

# **INSTRUCTIONS FOR AACAP COMMITTEES**

## **FOR THE DEVELOPMENT OF**

## **AACAP CLINICAL UPDATES**

### **AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY**

### **COMMITTEE ON QUALITY ISSUES**

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Originally developed by prior

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## OVERVIEW

The Committee on Quality Issues (CQI) of the American Academy of Child and Adolescent Psychiatry (AACAP), in collaboration with other AACAP Committees (hereafter known as Committee), is developing a **Clinical Updates** series in child and adolescent psychiatry in three broad topic areas:

- the psychiatric assessment and management of specific **populations** of children and adolescents (e.g., physically ill youth, gender non-conforming youth)
- the psychiatric assessment and management of children and adolescents in specific **settings** (e.g., schools, systems of care)
- the application of specific psychiatric **techniques** to children and adolescents (e.g., telepsychiatry, collaborative care).

AACAP Clinical Updates are different from AACAP Clinical Practice Guidelines, which address the assessment and treatment (psychopharmacological and psychosocial) of psychiatric **disorders** in children and adolescents and provide disorder-specific treatment recommendations or suggestions. While Clinical Practice Guidelines are based upon systematic searches and critical appraisals of the extant literature provided by the US Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) through contracts to Evidence-Based Treatment Centers, Clinical Updates will be based upon systematic searches and critical appraisals of the extant literature performed by the authoring Committees. While Clinical Practice Guidelines will be developed in close accordance with guideline standards of rigor and transparency promulgated by the Institute of Medicine, Clinical Updates will be informed by these standards but may not reach full accordance because of their more limited evidence base and less systematic review of the literature. Clinical Updates will not provide disorder-specific treatment recommendations or suggestions.

With the debut of Clinical Updates and Clinical Practice Guidelines, the former AACAP Practice Parameters have been retired.

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

### **TOPICS**

The CQI may invite a Committee to develop a Clinical Update on a specific topic deemed to be of interest to the AACAP membership. Alternatively, a Committee may suggest to the CQI that they wish to develop a Clinical Update on the topic addressed by their Committee.

### **AUTHORS**

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

It is generally advisable (but not required) that the Committee name one to three Committee individuals to contribute most of the writing of the Update, both to streamline the process and to create a consistent style of presentation. In this case, these lead authors will receive special designation as a principal author in the Update boilerplate (see Attribution section below).

All other Committee members will be attributed as authors if they meet requirements for authorship specified by the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP) as determined by the Committee co-chairs.

All CQI members will be attributed as authors if they meet requirements for authorship specified by JAACAP as determined by the CQI co-chairs.

### **OTHER CONTRIBUTORS**

The Committee may invite other non-Committee-member individuals to help conceptualize, contribute to, or review the Update. These individuals generally will be attributed in a separate section of the boilerplate (see *Development and Attribution* below). In rare circumstances in which an extraordinary contribution has been made to the Update by a non-Committee-member individual, inclusion in the author list will be considered by the CQI if the JAACAP author requirements are otherwise met.

### **ATTRIBUTION**

Clinical Updates will be attributed on the title page as official AACAP Actions authored by the American Academy of Child and Adolescent Psychiatry (AACAP) [name of committee] and AACAP Committee on Quality Issues.

Although JAACAP has jurisdiction over the final wording and layout of the title page, the following is an example of how authorship of a fictional Clinical Update document could be attributed on the title page:

#### ***AACAP OFFICIAL ACTION***

##### ***Clinical Update: Assessment and Management of Publishing Protocols***

*American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Publishing Protocols and AACAP Committee on Quality Issues*

The Committee chairs and members and Committee on Quality Issues chairs and members who participated in the development of the Clinical Update and meet JAACAP author requirements will be named in the boilerplate of the Update (see sample boilerplate text under *Development and Attribution* below). Unless as described above under the *Authors* section where some authors are designated as principal authors who will appear first, the order of authors will be as follows: Committee co-chairs, Committee members (alphabetically). The order of Committee on Quality Issues chairs and members' names who meet JAACAP author requirements will be as follows: CQI shepherd, other CQI members who contributed to the development of the Update (alphabetically), and CQI co-chairs.

Committee authors should understand that PubMed listings are idiosyncratic and may or may not include author names as listed in the boilerplate.

Topic experts, reviewers, and other contributors will be attributed alphabetically by name in the Update boilerplate (see *Development and Attribution* below).

## **COMMITTEE DUTIES**

Committees authoring Clinical Updates accept the following responsibilities:

1. Be thoroughly familiar with the *Instructions for AACAP Committees for the Development of AACAP Clinical Updates*.
2. Partner with the CQI shepherd and the AACAP staff liaison to complete all Update development tasks.
3. Prepare the initial Update outline and draft and subsequent revisions in a timely fashion (**approximately 12 months from initiation to approval**).
4. Incorporate comments of CQI members and other reviewers into the Update drafts.
5. Proof JAACAP page proofs immediately upon receipt.

