomized controlled trial **Study grouping:** Parallel group
Participants	**Baseline Characteristics** Tripple P ● *Children age (mean (SD))*: 10.35 (1.50) ● *Gender (% boys)*: 16/23 (69.6%) ● *Care givers age (Mean(SD))*: NS WL ● *Children age (mean (SD))*: 10.16 (1.31) ● *Gender (% boys)*: 22/25 (88%) ● *Care givers age (Mean(SD))*: NS **Included criteria: NS** **Excluded criteria: NS** **Pretreatment: NS**
Interventions	**Intervention Characteristics** Triple P ● *Description*: Triple P - group session ● *Duration*: 5 sessions group based (2 hours) and 3 individual sessions (15-30 min) (8 weeks in total) WL ● *Description*: Waiting list ● *Duration*: 8 weeks
Outcomes	*Funktionsniveau hos barnet/den unge, forældrerapporteret (CGAS) (higher better)* ● **Outcome type**: Continuous Outcome *ADHD kernesymptomer, forældrebedømt (lower better)* ● **Outcome type**: Continuous Outcome

Identification	**Sponsorship source:** **Country:** **Setting:** **Comments:** **Authors name:** Öztürk Yusuf **Institution:** **Email:** yusuf26es@hotmail.com **Address:**
Notes	Population is children aged 7-12 years og age with ADHD and receiving methylphenidate medication for at least 2 months. No baseline information provided to determine comparability between IV and WL group

Risk of bias table

Bias	Authors' judgement	Support for judgement
Random sequence generation (selection bias)	Low risk	Quote: "Sixty children who met the inclusion criteria for the trial were randomized using the online Random Sequence Generator (www.random.org on 01.06.2013)."
Allocation concealment (selection bias)	Unclear risk	No information provided
Blinding of participants and personnel (performance bias)	High risk	Not possible to blind
Blinding of outcome assessment (detection bias)	High risk	Self-reported outcomes
Incomplete outcome data (attrition bias)	Unclear risk	7 Dropouts in intervention and 5 in control group. Unbalanced numbers of discontinuation. Drop-out rates 23 og 16 % respectively. No reasons provided.
Selective reporting (reporting bias)	Low risk	Not referring to a protocol, but report on relevant outcomes

Other bias	Low risk	Quote: " Disclosure statement No potential conflict of interest was reported by the authors. ORCID Özyurt Gonka http://orcid.org/0000-0002-0508-0594 Akay" The study appears to be free from other sources of bias

Footnotes

Characteristics of excluded studies

Aghebati 2014

Reason for exclusion	Wrong intervention

Azevedo 2014

Reason for exclusion	Wrong comparator

Barkley 2000

Reason for exclusion	Wrong patient population

Breider 2019

Reason for exclusion	Wrong study design

Chacko 2009

Reason for exclusion	Wrong study design

Chacko 2018

Reason for exclusion	Wrong study design

Chacko 2018a

Reason for exclusion	Wrong patient population

ChronisTuscano 2020

Reason for exclusion	Wrong intervention

Daley 2013

Reason for exclusion	Wrong intervention

Dopfner 2020

Reason for exclusion	Study protocol without data

Dose 2020

Reason for exclusion	Wrong study design

Dose 2020a

Reason for exclusion	Wrong study design

Foubister 2020

Reason for exclusion	Wrong study design

Frisch 2020

Reason for exclusion	Wrong study design

Geissler 2019

Reason for exclusion	Wrong study design

Geissler 2020

Reason for exclusion	Wrong intervention

Hage 2018

Reason for exclusion	Wrong study design

Hautmann 2018

Reason for exclusion	Wrong study design

Jans 2015

Reason for exclusion	Wrong study design

Jones 2007

Reason for exclusion	Wrong patient population

Jones 2008

Reason for exclusion	Wrong study design

Joseph 2019

Reason for exclusion	Wrong indication

KhodabakhshiKoolaee 2011

Reason for exclusion	Conference abstract

Lange 2016

Reason for exclusion	Conference abstract

Lange 2016a

Reason for exclusion	Wrong study design

Leung 2017

Reason for exclusion	Wrong intervention

Loren 2015

Reason for exclusion	Wrong study design

Maddah 2018

Reason for exclusion	Wrong patient population

Mah 2020

Reason for exclusion	Wrong study design

Malik 2017

Reason for exclusion	Wrong study design

McEwan 2015

Reason for exclusion	Wrong study design

McGilloway 2012

Reason for exclusion	Wrong patient population

McGilloway 2014

Reason for exclusion	Wrong indication

McGoey 2005

Reason for exclusion	Wrong intervention

Mehri 2020

Reason for exclusion	Wrong intervention

Mehri 2020a

Reason for exclusion	Wrong intervention

Mikami 2010

Reason for exclusion	Wrong intervention

Mousavi 2019

Reason for exclusion	Wrong intervention

Sayal 2016

Reason for exclusion	Wrong study design

Scavenius 2020

Reason for exclusion	Wrong study design

Shimabukuro 2017

Reason for exclusion	Wrong study design

Sibley 2020

Reason for exclusion	Wrong study design

SonugaBarke 2002

Reason for exclusion	Wrong study design

Strayhorn 1989

Reason for exclusion	Wrong patient population

Strayhorn 1991

Reason for exclusion	Wrong patient population

Thorell 2009

Reason for exclusion	Wrong study design

Webster Stratton 2011

Reason for exclusion	Wrong intervention

Webster Stratton 2013

Reason for exclusion	Wrong study design

Footnotes

Characteristics of studies awaiting classification

Footnotes

Characteristics of ongoing studies

Footnotes

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Strayhorn 1991

Strayhorn J.M.; Weidman, C. S.. Follow-up one year after parent-child interaction training: Effects on behavior of preschool children.. Journal of the American Academy of Child and Adolescent Psychiatry 1991;30(1):138-143. [DOI:]

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Webster Stratton 2011

Webster-Stratton, Carolyn H.; Reid, M. Jamila; Beauchaine, Ted. Combining parent and child training for young children with ADHD.. Journal of Clinical Child & Adolescent Psychology 2011;40(2):191-203. [DOI:]

