

**INSTRUCTIONS FOR AUTHORS
OF AACAP PRACTICE PARAMETERS**

**AMERICAN ACADEMY OF CHILD AND ADOLESCENT
PSYCHIATRY**

WORK GROUP ON QUALITY ISSUES

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GENERAL PRINCIPLES

The Work Group on Quality Issues 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 Work Group on Quality Issues 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 Work Group on Quality Issues, acknowledged experts in the topic area, members of AACAP, relevant AACAP Components, 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 best available scientific evidence available as well as accumulated clinical experience.

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

Authors are selected by the Work Group on Quality Issues on the basis of knowledge, expertise, experience, and leadership in the areas addressed by the parameters. There are usually between one and three authors who write the parameters; if there are multiple authors, it can be useful to have authors with different perspectives. All authors must actively participate in writing the parameters (i.e., there are no “honorific” authors).

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 may ask experts in the topic area to review the parameters; 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. Partner with the WGQI parameter shepherd and the AACAP liaison to complete all parameter development tasks.
2. Be thoroughly familiar with the *Instructions for Authors of AACAP Practice Parameters*.
3. Collaborate with relevant AACAP components (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 at WGQI meetings as invited.
6. Incorporate comments of WGQI members into subsequent parameter drafts.
7. Select and incorporate comments of expert reviewers.
8. Present the parameter at the Member Forum at the AACAP Annual Meeting.
9. Incorporate comments of AACAP membership into the parameter.

10. Incorporate comments of WGQI Consensus Group into the parameter.
11. Incorporate comments of AACAP Council (if applicable) into the parameter.
12. Write (or suggest other authors to write) periodic updates of the parameter.

AUTHORSHIP AND COPYRIGHT

Attribution is given to authors in the attribution section of the parameter. Since 1998, authors are not indexed in MedLine; rather, authorship is attributed to the American Academy of Child and Adolescent Psychiatry.

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

Copyright to the practice parameters belongs to AACAP. Authors assign copyright to AACAP using a Copyright Assignment Form.

CONFLICT OF INTEREST

Practice parameters incorporate the values expressed in the AACAP *Code of Ethics*. Authors 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 WGQI identifies new parameter topics, topics due for revision and potential parameter authors. The WGQI seeks suggestions from AACAP Components and Council. After each WGQI meeting, the AACAP Council is given a list of all published practice parameters and all parameters under development.
- 2. Identification of WGQI Shepherd and AACAP Staff.** The WGQI assigns one of its members to “shepherd” the author in parameter development, assisted by the AACAP Staff. The shepherd and staff will be responsible for assisting the author in following the *Instructions for Authors*, incorporating WGQI members’ and other reviewers’ comments into drafts of the parameter, and inviting the author to present the parameter drafts at WGQI meetings.
- 3. Preparation of Parameter Drafts.** Minimum requirements for the first parameter draft are as follows: 1) a short Introduction paragraph about why the parameter is an important resource for the AACAP membership (this serves as justification for the development of the parameter); 2) a literature search precisely following the guidelines that are outlined under the *Methodology* section below and expanded in the attached Appendix (this allows us to standardize our search methodology across parameters according to evidence-based principles); 3) documentation of the literature search (including all of the components listed in the *Methodology* section below); and 4) based on the findings from the literature search, a list of approximately 8-12 recommendations (for treatment parameters) or principles (for other parameters) for best practices in the topic area. This draft is presented at the initial WGQI meeting attended by the author. After the initial meeting, the author works with the shepherd to develop a complete draft of the parameter, incorporating comments of WGQI members. When a complete first draft has been written and reviewed by the shepherd, the shepherd invites the author to present the draft at follow-up WGQI meetings. After each follow-up meeting, the author works with the shepherd to incorporate the comments of WGQI members. Follow-up drafts usually will be presented (at the shepherd’s invitation) to the WGQI via telephone conference call. The target timeline for this entire process should approximate 18 months. If the timeline should exceed 18 months, the WGQI reserves the right to re-assign primary authorship.
- 4. Expert Review.** Following WGQI review, the author asks acknowledged experts in the parameter topic area for additional review via email. The author incorporates experts’ comments into a subsequent parameter draft.
- 5. AACAP Member Review.** Following expert review, the draft of the parameter is posted on the AACAP website (on or around September 1) and is presented at the Member Forum at the AACAP Annual Meeting (in October). The author incorporates members’ comments into a subsequent parameter draft.