## **COPYRIGHT**

Copyright to the Clinical Update Series belongs to AACAP.

## **CONFLICT OF INTEREST**

Clinical Updates incorporate the values expressed in the AACAP *Code of Ethics*. Committee and CQI chairs, Committee and CQI members, topic experts, and reviewers are required to disclose potential conflicts of interest related to the Update. Potential conflicts of interest will be available to the public on the AACAP website, and potential conflicts of interest of Committee and CQI chairs will be listed in the boilerplate. Authors with conflicts or biases that could affect scientific objectivity are asked to decline participation.

## **CLINICAL UPDATE DEVELOPMENT PROCESS**

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

1. **Identification of Topics and Authors.** The CQI identifies new Update topics and potential Committees for Update authorship. The CQI also considers suggestions for topics offered by AACAP Committees, members, and executive leadership.
2. **Identification of CQI Shepherd and AACAP Staff Liaison.** The CQI assigns one of its members to “shepherd” the Committee in Update development, assisted by the AACAP staff liaison. The shepherd and liaison will be responsible for assisting the Committee in following the *Instructions for AACAP Committees* and incorporating CQI members’ and other reviewers’ comments into drafts of the Update.

3. **Preparation of Drafts.** Preparation of the Update should begin with a literature search of potential issues to be addressed in the Update. This search should be performed and documented according to the guidelines outlined under the METHODOLOGY section below. The results of the literature search should be used to generate the content of the Update. After the literature review, the Committee works with the CQI shepherd to develop an outline of the Update. When the outline has been written, the shepherd will present the outline to the CQI. If the CQI approves the draft outline, the shepherd invites the Committee to develop a complete first draft.
4. **CQI Review.** When the complete first draft has been written, the shepherd will present the complete first draft to the CQI for review and comment. After CQI review, the Committee works with the CQI shepherd to incorporate the comments of CQI members. This step can be an iterative process.
5. **Expert Review.** Following CQI review, the CQI will direct the Committee to nominate acknowledged experts in the Update topic area for additional review requested by the CQI. Topic experts may include members of other relevant AACAP committees, professionals from other disciplines, or representatives from relevant professional or consumer organizations. The Committee incorporates experts' comments into a subsequent Update draft.
6. **AACAP Member Review.** Following expert review, the draft of the Update is posted on the AACAP website for member review. The Committee incorporates members' comments into a subsequent Update draft.
7. **Consensus Group.** The draft of the Update is reviewed by a Consensus Group convened by the CQI. The Committee incorporates Consensus Group members' comments into a subsequent Update draft or provides commentary explaining why certain edits were not made. The Consensus Group typically comprises the following:
  - A. A chair of the CQI
  - B. The CQI shepherd
  - C. One or two additional CQI members
  - D. Several experts in the Update topic area
  - E. One or two representatives from other relevant AACAP Committees (if applicable), who are expected to keep their Committees apprised of the process
  - F. One or two representatives from the AACAP Assembly of Regional Organizations, who are expected to represent the interests of AACAP members
  - G. One or two representatives from the AACAP Council, who are expected to represent the interests and authority of the AACAP leadership

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

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

9. **Approval by AACAP Council.** Following the final CQI edits, the Update draft is reviewed and approved by a majority of a quorum of the AACAP Council. It is anticipated that the Council will make substantive changes to the Update only in extraordinary circumstances.
10. **Submission/Posting.** The Council-approved and edited Update is submitted to the *Journal of the American Academy of Child and Adolescent Psychiatry* (JAACAP) and is posted on the AACAP website.
11. **Proof-Reading.** The Update JAACAP page proofs are proof-read by the Committee co-chairs (with final approval of proof edits by CQI co-chairs).
12. **Publication.** The Clinical Update is published in JAACAP as an *AACAP Official Action*. The Clinical Update may also be published and distributed by AACAP in other ways.

Note: some of the steps above may occur concurrently to accelerate the review process.

## **CONTENT AND FORMAT OF CLINICAL UPDATES**

### **CONTENT**

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

### **TITLE**

Typical titles of Clinical Updates are as follows:

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

### **ABSTRACT**

A one-paragraph (150-word limit), structured abstract should summarize the content of the Clinical Update. The abstract should include: Objective; Method; Results; Conclusion. Up to five key terms are listed as keywords. The terms “clinical update,” “child and adolescent psychiatry” and other terms of the Committee’s choice can be used.

## **INTRODUCTION**

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

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

Other information that should be included in the introduction:

- Any important assumptions underlying the Update (Example: “This Update assumes familiarity with normal child development and the principles of child psychiatric diagnosis and treatment.”)
- Clarification of terminology (Example: “In this Update, unless otherwise noted, the term ‘child’ refers to both children and adolescents. Also, unless otherwise noted, ‘parents’ refers to the child’s primary caregivers, regardless of whether they are the biological or adoptive parents or legal guardians.”)