Webster Stratton 2013

Webster-Stratton, Carolyn; Reid, M. Jamila; Beauchaine, Theodore P.. One-year follow-up of combined parent and child intervention for young children with ADHD.. Journal of Clinical Child & Adolescent Psychology 2013;42(2):251-261. [DOI:]

Data and analyses

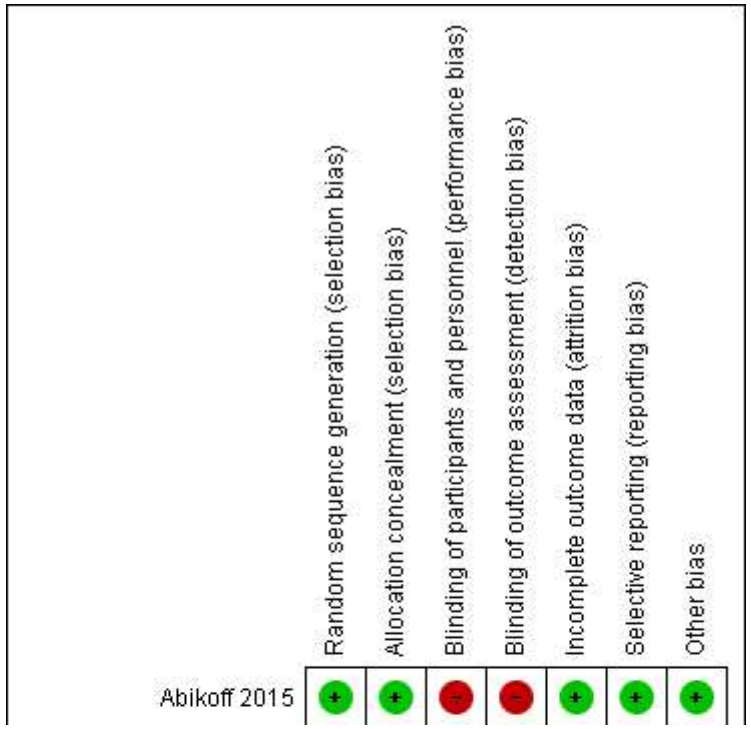
1 Forældretræning vs kontrol (WL/TAU)

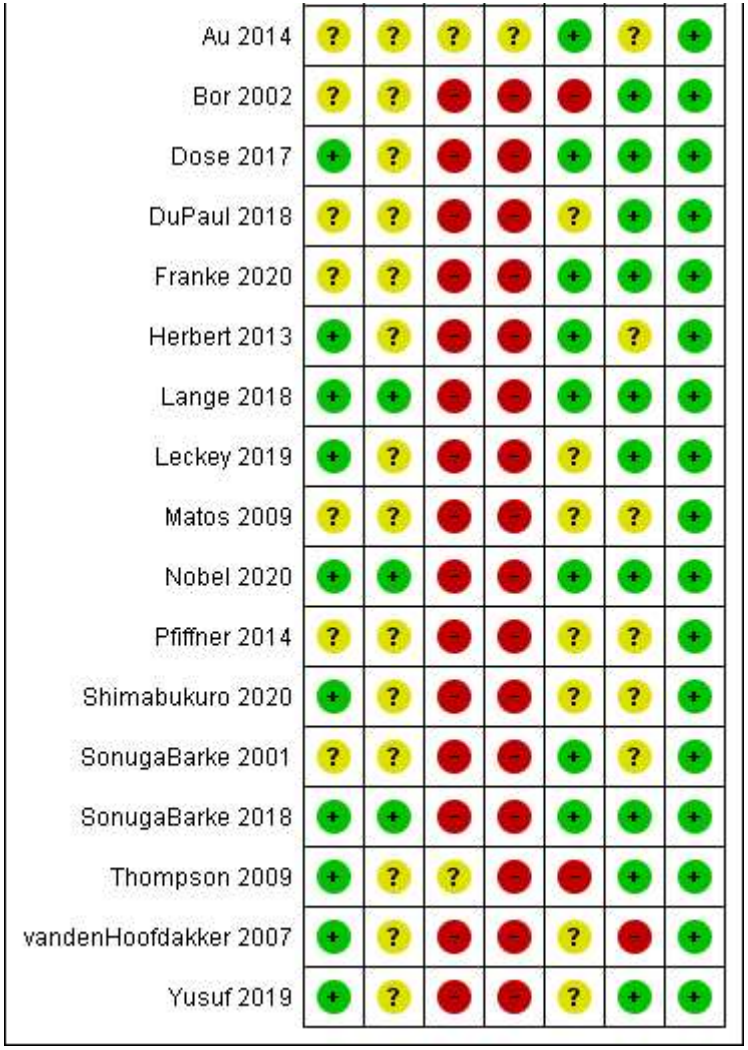
Outcome or Subgroup	Studies	Participants	Statistical Method	Effect Estimate
1.1 Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better)	7	500	Std. Mean Difference (IV, Random, 95% CI)	0.59 [0.40, 0.78]
1.1.1 Forældretræning vs vanlig behandling	2	270	Std. Mean Difference (IV, Random, 95% CI)	0.53 [0.29, 0.78]
1.1.2 Forældretræning vs venteliste	5	230	Std. Mean Difference (IV, Random, 95% CI)	0.65 [0.32, 0.98]
1.2 Funktionsniveau hos barnet/den unge, forældrerapporteret	3	271	Std. Mean Difference (IV, Random, 95% CI)	1.04 [-0.21, 2.28]
1.3 ADHD kernesymptomer kliniker/observatør	1	101	Mean Difference (IV, Fixed, 95% CI)	-4.57 [-5.98, -3.16]
1.4 ADHD kernesymptomer (Core symptoms), forældrebedømt (EoT)	16	1087	Std. Mean Difference (IV, Random, 95% CI)	-0.62 [-0.81, -0.42]
1.4.1 Forældretræning vs vanlig behandling	9	459	Std. Mean Difference (IV, Random, 95% CI)	-0.80 [-1.01, -0.58]
1.4.2 Intervention vs TAU	7	628	Std. Mean Difference (IV, Random, 95% CI)	-0.41 [-0.66, -0.16]
1.5 ADHD kernesymptomer (Core symptoms), forældrebedømt, min 3 mdr FU	4	282	Std. Mean Difference (IV, Random, 95% CI)	-0.48 [-0.72, -0.24]
1.6 Forældrestress	8	578	Std. Mean Difference (IV, Random, 95% CI)	-0.38 [-0.57, -0.18]
1.6.1 Intervention vs WL	5	297	Std. Mean Difference (IV, Random, 95% CI)	-0.53 [-0.76, -0.29]
1.6.2 Intervention vs TAU	3	281	Std. Mean Difference (IV, Random, 95% CI)	-0.20 [-0.47, 0.07]

