INSTRUCTIONS FOR AUTHORS

OF AACAP PRACTICE PARAMETERS

AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY

COMMITTEE ON QUALITY ISSUES

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GENERAL PRINCIPLES

The Committee on Quality Issues (CQI) develops practice parameters for the American Academy of Child and Adolescent Psychiatry in accordance with these general principles:

1. The purpose of the practice parameters is to encourage best practices in the discipline of child and adolescent psychiatry.

2. Parameters are developed in accordance with standards established by the American Medical Association (AMA Policy H-410.968) and other major professional organizations, as follows (Appendix I provides additional information):
   
   A. **Documentation.** Clinical practice guideline sponsors have provided sufficient documentation to enable an assessment of the process of development of the guideline.

   B. **Involvement of Physicians/Physician Organizations.** The guideline was developed with representation from practicing physicians and/or physician organizations.

   C. **Literature Review.** A literature search was performed; the inclusion/exclusion criteria for the literature search were specified, and the evidence derived from the literature search was rated.

   D. **Experts’ Credentials.** If expert opinion was used in the development of the guideline, credentials of the experts were described.

   E. **Appropriateness.** The guideline addresses the appropriateness of its recommendations to specific clinical conditions and settings.

   F. **Generalizability.** The guideline includes disclaimers and/or a discussion of the limitations and/or degree of generalizability of the recommendations specific to clinical conditions.

   G. **Currentness.** The guideline has been developed, reviewed, or updated within the last 5 years.

   H. **Update Mechanism.** There is a mechanism in place to update the guideline.

   I. **Wide Dissemination.** There is a mechanism in place to ensure that the guideline is readily available to all physicians who may be affected by its recommendations.

3. Parameter authors are selected by the CQI on the basis of their national reputation for expertise in the parameter topic area.

4. Parameters undergo extensive review by key constituent groups, including members of the CQI, acknowledged experts in the topic area, members of AACAP, relevant AACAP committees, and representatives from the AACAP Assembly of Regional Organizations and the AACAP Council. Final approval of AACAP practice parameters rests with the AACAP Council.

5. Practice parameter recommendations (for treatment parameters) or principles (for other parameters) are based on the critical appraisal of empirical evidence (when available) and clinical consensus (when not).
6. Practice parameters are not intended to be taken in isolation as standards of medical care. The standard of medical care in a particular situation depends on the details and circumstances of the case. Practice parameters are only one factor that should be considered in determining the appropriate care in a specific clinical situation.

7. While developed to guide the practice of child and adolescent psychiatrists, it is hoped that the practice parameters will be relevant and helpful to other medical and mental health professionals who work with children and adolescents with psychiatric disorders.

AUTHORS AND OTHER CONTRIBUTORS

QUALIFICATIONS

Parameter authors are selected by the CQI on the basis of knowledge, expertise, experience, and leadership in the areas addressed by the parameter. The first author may select up to two co-authors, for a recommended total of three principal authors (including the first author). All principal authors must reach the standard for authorship set by the Journal of the AACAP, which requires “substantial” contributions to all of the following: 1) conception and design of the study or analysis and interpretation of the data; 2) drafting the article or revising it critically for important intellectual content; and 3) final approval of the version to be published. Moreover, authors must have participated sufficiently to take public responsibility for the content.

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

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

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

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

Authors of practice parameters accept the following responsibilities:

1. Be thoroughly familiar with the Instructions for Authors of AACAP Practice Parameters.

2. Partner with the CQI parameter shepherd and the AACAP staff liaison to complete all parameter development tasks.

3. Collaborate with relevant AACAP committees (if applicable) in parameter development.

4. Prepare the initial parameter draft and subsequent revisions in a timely fashion (approximately 18 months from initiation to approval).

5. Present parameter drafts to CQI members.

6. Incorporate comments of CQI members into subsequent parameter drafts.

7. Submit the parameter to experts for review.

8. Incorporate comments from experts into subsequent parameter drafts.

9. Submit the parameter for posting on the AACAP Web site for member review.

10. Incorporate comments of AACAP membership into subsequent parameter drafts.

11. Submit the parameter for CQI Consensus Group review.

12. Incorporate comments of CQI Consensus Group members into subsequent parameter drafts.

13. Submit the parameter for AACAP Council review.

14. Incorporate comments of AACAP Council (if applicable) into subsequent parameter drafts.

15. Submit the finalized parameter for final AACAP Council vote.

16. Write (or suggest other authors to write) periodic updates of the parameter as invited by the CQI.

AUTHORSHIP AND COPYRIGHT
Because a practice parameter is an Official Action of AACAP, AACAP is considered to be the author and is the holder of the copyright. However, attribution is given to primary authors both under title and in the Attributions section of the parameter. In PubMed, authorship usually is attributed to the principal authors along with the CQI members, although PubMed’s practices vary and cannot be dictated by AACAP.