## **METHODOLOGY**

AACAP Clinical Updates should critically appraise evidence using transparent literature review methodology consistent with worldwide standards. The single most useful guide for this process is The Cochrane Library’s *Handbook for Authors*.

The following outline can help guide committee authors to produce high-quality literature searches:

1. For each of the potential issues under study in the Update, create search terms, using Boolean operators (e.g., OR, AND) to join individual terms and sets of terms as appropriate. To ensure a complete search (i.e., all relevant results are found), use *Medical Index Subject Heading* (MeSH) terms for all searches in MEDLINE and *thesaurus* terms for all searches in PsycINFO. *Keyword* searches can also be used, but only as a supplement to MeSH and thesaurus terms.

Other resources (not required):

- <https://doi.org/10.1371/journal.pmed.1000100>
- [SRDR: Systematic Review Data Repository™ | Agency for Healthcare Research and Quality \(ahrq.gov\)](https://www.aahrq.gov/data-repository)
- PICO Portal that can be used as a data-management tool: [Documentation \(requires membership, with cost, but several academic institutions have institutional licenses\) - PICO Portal | PICO Portal](#)

2. Search multiple databases. The most fruitful databases in child and adolescent psychiatry are MEDLINE, PsycINFO, CENTRAL, and EMBASE. Searching these four databases will generally suffice if the bibliographies of retrieved articles are also examined for relevant references not included in the databases.
3. Search first for systematic reviews and meta-analyses that used well-defined methodology as the highest level of empirical evidence. The Cochrane Database of Systematic Reviews (CDSR) contains many systematic reviews (SR); however, if the topic is not found in CDSR, search other databases using the “article types” filter that retrieves only systematic reviews and/or meta-analyses.
4. Next use the “article types” filter to search for individual studies, choosing the appropriate types of studies (e.g., randomized controlled trial, cohort study, case-control study, case study) as indicated by the issue under study.
5. Use additional filters to specify additional “winnowing” criteria (e.g., human, English language, ages, publication dates). Avoid using these filters in the initial search; rather include them in subsequent searches so the reader can follow how the search began with a sensitive, inclusive search, but then became highly specific by focusing on the most relevant studies. Report the results for each search as the numbers narrow (“winnowing”). This ensures transparency, as anyone should be able to duplicate the search and obtain the same results. Do not ask the reader to take “on faith” a large reduction from over 2000 references in the initial search to the 50 listed in the Update’s bibliography without documenting the winnowing process.
6. Finally, the entire search process summarized above should be documented in the Methodology section of the Update, including the following specific information:
  - An explicit statement that the update is based on a systematic review of the literature
  - Listing of databases searched
  - Summary of search terms used
  - Specific time period covered by the search, including the beginning date (month/year) and end date (month/year)
  - Date(s) (month/year) when the search was done
  - Number of hits in initial searches and at each stage of the winnowing process
  - Description of study selection that includes the number of studies identified, the number of studies included, and a summary of inclusion and exclusion criteria

Examples of required documentation in text and Figure for MEDLINE and PsychINFO searches and study selection (“winnowing”) are provided in Appendix I.

## **DEFINITIONS**

Unfamiliar terms should be defined in this section, listed alphabetically.

## **HISTORICAL REVIEW**

Brief history of the topic can be provided, describing changes over time in approach to the



issue (e.g., changes in policies of seclusion and restraint, changes in federal mandates pertaining to the education of children with disabilities, changes in the power of the state in child welfare decisions).

### **CLINICAL UPDATE**

This section should succinctly update the topic based upon recent findings from the literature review. Evidence tables should be provided in every document (see examples in Appendix II). Where empirical evidence is not available, the source of the opinion stated in the Update should be noted and referenced (e.g., “Clinical consensus [reference] supports”)

### **CONCLUSION**

A short summary of the clinical update with salient points should form the conclusion.

### **DEVELOPMENT AND ATTRIBUTION**

The development and attribution section (“boilerplate”) summarizes the process of Clinical Update development and indicates the name(s) of all Committee and CQI members and reviewers. Correct degrees should be provided (e.g., M.D., Ph.D.). Academic affiliations are not included. Potential conflicts of interest are disclosed in the boilerplate for the Committee and CQI chairs and principal authors (if different from chairs). Disclosures for all other named individuals are available on the AACAP website. The attribution boilerplate is presented below (subject to editing by JAACAP). Please copy and paste this boilerplate into the Clinical Update document, filling in blanks as appropriate.

**This Clinical Update was developed by the AACAP [Committee name (initials)]: [names of Committee Co-Chairs, names of Committee members] and the AACAP Committee on Quality Issues (CQI): [name of CQI shepherd, names of CQI members, names of CQI co-chairs].**

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

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

**The [Committee Initials] acknowledges the following individuals for their contributions to this Update: [topic experts’ names (topic experts), other names (role)].**

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

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

From [month, year] to [month, year], this Clinical Update was reviewed and approved by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were as follows: [co-chair's name, shepherd's name, members' names] (CQI); [names] (topic experts); [names and committee affiliations] (AACAP Committees); [names] (AACAP Assembly of Regional Organizations); and [names] (AACAP Council).