1.7 Adfærdsvanskeligheder, forældrebedømt	16	1054	Std. Mean Difference (IV, Random, 95% CI)	-0.45 [-0.61, -0.29]
1.7.1 Intervention vs WL	9	426	Std. Mean Difference (IV, Random, 95% CI)	-0.58 [-0.82, -0.34]
1.7.2 Intervention vs TAU	7	628	Std. Mean Difference (IV, Random, 95% CI)	-0.33 [-0.50, -0.15]
1.8 Adfærdsvanskeligheder, forældrebedømt (min 3 mdr FU)	5	312	Std. Mean Difference (IV, Random, 95% CI)	-0.35 [-0.58, -0.12]
1.9 Livskvalitet hos barnet	1	143	Mean Difference (IV, Fixed, 95% CI)	2.56 [-0.38, 5.50]
1.10 Skadevirkninger	1		Risk Ratio (IV, Fixed, 95% CI)	No totals

Figures

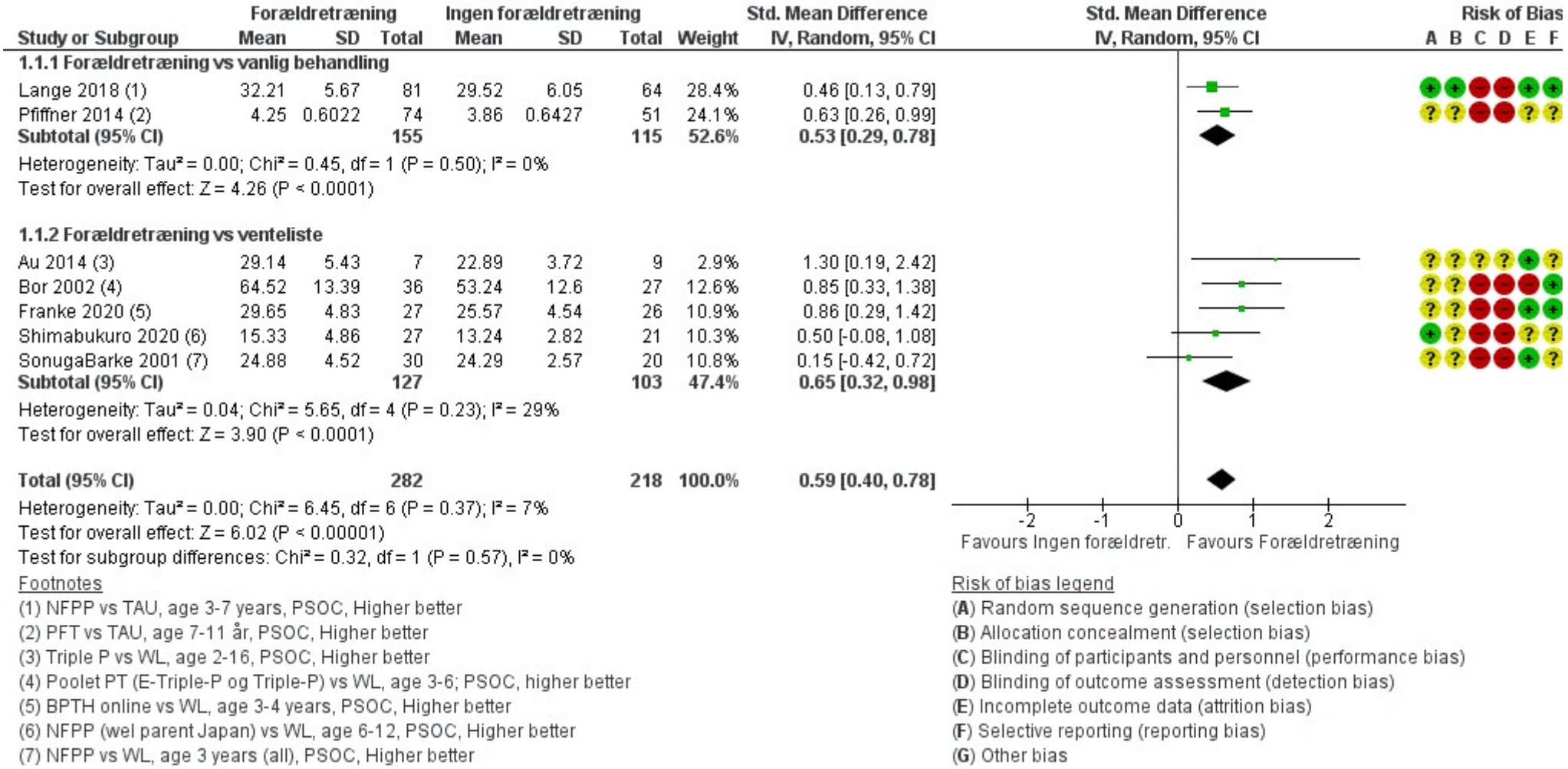
Figure 1





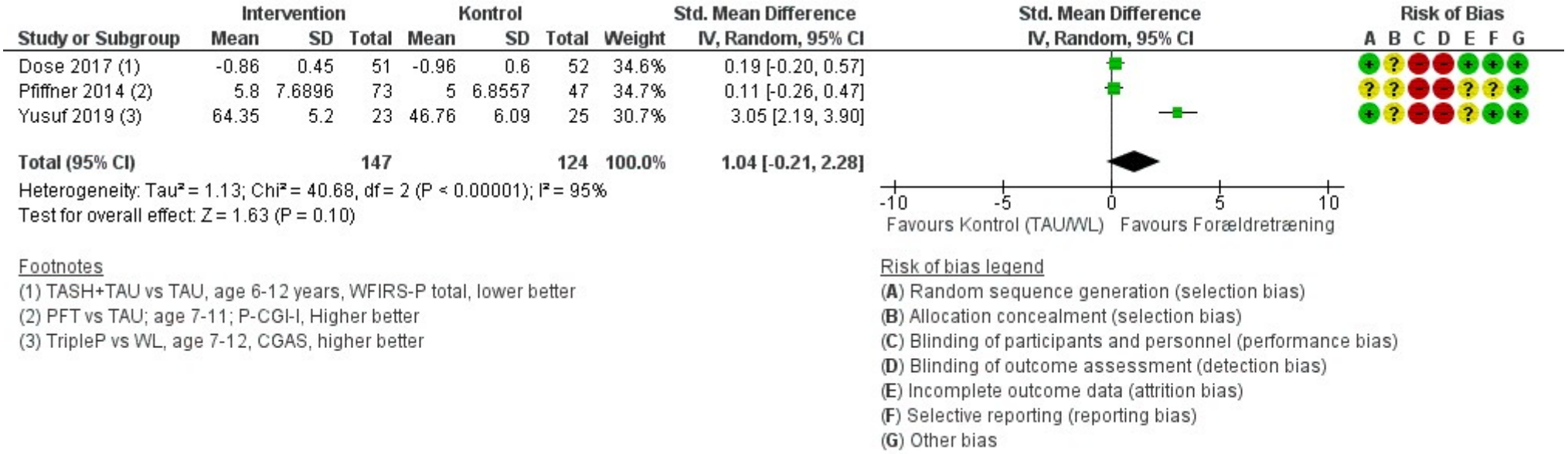
Risk of bias summary: review authors' judgements about each risk of bias item for each included study.

Figure 2 (Analysis 1.1)



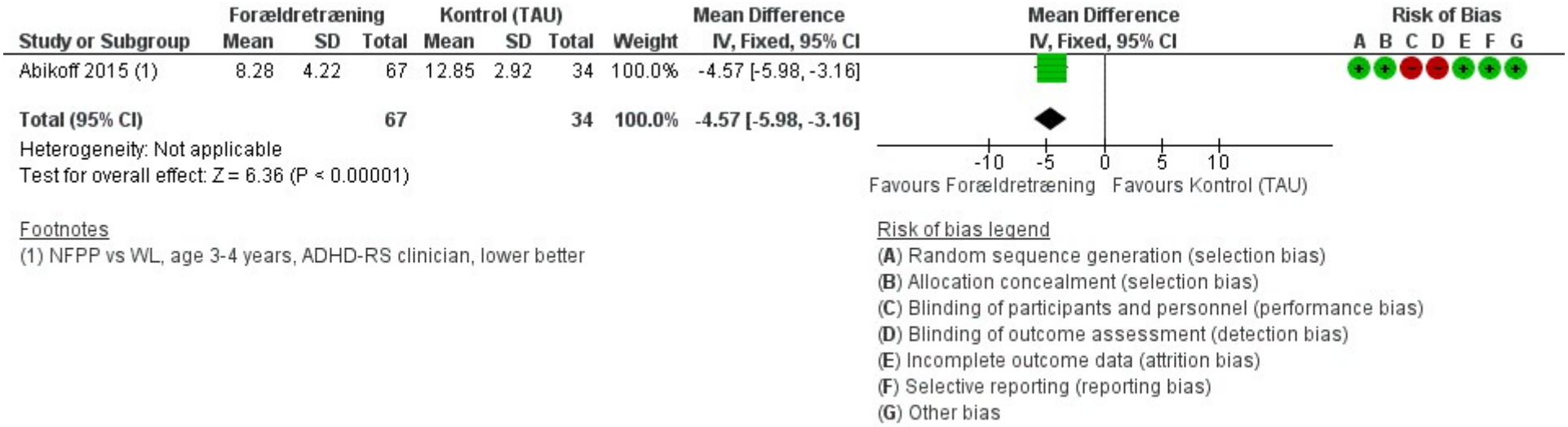
Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.1 Oplevet forældrekompetence, Parenting Sense of Competence Scale (PSOC) - self efficacy subscale (higher better).

Figure 3 (Analysis 1.2)



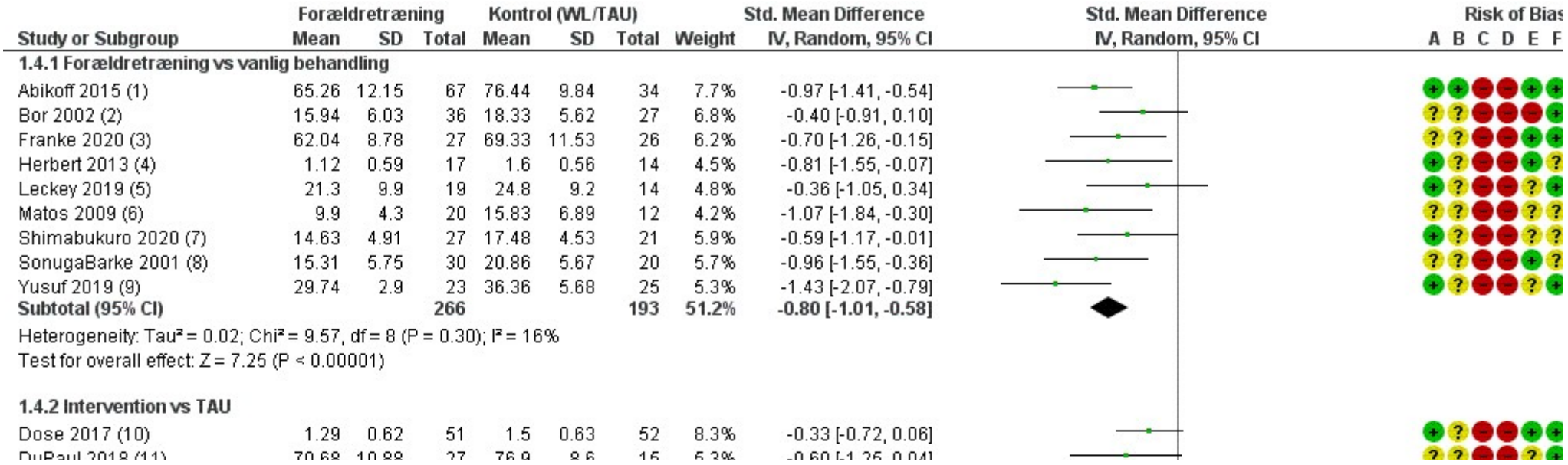
Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.2 Funktionsniveau hos barnet/den unge, forældrerapporteret.