6. **Consensus Group.** Following AACAP member review, the draft of the parameter is reviewed via email (and conference call if indicated) by a Consensus Group convened by the WGQI. The Consensus Group typically comprises the following:

- A. A Chair of the WGQI
- B. The parameter author(s)
- C. The parameter shepherd
- D. One or two additional WGQI members.
- E. Several experts in the parameter topic area
- F. One or two representatives from relevant AACAP Components (if applicable), who are expected to keep their components 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

If consensus cannot be achieved via email or telephone communication, members of the Consensus Group may meet face-to-face, preferably at the AACAP Annual Meeting, to resolve differences.

7. **Approval by AACAP Council.** Following Consensus Group approval, the draft of the parameter is sent for professional editing. The final, edited parameter draft then must be approved unanimously by 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 WGQI Consensus Group for consideration.

8. **Publication.** The approved practice parameter will be published in the *Journal of the American Academy of Child and Adolescent Psychiatry*, and will be posted on the AACAP website. The parameter may also be published and distributed by AACAP in other ways.

9. **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 will publish two broad types of parameters: patient-oriented parameters and clinician-oriented parameters.

Patient-oriented parameters are created to guide clinicians toward the best 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., stimulant medication, electroconvulsive therapy)

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

- General psychiatric assessments (e.g., diagnostic, family, forensic)
- Treatment techniques (e.g., psychotherapy, psychoanalysis)
- Diagnostic procedures (e.g., neuropsychological testing)
- Clinical management of specific populations (e.g., youths in foster care, gay/lesbian/bisexual/transgender youths, youths in juvenile detention and correctional facilities).

Following a brief introductory review of the topic, parameters are designed to succinctly present the most important treatment recommendations or clinical principles pertinent to the parameter topic. Treatment recommendations are based both on empirical evidence and clinical consensus, and are graded according to the strength of the empirical and clinical support. Although empirical evidence may be available to support certain principles, principles are primarily based on expert opinion and clinical experience.

Parameters have a 10,000 word limit, including references and tables; therefore, material presented in the introductory 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 the Child
2. Practice Parameter for Psychodynamic Psychotherapy with Children
3. Practice Parameter for the Use of Neuropsychological Testing in Children and Adolescents
4. Practice Parameter for the Assessment and Treatment of Youth in Juvenile Detention and Correctional Facilities

ABSTRACT

A one-paragraph (150 word limit) abstract should summarize the content of the parameter. Up to seven 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 and reviewers. Correct titles should be provided (e.g., M.D., Ph.D.). Academic affiliations are not included. Potential conflicts of interest are disclosed at the end of the parameter for all authors and the WGQI chairs. Disclosures for all other named individuals are available on the AACAP website. The attribution boilerplate is as follows:

This parameter was developed by [author(s)’ names], primary authors, and the Work Group on Quality Issues [names of co-chairs, names of members]. AACAP staff: [names].

AACAP practice parameters are developed by the AACAP Work Group on Quality Issues (WGQI) in accordance with American Medical Association policy. Parameter development is an iterative process between the primary author(s), the WGQI, topic experts, and representatives from multiple constituent groups, including the AACAP membership, relevant AACAP Components, the AACAP Assembly of Regional Organizations, and the AACAP Council. Details of the

parameter development process can be accessed on the AACAP website. Responsibility for parameter content and review rests with the author(s), the WGQI, the WGQI 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 treatment practices. Recommendations are based on 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 expert opinion derived from clinical experience. 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 mental health clinicians.

The authors wish to acknowledge the following experts for their contributions to this parameter: [experts' names].

This parameter was reviewed at the Member Forum at the AACAP Annual Meeting in [month, year].

From [month, year] to [month, year], this parameter was reviewed by a Consensus Group convened by the WGQI. Consensus Group members and their constituent groups were as follows: WGQI [co-chair's name, shepherd's name, members' names]; Topic Experts [names]; AACAP Components [names and component affiliations]; AACAP Assembly of Regional Organizations [names]; and AACAP Council [names].

Disclosures of potential conflicts of interest for authors and WGQI chairs are provided at the end of the parameter. Disclosures of potential conflicts of interest for all other individuals named above are provided on the AACAP web site on the Practice Information page.

This practice parameter was approved by the AACAP Council on [date].

This practice parameter is available on the internet (www.aacap.org).

Reprint requests 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”)
- The intended audience or users (Example: “This parameter is intended to guide the practice of child and adolescent psychiatrists; however, information in the parameter also may prove useful for other medical and mental health professionals that [insert topic of parameter].”)

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 unless otherwise noted. 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 organize knowledge 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 most relevant pages from this *Handbook* are attached to these Instructions as Appendix II and are summarized below.