This Clinical Update was approved by the AACAP Council on [date].

This Clinical Update is available at [www.aacap.org](http://www.aacap.org).

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

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

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## **REFERENCES**

It is not necessary to be exhaustive in developing the references. The purpose of the Update is to present literature that is compelling, relevant, and integral to the Update topic. The reference list should be consistent with the yield of searched articles that were retrieved for full-text review, along with references obtained in other ways (e.g., chapter bibliographies, websites, etc.)

## **ALGORITHMS/TABLES/FIGURES**

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

## **APPENDICES**

As noted in the METHODOLOGY instructions, Figures or Appendices may be needed to describe the literature search and winnowing procedures.

Examples of required documentation for MEDLINE and PsychINFO searches and study selection (“winnowing”) is provided in Appendix I.

## **PREPARATION OF DRAFTS**

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

## **LENGTH**

The draft should approximate 10,000 words, excluding abstract, tables, references, and boilerplate. All drafts should have an accurate word count on the cover sheet.

## **STYLE**

Style refers to the preferred usage for spelling, punctuation, and references. The AACAP uses the *AMA Manual of Style*, the *APA American Psychiatric Glossary*, and Webster's *Collegiate Dictionary*.

The text should be justified to the left side of the page. Do not attempt to hyphenate words in order to justify the right side of the page, since the hyphenation changes as the drafts evolve.

**COVER SHEET AND FIRST PAGE**

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

Do not indicate the draft number (e.g., Draft #1 or Draft #4). Simply put the date on which the author finished the draft and is submitting it to the CQI.

**HEADING LEVELS**

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

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

Example:

**CLINICAL UPDATE: TELEPSYCHIATRY WITH CHILDREN AND ADOLESCENTS**

-----

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

Example:

**ASSESSMENT**

-----

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

Example:

SYMPTOM RATING SCALES

-----

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

Example:

Types of Symptom Rating Scales

-----

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

Example:

*Illness coping scales.*

-----

## **REFERENCES**

References should be in the style of the *Journal*. Double check [www.jaacap.org](http://www.jaacap.org) if unsure of which style to use. If using bibliographic software, please be sure that the software is formatted appropriately. **DRAFTS WITH REFERENCES IN INCORRECT STYLE WILL BE RETURNED TO THE AUTHORS FOR REVISION.** Every effort should be made to list references accurately from primary source materials.

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

## **APPENDICES**

Sources for Appendix material:

1. [Clinical Update: Collaborative Mental Health Care for Children and Adolescents in Pediatric Primary Care \(jaacap.org\)](#)
2. [Clinical Update: Child and Adolescent Behavioral Health Care in Community Systems of Care \(jaacap.org\)](#)
3. [Clinical Update: Telepsychiatry With Children and Adolescents \(jaacap.org\)](#)