Figure 4 (Analysis 1.3)



Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.3 ADHD kernesymptomer kliniker/observatør.

Figure 5 (Analysis 1.4)

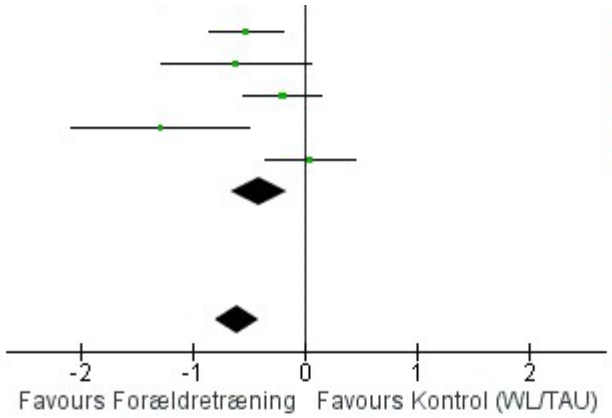


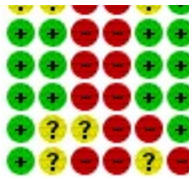
Lange 2018 (12)	29.18	9.08	84	33.98	8.82	64	9.2%	-0.53 [-0.86, -0.20]
Nobel 2020 (13)	24.5	11	20	31.6	11.6	16	5.0%	-0.62 [-1.29, 0.06]
SonugaBarke 2018 (14)	1.7	0.67	133	1.83	0.56	42	8.9%	-0.20 [-0.55, 0.15]
Thompson 2009 (15)	11.62	6.19	17	20.46	7.17	13	4.0%	-1.30 [-2.10, -0.49]
vandenHoofdakker 2007 (16)	19	6.2	47	18.7	7.7	47	8.1%	0.04 [-0.36, 0.45]
Subtotal (95% CI)			**379**			**249**	**48.8%**	**-0.41 [-0.66, -0.16]**

Heterogeneity: Tau² = 0.05; Chi² = 12.00, df = 6 (P = 0.06); I² = 50%
Test for overall effect: Z = 3.21 (P = 0.001)

Total (95% CI)			**645**			**442**	**100.0%**	**-0.62 [-0.81, -0.42]**

Heterogeneity: Tau² = 0.08; Chi² = 32.46, df = 15 (P = 0.006); I² = 54%
Test for overall effect: Z = 6.18 (P < 0.00001)
Test for subgroup differences: Chi² = 5.39, df = 1 (P = 0.02), I² = 81.5%



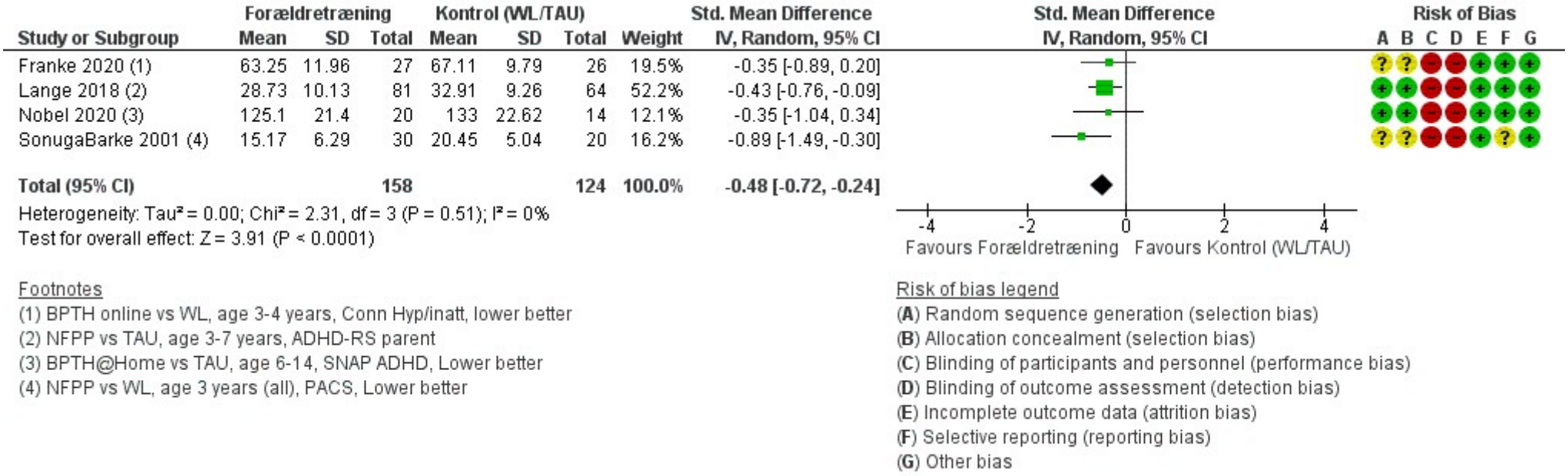


Footnotes
(1) NFPP vs WL, age 3-4 years, ADHD-RS parent, lower better
(2) Poolet PT (E-Triple-P og Triple-P) vs WL, age 3-6; EFBI, lower better
(3) BPTH online vs WL, age 3-4 years, Connors Hyp/inatt, lower better
(4) PHYP vs WL, age 3-6, DBRS inatt, Lower better
(5) IY-PT Only vs WL, age 3-7, Conners ADHD Index, Lower better
(6) BPTH@Home vs WL, age 4-6, DBRS inattention, Lower better
(7) NFPP (Well parent Japan) vs WL, age 6-12, SNAP inatt, Lower better
(8) NFPP vs WL, age 3 years (all), PACS, Lower better
(9) TripleP vs WL, age 7-12, ADHD-RS P, Lower better
(10) TASH+TAU vs TAU, age 6-12 years, FBB-ADHS total, lower better
(11) Poolet PBT (F2F og online) vs WL, age 3-6; ADHD-RS, Lower better
(12) NFPP vs TAU, age 3-7 years, ADHD-RS parent, Lower better
(13) BPTH@Home vs TAU, age 6-14, SNAP Inatt, Lower better
(14) NFPP vs TAU, age 3-6, SNAP ADHD, Lower better
(15) NFPP vs TAU, age 3-6 years, CPRS total, Lower better
(16) BPT+RCC vs RCC, age 4-12 years, CPRS-total, Lower better