All parameters should provide the following information pertaining to the literature review in the Methodology section:

- Titles of databases searched (e.g., MEDLINE)
- Names of the hosts (e.g., Silver Platter version 2.0)
- Date search was run (month, day, year)
- Years covered by the search
- Complete strategy used, including all search terms and the winnowing process

For treatment recommendations in patient-oriented parameters, the following additional guidance is provided:

1. For each treatment recommendation, first search the Cochrane Database of Systematic Reviews for supporting evidence.
2. Then proceed to searches of individual studies. For each recommendation, create at least three sets of search terms: 1) terms to search for the disorder of interest; 2) terms to search for the treatment(s) to be evaluated; and 3) terms to search for the types of study design to be included (certainly randomized controlled trials, but other types of evidence [non-randomized controlled trials, uncontrolled trials, case series/reports] should also be considered for inclusion). Use multiple terms for each set, joining the terms with the Boolean 'OR' operator. These three sets of terms can then be joined together with the 'AND' operator. Language, age and date restrictions should be avoided in the initial "sensitive" search.
3. Using the search terms, search multiple databases. The most fruitful databases in child and adolescent psychiatry are CENTRAL, MEDLINE, EMBASE, and PsycINFO. Searching these four databases will suffice if the bibliographies of retrieved articles are also examined for relevant references not included in the databases.
4. Winnow the large number of hits generated by a sensitive search using an explicit and transparent process, such as dropping references on the basis of study design, date of publication, sample size, age group, and relevance. At each filtering step, state how the process affected the number of hits.
5. 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., Silver Platter version 2.0)
 - Date search was run (month, day, year)
 - Years covered by the search
 - Complete strategy used, including all search terms and the winnowing process

DEFINITIONS

Unfamiliar terms should be defined in this section.

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-IV-TR for a review of the diagnostic criteria for the disorder). 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 treatment practices are stated in accordance with the strength of the underlying empirical and/or clinical support, as follows:

- **Minimal Standard [MS] is applied to recommendations that are based on rigorous empirical evidence (e.g., randomized, controlled trials) and/or overwhelming clinical consensus. Minimal standards apply more than 95% of the time (i.e., in almost all cases).**
- **Clinical Guideline [CG] is applied to recommendations that are based on strong empirical evidence (e.g., non-randomized controlled trials) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time (i.e., in most cases).**

- **Option [OP] is applied to recommendations that are acceptable 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’t’s” regarding this topic (approximately 8-12). Recommendations/principles should be a single declarative statement. They should be clustered by topic area; for example, all recommendations/principles pertaining to assessment should be grouped together; all recommendations/principles pertaining to treatment should be grouped together, etc. Recommendations/principles should be sequenced in a logical order; for example, recommendations pertaining to screening for a disorder should precede recommendations pertaining to comprehensively assessing a disorder; and recommendations pertaining to identifying target symptoms for a medication should precede information about medication doses and side effects. Treatments with the strongest empirical and/or clinical support should be addressed before treatments with less support.

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:

- Psychiatrists should understand how to initiate, develop, and maintain consultative relationships with schools.
- Psychiatrists should be knowledgeable about legislation that establishes and protects the educational rights of students with mental disabilities.
- Psychiatrists 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 standard of care, nor should they 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. The most important references are marked with an asterisk, to indicate to readers those that are particularly recommended.

PREPARATION OF DRAFTS

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

LENGTH

The draft should not exceed 10,000 words, including abstract, boilerplate material, conclusions, recommendations, tables and references. All drafts should have an accurate word count on the cover sheet. 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, since 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 to the edited version of the parameter to the authors. Please use this copy to make revisions for the next draft.

COVER SHEET AND FIRST PAGE

The cover sheet of the draft should include the following information: title of the practice parameter; first author's name, address, telephone, fax number and email address. The first page of parameter should list the title, draft date and word count followed by the parameter 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 Clinical Affairs 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:

PSYCHOPHARMACOLOGY

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

Example:

STIMULANTS

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*. If using bibliographic software please be sure that 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. Also, that all items in the References were actually cited in the text.

References that are particularly relevant to the parameter or that have been heavily relied on in the preparation of the parameter should be marked with an asterisk. A statement is included before the first reference: "References marked with an asterisk are particularly recommended."

References for all Practice Parameters scheduled to be published in 2008 and forward must adhere to the AMA Manual of Style, 10th Edition. If you are using End Note or Reference Manager as a bibliographic tool, choose JAMA as the reference style to prepare your references in the text and list.

Cite references within the text, tables, and legends in numerical order using Arabic superscript numbers outside periods and commas within the text. When multiple references are cited at a given place in the text, use a hyphen to join the first and last numbers of a closed series, use commas without space to separate non-sequential references. Do not place the number in parentheses or brackets.

Use initials and surnames of authors.