## APPENDIX I – Examples of text and Figures regarding literature searches

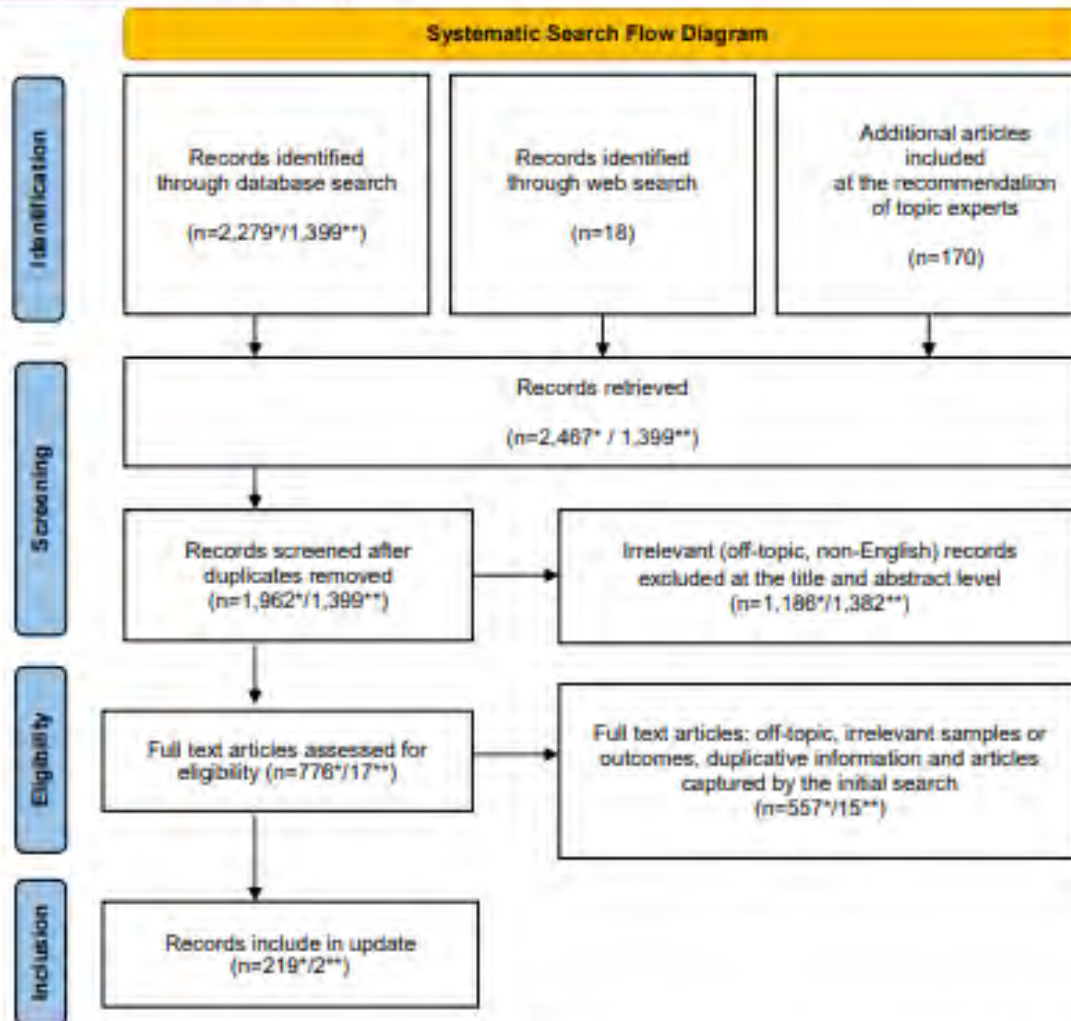
### Example 1

#### METHODOLOGY

Initial Search A medical librarian conducted a systematic search of the literature on collaborative (including integrated) behavioral health in pediatric primary care spanning the period January 1, 2001, to April 7, 2016, using Medline, PsycINFO, and Embase databases. Overall, this search yielded 2,279 citations. In addition to the database search, a number of other sources were used that were deemed of importance to the field, including recommendations of topic experts (n = 170) and organization websites (n = 18), for a total search yield of 2,467 citations. After removing duplicates, 1,962 citations remained. The authors of this Update examined all 1,962 titles and abstracts for topic relevance and English language. Of the 1,962 citations, 776 were identified for full-text review. After removing irrelevant citations (off-topic, irrelevant samples or outcomes, duplicative information), 219 citations remained. Follow-up Search Using the same databases and search terms, a medical librarian conducted a systematic review of the literature spanning the period April 8, 2016, to March 16, 2021. This search yielded 1,399 unduplicated citations. The authors of this Update examined all 1,399 titles and abstracts. After removing previously identified citations, 17 citations remained for full-text review. After removing irrelevant citations (off-topic, irrelevant samples or outcomes, duplicative information), 2 citations remained. The search methodology is depicted in Figure 1.

Citation (after Figure 1): Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71. <https://doi.org/10.1136/bmj.n71>

FIGURE 1 Systematic Search Flow Diagram



Note: \*initial search; \*\*follow-up search from Page et al.<sup>11</sup> For more information, visit <http://www.painand-stressment.org/>. Please note color figures are available online.