Risk of bias legend
(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

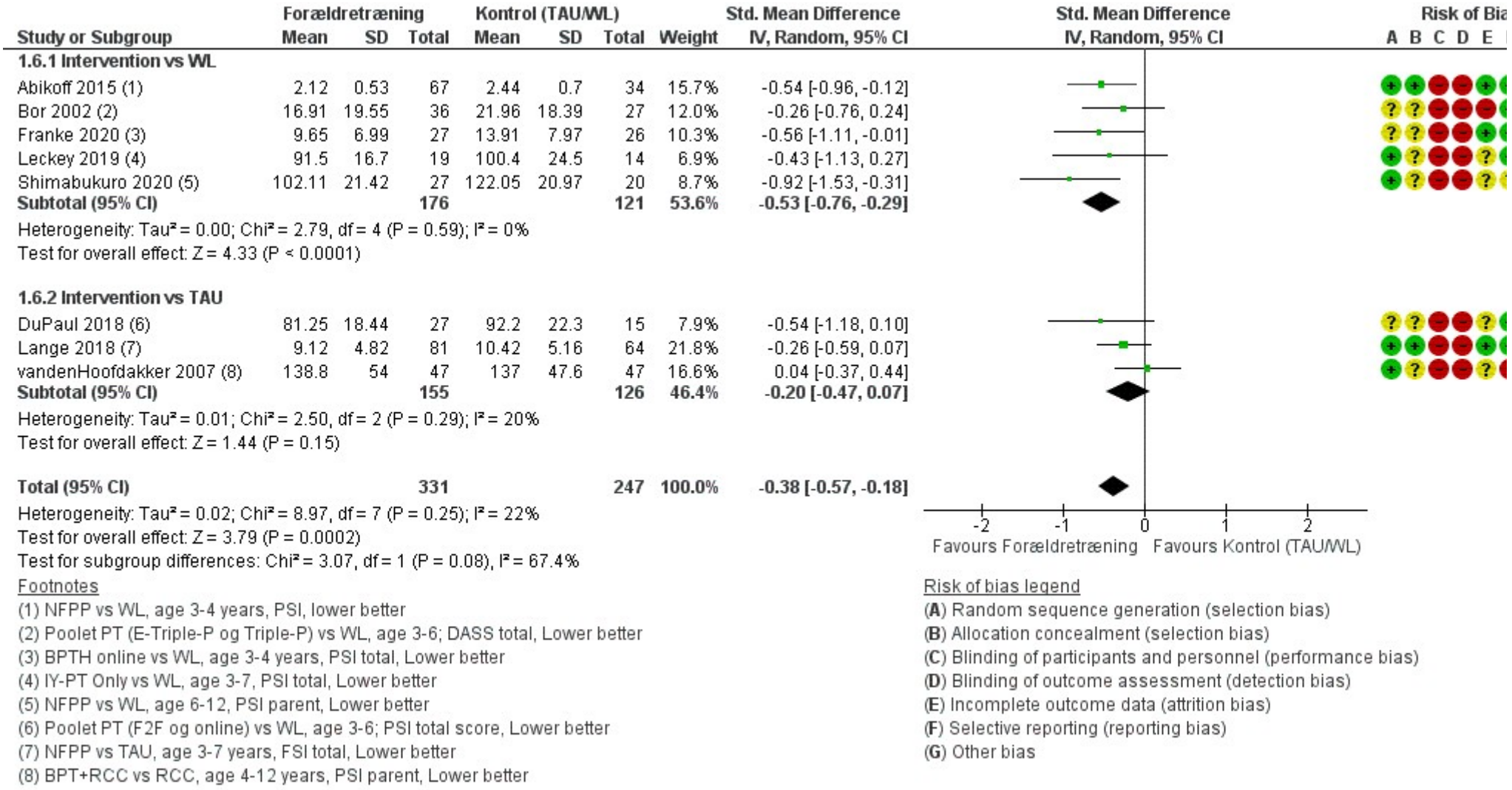
Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.4 ADHD kernesymptomer (Core symptoms), forældrebedømt (EoT).

Figure 6 (Analysis 1.5)



Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.5 ADHD kernesymptomer (Core symptoms), forældrebedømt, min 3 mdr FU.