List all authors when there are six or fewer; for seven or more, list only the first three and add ", et al."

Refer to the U.S. National Library of Medicine's List of Journals Indexed in Index Medicus or for Online Users for the appropriate abbreviations of journal titles (<ftp://nlmpubs.nlm.nih.gov/online/journals/lsiweb.pdf>)

For more information on references style of JAACAP, see the latest issue of the journal's *Instructions for Authors*. In all questions of style, the JAACAP style takes precedence.

Keep the left side of the page justified. Do not indent either the first or subsequent lines of the references.

Sample References

Journal Articles

Salzinger S, Rosario M, Feldman RS, Ng-Mak DS. Adolescent suicidal behavior: associations with preadolescent physical abuse and selected risk and protective factors. *J Am Acad Child Adolesc Psychiatry*. 2007;46(7):859-866.

More than 6 authors:

Daviss WB, Perel JM, Birmaher B, et al. Steady-state clinical pharmacokinetics of bupropion extended-release in youths. *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1503-1509.

Book

Cloninger CR, Przybeck TR, Svrakic DM, Wetzel RD. *The Temperament and Character Inventory (TCI): A Guide to Its Development and Use*. St. Louis, MO: Center for Psychobiology of Personality, Washington University; 1994.

Lilienfeld S, Lynn S, Lohr, J. eds. *Science and Psuedoscience in Clinical Psychiatry*. New York, NY: The Guilford Press; 2003.

Book Chapter

Coie J, Miller-Johnson S. Peer factors and interventions. In: Loeber R, Farrington D, eds. *Child Delinquents: Development, Intervention, and Service Needs*. Thousand Oaks, CA: Sage Publications, Inc.; 2001:191-209.

Instrument Manual

Wechsler D. *Manual for the Wechsler Intelligence Scale for Children Third Edition (WISC-III)*. San Antonio TX: Psychological Corporation; 1991.

World Wide Web Citations

FDA/Center for Food Safety & Applied Nutrition. <http://vm.cfsan.fda.gov>. Accessed June 23, 2007.

Antidepressant medications for children and adolescents: information for parents and caregivers. National Institute of Mental Health Web site. http://www.nimh.nih.gov/healthinformation/antidepressant_child.cfm. Updated April 20, 2007. Accessed August 15, 2007.

Davis, RM. Reducing alcohol abuse and underage drinking. American Medical Association Web site. <http://www.ama-assn.org/ama/pub/category/18062.html>. Published October 18, 2007. Updated October 18, 2007. Accessed November 2, 2007.

Material Without Named Author(s) or With Named Authors and a Group

New Freedom Commission on Mental Health. Achieving the promise: transforming mental health care in America. Final report. DHHS Pub. No. SMA-03-3832. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2003.

Kratochvil C, Emslie G, Silva S, et al; The TADS Team. Acute time to response in the Treatment for Adolescents with Depression Study (TADS). *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1412-1418.

Unpublished Material

Accepted but not yet published:

Gothelf D, Furfaro JA, Hoeft F, et al. Neuroanatomy of fragile X syndrome is associated with aberrant behavior and FMRP. *Ann Neurol*. In press.

Rettew DC. Temperament and psychopathology: beyond associations. In: Hudziak JJ, ed. *Genetic and Environmental Influences on Deveopmental Psychopatholgoy and Wellness*. Arlington, VA: American Psychiatric Publishing. In press.

Presented at a meeting but not yet published:

Brent D. TORDIA: a test of treatment strategies in depressed adolescents who have not responded to an adequate trial of a selective serotonin reuptake inhibitor. Paper presented at: 47th Annual Meeting of NCDEU; June 2007; Boca Raton, FL.

Online Journals

Riggs PD, Mikulich-Gilbertson SK, Davies RD, Lohman M, Klein, C, Stover SK. A randomized controlled trial of fluoxetine and cognitive behavioral therapy in adolescents with major depression, behavior problems, and substance use disorders. *Arch Pediatr Adolesc Med.* 2007; 161(11):1026-1034. <http://archpedi.ama-assn.org/cgi/content/full/161/11/1026>. Accessed November 2, 2007.

Turowski SG, Jank KE, Fung H-L. Inactivation of hepatic enzymes by inhalant nitrite—in vivo and in vitro studies. *Am Assoc Pharm Sci J.* 2007;9(3): E298-E305. <http://aapsj.org/view.asp?art=aapsj0903032>. Accessed November 2, 2007.

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

* Shaneyfelt TM, Mayo-Smith MF, Rothwangl J (1999), Are guidelines following guidelines? The methodological quality of clinical practice guidelines in the peer-reviewed medical literature. JAMA 281: 1900-1905.