## Example 2;

### METHODOLOGY

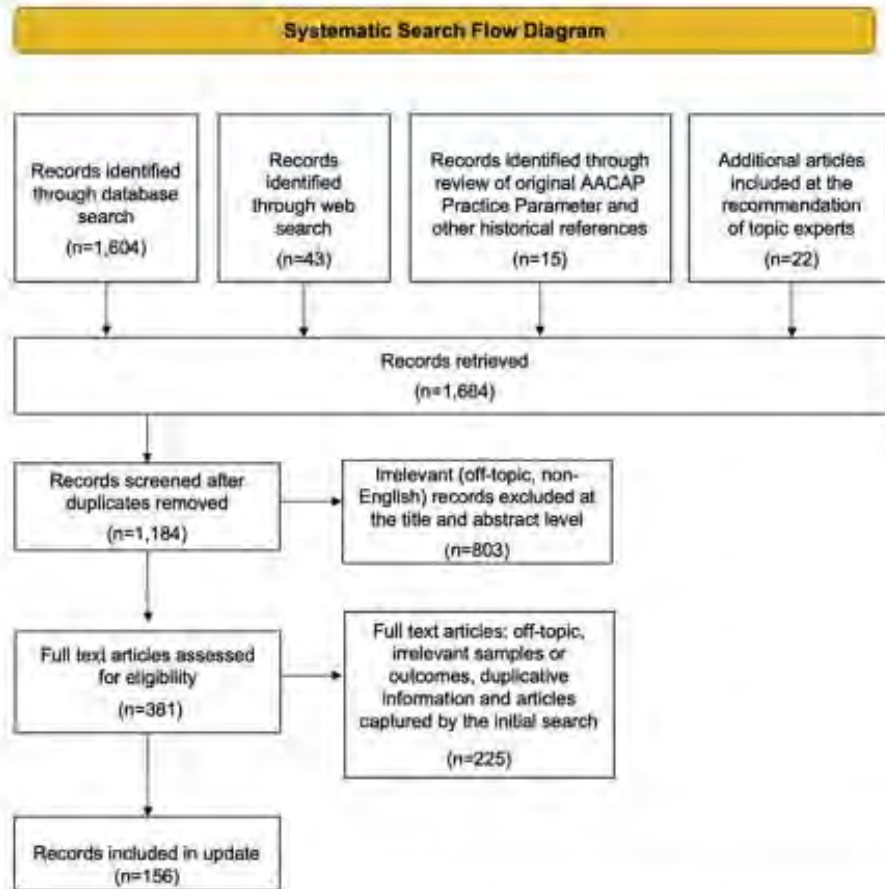
The list of references for this clinical update was obtained by conducting a search in Embase, PsycINFO, PubMed, and Cochrane on April 26, 2016, which was updated on April 1, 2019, and June 10, 2021. Through consultation with a medical librarian, the following search terms were developed: systems of care, system of care, wrap around, wraparound, with filters for community mental health, mental health service, psychiatric, youth, child and adolescent. The search was limited to references after 2002, English language, and human subjects. There were 1,604 records identified through the database search. The records were then reviewed at the title and abstract level. In addition to the search references described above, several other sources were used that were deemed to be of importance to the field. Topic experts were consulted to ensure that appropriate studies and topics were included. The gray literature was reviewed by examining key websites and organizations. Book chapters from key authors were included. For specific topics, such as the section on trauma, the references were supplemented with additional articles, given that the topic may not have been fully covered in the search. Additional references also were added at the suggestion of the expert reviewers. A total of 1,684 records were retrieved, with 1,184 remaining after duplicates were removed. Based on relevance to the topic, 381 records were selected to review at the full-text level. Of these, 156 references were included in the update, after exclusions of articles that were off topic, studied irrelevant samples, had outdated information, or contained duplicative information.

A separate search using the original 2007 Practice Parameter terms and search engines was also conducted in April 2016 and again in June 2021. This search yielded 116 references without removal of duplicates. The search results were examined and compared to more recent search terms to assess face validity of results. It was determined that the revised search terms were more inclusive. Based on the greater inclusiveness of the newer search terms, as well the face validity determined by SOC members, the newer search terms were used for this Update. The search methodology is depicted in Figure 1.

**Citation:** Page MJ, McKenzie JE, Bossuyt PM, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*. 2021;372:n71. <https://doi.org/10.1136/bmj.n71>



**FIGURE 1** Systematic Search Flow Diagram



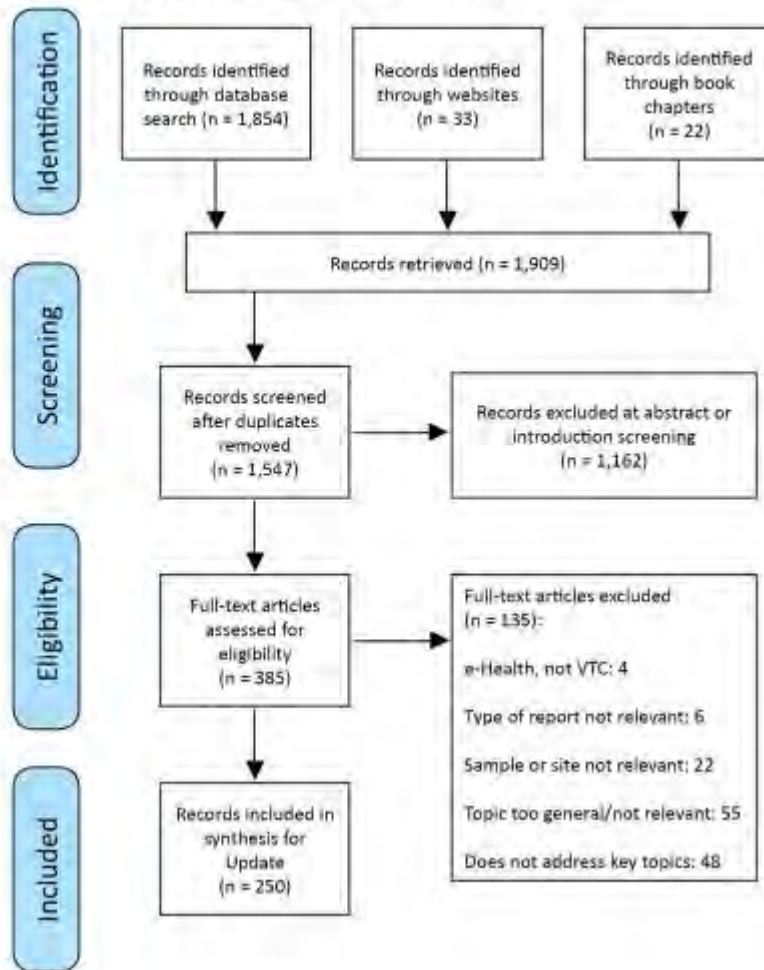
Note: From Page et al.<sup>13</sup> (For more information, visit: <http://www.prisma-statement.org/> Published under Creative Commons license: CC BY (<https://creativecommons.org/licenses/by/4.0/>))