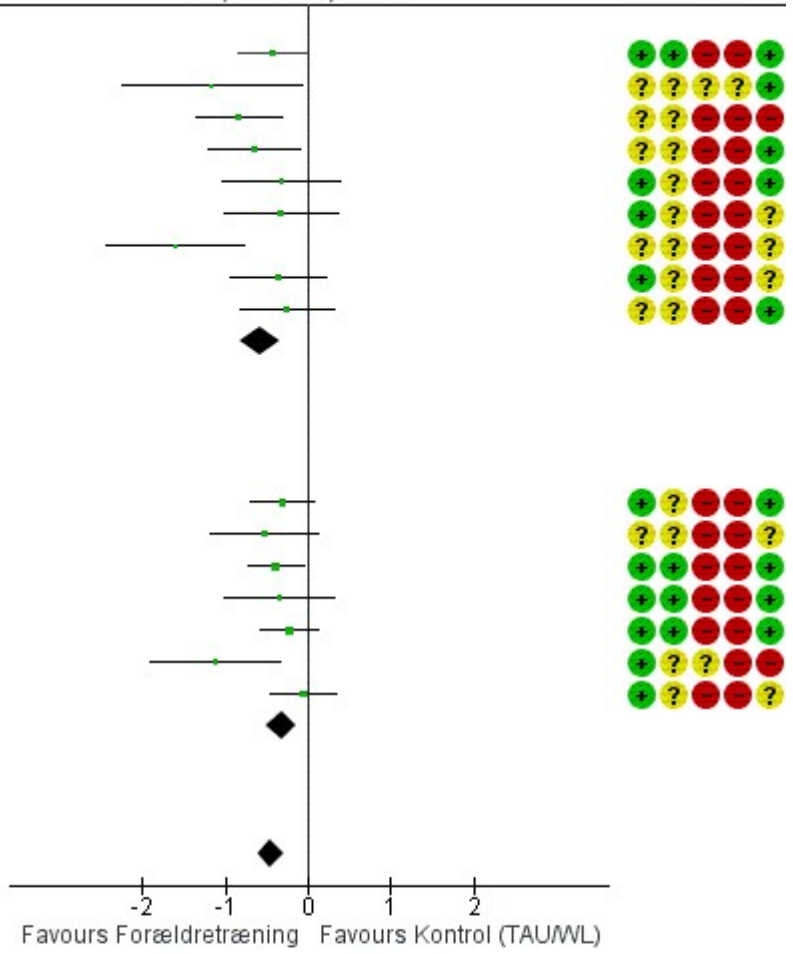
Figure 7 (Analysis 1.6)



Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.6 Forældrestress.

Figure 8 (Analysis 1.7)

Study or Subgroup	Forædretræning Mean	SD	Total	Kontrol (TAU/WL) Mean	SD	Total	Weight	Std. Mean Difference IV, Random, 95% CI
1.7.1 Intervention vs WL								
Abikoff 2015 (1)	0.84	0.52	67	1.1	0.72	34	8.8%	-0.43 [-0.85, -0.02]
Au 2014 (2)	128.14	26.19	7	155.67	19.21	9	1.9%	-1.16 [-2.25, -0.07]
Bor 2002 (3)	123.2	35.96	36	152.12	31.91	27	6.6%	-0.83 [-1.35, -0.31]
Franke 2020 (4)	66.91	11.55	27	73.81	9.26	26	6.0%	-0.65 [-1.20, -0.09]
Herbert 2013 (5)	1.01	0.67	17	1.26	0.84	14	4.0%	-0.32 [-1.04, 0.39]
Leckey 2019 (6)	4.3	2.1	19	5	2.1	14	4.2%	-0.33 [-1.02, 0.37]
Matos 2009 (7)	51.52	10.51	20	68.36	9.74	12	3.1%	-1.60 [-2.43, -0.77]
Shimabukuro 2020 (8)	4.67	3.14	27	6.14	4.92	20	5.5%	-0.36 [-0.95, 0.22]
SonugaBarke 2001 (9)	16.79	7.09	30	18.48	6.02	20	5.8%	-0.25 [-0.82, 0.32]
Subtotal (95% CI)			**250**			**176**	**46.0%**	**-0.58 [-0.82, -0.34]**
Heterogeneity: Tau² = 0.04; Chi² = 11.19, df = 8 (P = 0.19); I² = 29%								
Test for overall effect: Z = 4.68 (P < 0.00001)								
1.7.2 Intervention vs TAU								
Dose 2017 (10)	1.26	0.68	51	1.47	0.65	52	9.6%	-0.31 [-0.70, 0.08]
DuPaul 2018 (11)	68.33	15.3	27	75.9	11.3	15	4.8%	-0.53 [-1.17, 0.11]
Lange 2018 (12)	4.04	2.37	84	4.92	2.13	64	11.6%	-0.39 [-0.71, -0.06]
Nobel 2020 (13)	133.3	27.1	20	143	28	16	4.5%	-0.34 [-1.01, 0.32]
SonugaBarke 2018 (14)	152.4	40.71	133	161.58	34.83	42	10.9%	-0.23 [-0.58, 0.12]
Thompson 2009 (15)	14.37	7.8	17	22.63	6.3	13	3.4%	-1.12 [-1.90, -0.33]
vandenHoofdakker 2007 (16)	67.1	8.8	47	67.6	9.3	47	9.2%	-0.05 [-0.46, 0.35]
Subtotal (95% CI)			**379**			**249**	**54.0%**	**-0.33 [-0.50, -0.15]**
Heterogeneity: Tau² = 0.00; Chi² = 6.44, df = 6 (P = 0.38); I² = 7%								
Test for overall effect: Z = 3.68 (P = 0.0002)								
Total (95% CI)			**629**			**425**	**100.0%**	**-0.45 [-0.61, -0.29]**
Heterogeneity: Tau² = 0.03; Chi² = 20.97, df = 15 (P = 0.14); I² = 28%								
Test for overall effect: Z = 5.60 (P < 0.00001)								
Test for subgroup differences: Chi² = 2.81, df = 1 (P = 0.09), I² = 64.5%								



Footnotes

(1) NFPP vs WL, age 3-4 years, NYPRS-Defiance, lower better
(2) Triple P vs TAU, age 2-16 years, ECBI intensity, Lower better
(3) Poolet PT (E-Triple-P og Triple-P) vs WL, age 3-6; ECBI Intensity, Lower better
(4) BPTH online vs WL, age 3-4 years, CERS-DA, lower better
(5) Phyp vs WL, age 3-6, DBRS ODD, Lower better

Risk of bias legend

(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)

(6) IY-PT vs WL, age 3-7, SDQ-parent conduct, lower better
(7) BPTH@Home vs WL, age 4-6, ECBI inattention, Lower better
(8) NFPP (Well Parent Japan) vs WL, age 6-12, Snap ODD, Lower better
(9) NFPP vs WL, age 3 years (all), PACS conduct, Lower better
(10) TASH+TAU vs TAU, age 6-12 years, FBB-SVV ODD, lower better
(11) Poolet PT (F2F og online) vs WL, age 3-6; Conners, Lower better
(12) NFPP vs TAU, age 6-12, SDQ-parent conduct, lower better
(13) BPTH@HOME vs TAU, age 6-14, ECBI Inatt, Lower better
(14) NFPP vs TAU, age 3-6, ECBI inatt, Lower better
(15) NFPP vs TAU, age 3-6 years, PACS conduct, Lower better
(16) BPT+RCC vs RCC, age 4-12 years, CBCL Externaliz, Lower better