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

CONFLICT OF INTEREST

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

PARAMETER DEVELOPMENT PROCESS

Parameter development proceeds as follows:

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

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

3. Preparation of Parameter Drafts. Preparation of the parameter should begin with a literature search, which should be performed and documented according to the guidelines outlined under the METHODOLOGY section below. The results of the literature search should be used to generate a list of approximately 8-12 recommendations (for patient-oriented parameters) or principles (for clinician-oriented parameters) for best practices in the topic area. The results of the literature search and list of recommendations/principles are presented at the initial CQI meeting attended by the author.

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

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

5. **Expert Review.** Following CQI review, the author asks acknowledged experts in the parameter topic area for additional review. Experts may include members of relevant AACAP committees. The author incorporates experts’ comments into a subsequent parameter draft.

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

7. **Consensus Group.** Following AACAP member review, the draft of the parameter is reviewed) by a Consensus Group convened by the CQI. The author incorporates Consensus Group members’ comments into a subsequent parameter draft. The Consensus Group typically comprises the following:

   A. A Chair of the CQI
   B. The parameter author(s)
   C. The parameter shepherd
   D. One or two additional CQI members
   E. Several experts in the parameter topic area
   F. One or two representatives from relevant AACAP Committees (if applicable), who are expected to keep their committees apprised of the process
   G. Two representatives from the AACAP Assembly of Regional Organizations, who are expected to represent the interests of AACAP members
   H. Two representatives from the AACAP Council, who are expected to represent the interests and authority of the AACAP leadership

8. **Final Edits.** Following Consensus Group approval (which must be unanimous), the draft of the parameter is edited by the CQI chairs and staff liaison as needed to assure conformity to the *Instructions for Authors*.

9. **Approval by AACAP Council.** The final, edited parameter draft must be approved by a majority of a quorum of the AACAP Council. It is anticipated that the Council will only make substantive changes in extraordinary circumstances. Any substantive changes suggested by Council will be submitted to the CQI Consensus Group for consideration.
10. **Publication.** The approved practice parameter will be published in the *Journal of the American Academy of Child and Adolescent Psychiatry* as an AACAP Official Action, and will be posted on the AACAP Web site. The parameter may also be published and distributed by AACAP in other ways.

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

### CONTENT AND FORMAT OF PRACTICE PARAMETERS

**CONTENT**

The AACAP publishes two broad types of parameters: patient-oriented parameters and clinician-oriented parameters.

Patient-oriented parameters are created to guide clinicians toward the best assessment and treatment practices. These parameters provide specific **recommendations** about:

- The assessment and treatment of specific disorders (e.g., ADHD, depression, anxiety)
- The provision of specific treatments (e.g., atypical antipsychotic medication, psychodynamic psychotherapy)

Clinician-oriented parameters are created to provide clinicians with the knowledge needed to develop practice-based skills. These parameters provide specific **principles** guiding:

- General and special psychiatric assessments (e.g., diagnostic, family, forensic)
- Clinical assessment and management of specific populations (e.g., youth in foster care, gay/lesbian/bisexual/transgender youth).

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

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

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

TITLE

Typical titles of each of the types of parameters are as follows:
Patient-Oriented Parameters:

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

Clinician-Oriented Parameters:

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

ABSTRACT

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

DEVELOPMENT AND ATTRIBUTION

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

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

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

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

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

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

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

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

From [month, year] to [month, year], this Parameter was reviewed by a Consensus Group convened by the CQI. Consensus Group members and their constituent groups were [co-chair’s name, shepherd’s name, members’ names] (CQI); [names] (topic experts); [names] (AACAP [name of committee]); [names] (AACAP Assembly of Regional Organizations); and [names] (AACAP Council).

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

This Practice Parameter is available on the internet (www.aacap.org).