### Example 3

#### METHODOLOGY

A medical librarian conducted a systematic review of the literature in April 2016 and updated the search through March 2017. Searches were performed in the following databases—on the Ovid platform: Medline, PsycInfo, Cochrane Database of Systematic Reviews, and Cochrane Central Register of Controlled Trials; elsewhere: Embase, Web of Science, and the National Guideline Clearinghouse. Retrieval was limited to publication dates from January 2004 to March 2017, in the English language, and on human species. In Medline, PsycInfo, and Embase, appropriate Medical Subject Headings (MeSH), terms from the Thesaurus of Psychological Index Terms, and Emtree headings were used, respectively, in addition to text words, and the search strategy was adapted for other databases as appropriate. Terms searched were telepsychiatry, telepsychology, telemental, telebehavioral medicine, teletherapy, telehealth, telepractice, telemedicine, video conferencing, remote consultation, and mental disorders. The final 1,547 records screened after duplicates were removed included high-level studies such as meta-analyses (n = 146) and lower-level studies such as randomized controlled trials, intervention trials, pre-post interventions, case series, observational studies, and program descriptions (n = 1,346), as well as various expert opinions and experience (n = 55). In addition to the systematic search, we included material from 3 other sources. We included book chapters from texts published by recognized leaders in telepsychiatry, particularly chapters addressing topics not well addressed in the research literature, such as ethics and cultural competence. Second, we retained several articles published before 2004 from the original Practice Parameter for Telepsychiatry With Children and Adolescents<sup>18</sup> because of their relevance to establishing a telepsychiatry practice. Third, we reviewed multiple websites. The most up-to-date information on telemedicine law, regulation, policy, models of care, prescribing, coding, and reimbursement are addressed on these dynamic websites. We also queried the telemental health special interest group of the American Telemedicine Association (ATA) and telemedicine clinicians at international and national centers regarding trending issues. The evidence supporting telepsychiatry practice with adults greatly outweighs the evidence for practice with children and adolescents. Therefore, we included material gleaned from work with adults in diverse settings if deemed relevant to the feasibility, acceptability, sustainability, or effectiveness of telepsychiatry practice with youth. The search methodology is depicted in Figure 1.

**FIGURE 1** Literature search flow diagram. Note: VTC = video teleconferencing.



## APPENDIX II – Examples of Evidence Tables

### Example 1

**TABLE 3** Published Findings From Educational Programs for Primary Care Practitioners Targeting Common Psychiatric Disorders (≥50 Participants)

<b>Educational program/location</b>	<b>Study design</b>	<b>Participants</b>	<b>Focus and structure</b>	<b>Key outcomes</b>
Practitioner Training in Child and Adolescent Psychiatry (PTCAP), Ontario, Canada <sup>43</sup>	Cluster randomized trial	76 rural PCCs	Anxiety, depression, ADHD, disruptive behavior 8-h in-person course	Compared to controls, participants had greater confidence in managing diagnosable MH conditions, managing general MH concerns, making necessary referrals, and obtaining consults
Communication Skills Training, Maryland <sup>44</sup>	Cluster-randomized trial	58 PCCs	Communication skills	Compared to control parents, participant parents had greater MH symptom reduction
Child and Adolescent Psychiatry Primary Care (CAP PC), New York <sup>45-49</sup>	Post-test; qualitative survey; pre/post-test	927 PCCs in statewide child psychiatry consultation program	ADHD, depression, anxiety, aggression 16-h in-person “mini-fellowship” with 12-h case-based conference calls Alternative 5-h in-person “core training” CME credits offered	Participants reported high satisfaction with program Participation was associated with greater confidence about interacting with families about MH problems, assessing problems, prescribing medications, and developing treatment plans

**TABLE 4** Published Findings From Statewide Child Psychiatry Access Programs

<b>Consultation program/location</b>	<b>Study design</b>	<b>Enrollment/adoption</b>	<b>Services</b>	<b>Key outcomes</b>
Project TEACH, New York <sup>45-49</sup>	Periodic qualitative and quantitative surveys	3,000 PCCs 78% of registered PCCs used consultation Most common reasons for consultation: medication question, resource/ referral request	Real-time child and adolescent psychiatrist telephone consultation; scheduled face-to-face or televideo child and adolescent psychiatrist consultation; resource and referral services; education (multiple modalities, eg, teleconferences, newsletters)	Consultation was helpful to participants Consultation increased participants’ knowledge, skills, and confidence to provide MH care Participants would recommend the program to other PCCs Satisfaction with the program was high High-volume callers were more likely to have cared for patients with MH problems, to have participated in MH education, and to feel more comfortable managing cases on their own
Massachusetts Child Psychiatry Access Program (MCPAP), Massachusetts <sup>77-88</sup>	Periodic qualitative and quantitative surveys	3,000 PCCs 79% of registered PCCs used consultation Most common reasons for consultation: medication question, resource/ referral request	Real-time child and adolescent psychiatrist telephone consultation; scheduled face-to-face and televideo child and adolescent psychiatrist consultation; resource and	On average, 5.2 calls per 1,000 patients per year Consultations were useful to participants Participants were able to receive consultation in a timely manner Participants had more interest in MH