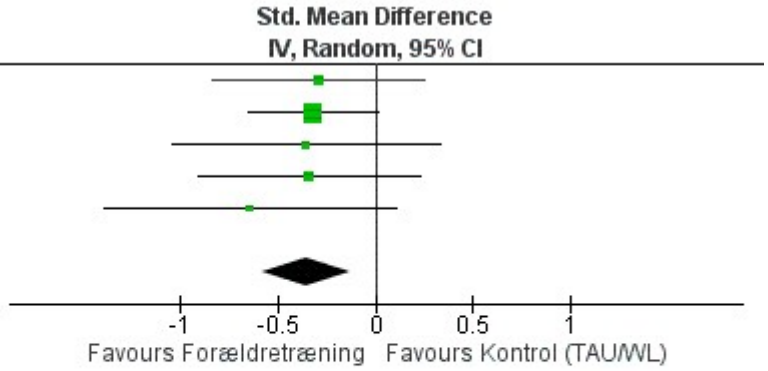
(F) Selective reporting (reporting bias)
(G) Other bias

Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.7 Adfærdsvanskeligheder, forældrebedømt.

Figure 9 (Analysis 1.8)

	Forældretræning			Kontrol (TAU/WL)				Std. Mean Difference
Study or Subgroup	Mean	SD	Total	Mean	SD	Total	Weight	IV, Random, 95% CI
Franke 2020 (1)	69.08	9.7	27	71.94	9.7	26	17.4%	-0.29 [-0.83, 0.25]
Lange 2018 (2)	3.99	2.36	81	4.77	2.52	64	46.9%	-0.32 [-0.65, 0.01]
Nobel 2020 (3)	125.1	21.4	20	133	22.62	14	10.8%	-0.35 [-1.04, 0.34]
SonugaBarke 2001 (4)	16.96	5.79	30	19.1	6.83	20	15.7%	-0.34 [-0.91, 0.23]
Thompson 2009 (5)	16.56	6.72	17	21.15	7.33	13	9.3%	-0.64 [-1.38, 0.10]
Total (95% CI)			**175**			**137**	**100.0%**	**-0.35 [-0.58, -0.12]**

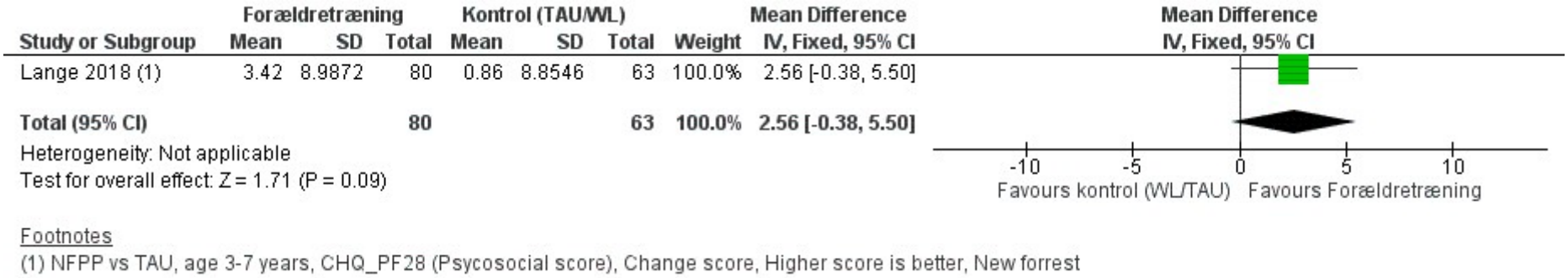
Heterogeneity: Tau² = 0.00; Chi² = 0.66, df = 4 (P = 0.96); I² = 0%
Test for overall effect: Z = 3.04 (P = 0.002)



Footnotes
(1) IBPTH Online vs WL, age 3-4 years, CERS-DA, lower better
(2) NFPP vs TAU, age 3-7, SDQ parent, lower better
(3) BPTG@HOME vs TAU, age 6-14, ECBI Inatt, Lower better
(4) NFPP vs WL, age 3 years (all), PACS conduct, Lower better
(5) NFPP vs TAU, age 3-6 years, PACS conduct, Lower better

Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.8 Adfærdsvanskeligheder, forældrebedømt (min 3 mdr FU).

Figure 10 (Analysis 1.9)

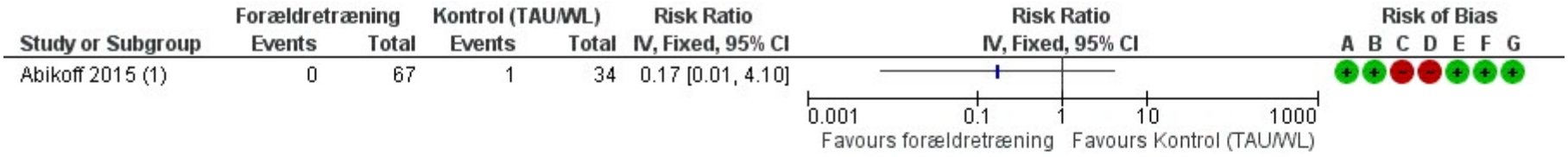


Footnotes

(1) NFPP vs TAU, age 3-7 years, CHQ_PF28 (Psycosocial score), Change score, Higher score is better, New forrest

Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.9 Livskvalitet hos barnet.

Figure 11 (Analysis 1.10)



Footnotes

(1) NFPP vs WL, age 3-4 years,

Risk of bias legend

(**A**) Random sequence generation (selection bias)
(**B**) Allocation concealment (selection bias)
(**C**) Blinding of participants and personnel (performance bias)
(**D**) Blinding of outcome assessment (detection bias)
(**E**) Incomplete outcome data (attrition bias)
(**F**) Selective reporting (reporting bias)
(**G**) Other bias

Forest plot of comparison: 1 Forældretræning vs kontrol (WL/TAU), outcome: 1.10 Skadevirkninger.