Disclosures:

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

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INTRODUCTION
According to the American Medical Association (Appendix I), the following information should be included in the introduction section of the parameter:

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

Other information that should be included in the introduction:

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

The Introduction section should approximate 200 words.

METHODOLOGY

AACAP practice parameters should critically appraise evidence using transparent literature review methodology consistent with worldwide standards. The single most useful guide for this process is The Cochrane Library’s *Handbook for Authors*. The following outline can help guide committee authors to produce high-quality searches:

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

2. Search multiple databases. The most fruitful databases in child and adolescent psychiatry are MEDLINE, PsycINFO, CENTRAL, and EMBASE. Searching these four databases will generally suffice if the bibliographies of retrieved articles are also examined for relevant references not included in the databases.

3. Search first for systematic reviews and meta-analyses that used well-defined methodology as the highest level of empirical evidence. The Cochrane Database of Systematic Reviews (CDSR) contains many
systematic reviews (SR); however if the topic is not found in CDSR, search other databases using the “article types” filter that retrieves only systematic reviews and/or meta-analyses.

4. Next use the “article types” filter to search for individual studies, choosing the appropriate types of studies (e.g., randomized controlled trial, cohort study, case-control study, case study) as indicated by the issue under study.

5. Use additional filters to specify additional “winnowing” criteria (e.g., human, English language, ages, publication dates). Avoid using these filters in the initial search; rather include them in subsequent searches so the reader can follow how the search began with a sensitive, inclusive search, but then became highly specific by focusing on the most relevant studies. Report the results for each search as the numbers narrow (“winnowing”). This ensures transparency, as anyone should be able to duplicate the search and obtain the same results. Do not ask the reader to take “on faith” a large reduction from over 2000 references in the initial search to the 50 listed in the parameter’s bibliography without documenting the winnowing process.

6. Finally, the entire search process summarized above should be documented in the Methodology section of the parameter, including the following specific information:

   - Titles of databases searched (e.g., MEDLINE)
   - Names of the hosts (e.g., PubMed)
   - Date searches were run (month, day, year)
   - Time period covered by the search
   - Search terms used
   - Number of hits in initial searches and at each stage of the winnowing process

Example (can be written in narrative form in the parameter):

MEDLINE
PubMed
April 15, 2013
[2003-2013]
1. Dysthymic Disorder [MESH Term]: 1207 references
2. Cognitive Therapy [MESH Term]: 11266 references
3. #1 and #2: 57 references
4. #3 limited to systematic reviews, meta-analyses & RCTs: 26 references
5. #4 limited to age 0 to 18: 8 references

**DEFINITIONS**

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

Brief history of the topic can be provided, describing changes over time in assessment, treatment, or approach to the issue (e.g., changes in policies of seclusion and restraint, changes in federal mandates pertaining to the education of children with disabilities, changes in the power of the state in child welfare decisions).

The Historical Review section should approximate 400 words.

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

CLINICAL PRESENTATION AND COURSE

EPIDEMIOLOGY

ETIOLOGY or RISK AND PROTECTIVE FACTORS

DIFFERENTIAL DIAGNOSIS

COMORBIDITIES

DESCRIPTION OF PROCEDURE

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

EVIDENCE BASE FOR PRACTICE PARAMETERS

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

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

- Clinical Standard [CS] is applied to recommendations that are based on rigorous empirical evidence (e.g., meta-analyses, systematic reviews,
individual randomized controlled trials) and/or overwhelming clinical consensus

- Clinical Guideline [CG] is applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials, cohort studies, case-control studies) and/or strong clinical consensus

- Clinical Option [OP] is applied to recommendations that are based on emerging empirical evidence (e.g., uncontrolled trials or case series/reports) or clinical opinion, but lack strong empirical evidence and/or strong clinical consensus

- Not Endorsed [NE] is applied to practices that are known to be ineffective or contraindicated

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

- [rct] Randomized, controlled trial is applied to studies in which subjects are randomly assigned to two or more treatment conditions

- [ct] Controlled trial is applied to studies in which subjects are non-randomly assigned to two or more treatment conditions

- [ut] Uncontrolled trial is applied to studies in which subjects are assigned to one treatment condition

- [cs] Case series/report is applied to a case series or a case report

RECOMMENDATIONS/PRINCIPLES

Authors should think of this section as the most important practical “do’s and don’ts” regarding this topic (approximately 8-12). Recommendations/principles should be a single declarative statement; any modifying or additional information should be placed in the text following the recommendation/principle. Recommendations/principles should be clustered by topic area and sequenced in a logical order. For example, all recommendations/principles pertaining to screening and assessment should be grouped together under an Assessment heading; all recommendations/principles pertaining to treatment should be grouped together under a Treatment heading.