**TABLE 6** Published Findings From Integrated Collaborative Mental Health Care in Pediatric Primary Care

Integrated collaborative care program/location	Study design and service Team structure and roles	Study population	Target disorders	Key outcomes
Youth Partners-in-Care (YPIC), California <sup>159,160</sup>	Randomized controlled trial Prescribers: PCCs trained in depression management Care coordination/psychosocial intervention: integrated care managers (MH or nursing) trained in cognitive-behavioral therapy for depression	418 Adolescents and young adults in 5 pediatric primary care practices	Depressive symptoms	Compared to usual care patients, intervention patients/families reported significantly: <ul style="list-style-type: none"> <li>• fewer depressive symptoms</li> <li>• higher MH quality of life</li> <li>• greater satisfaction with MH care</li> <li>• higher rates of health care</li> <li>• greater psychotherapy or counseling</li> <li>• lower likelihood of severe depression at follow-up</li> <li>• shorter time to recovery</li> </ul> Compared to usual care patients receiving SSRI medication, intervention patients reported: <ul style="list-style-type: none"> <li>• non-significant favorable trend in depressive symptoms</li> </ul>
Brief Cognitive-Behavioral Therapy for Depressed Adolescents Receiving Antidepressant Medication, Oregon <sup>161</sup>	Randomized controlled trial Prescribers: PCCs Care coordination/ psychosocial intervention: master's-level psychologists trained in cognitive-behavioral therapy for depression	152 Adolescents in a health maintenance organization	Major depressive disorder	Compared to usual care patients receiving SSRI medication, intervention patients reported: <ul style="list-style-type: none"> <li>• non-significant favorable trend in depressive symptoms</li> </ul>
Doctor-Office Collaborative Care (DOCC), Pennsylvania <sup>162</sup>	Randomized controlled trial Prescribers: PCCs Care coordination/psychosocial intervention: integrated care managers (social worker, counselor, or nurse) trained in cognitive-behavioral therapy and parent	78 Children in 4 pediatric primary care practices	Behavior problems	Compared to enhanced usual care patients, intervention patients reported significantly: <ul style="list-style-type: none"> <li>• higher service use and completion</li> <li>• greater improvement in behavioral and emotional problems</li> <li>• overall clinical response</li> </ul>

### Example 3

**TABLE 1** Evidence-Base Supporting Child and Adolescent Telepsychiatry

Citation	Sample	Assessment	Findings
<b>Randomized controlled trials</b>			
Nelson <i>et al.</i> , 2003 <sup>20</sup>	28 youth (age 8–14 y; mean 10.3 y) with depression	diagnostic interview and scale	comparable improvement of depressive symptoms in response to therapy delivered in person or through ITV
Starch <i>et al.</i> , 2011 <sup>21</sup>	31 youth (age 7–16 y; mean 11.1 y) with OCD	ADIS-IV-C/P, CY-BOCS, COIS, MASC, CDI, satisfaction with services	ITV was superior to in-person care on all primary outcome measurements, with significantly larger percentage of individuals in the ITV group meeting remission criteria
Himle <i>et al.</i> , 2012 <sup>22</sup>	20 children (age 8–17 y) with Tourette's disorder or chronic motor tic disorder	YGTS, PTQ, CGIS, CGH	youth in ITV and in-person service delivery modalities experienced significant tic decrease with no between-group differences
Myers <i>et al.</i> , 2015 <sup>23</sup>	223 youth (age 5.5–12.9 y) with ADHD	DISC-IV, CBCL, VADPRS, VADTRS, CIS	caregivers reported improved inattention, hyperactivity, combined ADHD, ODD, role performance, and impairment; teachers reported improvement in ODD and role performance
Xie <i>et al.</i> , 2013 <sup>24</sup>	22 children (age 6–14 y) with behavioral disorder	PCQ-CA, VADPRS, CGAS	parent training through ITV was as effective as in-person training and was well accepted by parents
Tse <i>et al.</i> , 2015 <sup>25</sup>	38 children (age 5.5–12 y) with ADHD	VADRS, CIS, PSI, CSQ, PHQ-9, FES	parents of children with ADHD received parent training in person or through ITV; children in the 2 groups improved comparably; parents' distress did not change for those who received training through ITV