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

- The psychiatric assessment of children and adolescents should routinely include screening questions about depressive symptomatology.

- During all treatment phases, for a child or adolescent who is not responding to appropriate pharmacological and/or psychotherapeutic treatments, consider factors associated with poor response.
• Children with risk factors associated with development of depressive disorders should have access to early intervention services.

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

• Clinicians should understand how to initiate, develop, and maintain consultative relationships with schools.
• Clinicians should be knowledgeable about legislation that establishes and protects the educational rights of students with mental disabilities.
• Clinicians should be able to conduct a comprehensive assessment of a student with an emphasis on understanding barriers to learning, and participate in comprehensive treatment planning with clinical, school, home, and community components as indicated.

ALGORITHMS/TABLES/FIGURES

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

PARAMETER LIMITATIONS

The following disclaimer is included as boilerplate:

AACAP Practice Parameters are developed to assist clinicians in psychiatric decision making. These Parameters are not intended to define the sole standard of care. As such, the Parameters should not be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all of the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources.

REFERENCES

It is not necessary to be exhaustive in developing the references. The purpose of the parameters is to present literature that is compelling, relevant, and integral to the parameter topic.

PREPARATION OF DRAFTS

At all phases of production, drafts are submitted to the AACAP Clinical Practice Department for reproduction and distribution to the Committee, the general membership, reviewers, Council, and Assembly. Drafts are submitted via email.

LENGTH
The draft should not exceed 10,000 words, including abstract, introduction, methodology, background, recommendations/principles, tables and references. All drafts should have an accurate word count on the first page. Some practice parameters will be much less than 10,000 words.

**STYLE**

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

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

After the draft has been submitted, the staff of the Clinical Practice Department will copyedit the material and prepare it for distribution. The staff will take care of the headers, the footers, and line numbers. **Staff will return the edited version of the parameter to the authors. Please use this copy to make revisions for the next draft.**

**FIRST PAGE**

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

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

**HEADING LEVELS**

Heading levels for the narrative portion of the parameters are as follows:

- ----------------------------------

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

Example:

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

- ----------------------------------

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

Example:

**TREATMENT**
LEVEL 2: Upper case, roman (non-bold), flush left, freestanding.
Example:
STIMULANT MEDICATION

LEVEL 3: Mixed case, roman (non-bold), flush left, freestanding.
Example:
Uses of Stimulants in Children

LEVEL 4: First word capitalized, indented as for a paragraph, italic, with a period at the end of the phrase.
Example:
Medication efficacy and side effects.

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

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

STANDARDS FOR DEVELOPING SCIENTIFICALLY SOUND GUIDELINES*

STANDARDS ON GUIDELINE DEVELOPMENT AND FORMAT

1. Purpose of the guideline is specified
2. Rationale and importance of the guideline are explained
3. The participants in the guideline development process and their areas of expertise are specified
4. Targeted health problem or technology is clearly defined
5. Targeted patient population is specified
6. Intended audience or users of the guideline are specified
7. The principal preventive, diagnostic, or therapeutic options available to clinicians and patients are specified
8. The health outcomes are specified
9. The method by which the guideline underwent external review is specified
10. An expiration date or date of scheduled review is specified

STANDARDS ON EVIDENCE IDENTIFICATION AND SUMMARY

11. Method of identifying scientific evidence is specified
12. Time period from which evidence is reviewed is specified
13. The evidence used is identified by citation and referenced
14. Method of data extraction is specified
15. Method for grading or classifying the scientific evidence is specified
16. Formal methods of combining evidence or expert opinion are used and described
17. Benefits and harms of specific health practices are specified
18. Benefits and harms are quantified
19. The effect on health care costs from specific health practices is specified
20. Costs are quantified

STANDARDS ON THE FORMULATION OF RECOMMENDATIONS

21. The role of value judgments used by the guideline developers in making recommendations is discussed
22. The role of patient preferences is discussed
23. Recommendations are specific and apply to the stated goals of the guideline
24. Recommendations are graded according to the strength of the evidence
25. Flexibility in the recommendations is specified
