McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. Classification ratings of I through V are used. Ratings are applied as clinical content is updated; therefore, a rating may not appear after each reference. Classification ratings appear in parentheses at the end of a reference.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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</thead>
<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
</tr>
<tr>
<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
</tr>
<tr>
<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
</tr>
<tr>
<td>Class IV</td>
<td>Evidence-based guideline</td>
</tr>
<tr>
<td>Class V</td>
<td>Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series</td>
</tr>
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</table>

**Class I**

A meta-analysis is an analysis of data pooled from multiple trials. A systematic review is a qualitative means of summarizing multiple trials on the same intervention. Class I studies can show a statistically significant difference in support of an intervention when smaller studies could not. A meta-analysis or systematic review that finds insufficient evidence to support or refute an intervention (due to a lack of properly designed trials) is inconclusive. A potential weakness of Class I studies is that they may only assess published studies. Since studies demonstrating significant differences are more likely to be published than those that do not, publication bias is of concern.

**Class II**

A randomized controlled trial (RCT) is an experimental study design in which subjects are randomly assigned to an intervention or a control group. A RCT is the gold standard for testing cause and effect relationships. Intention-to-treat analysis should be performed to account for missing data points.

**Class III**

Observational or epidemiologic studies can suggest an association between events or findings. These associations cannot be used to establish causality. Cross-sectional, cohort, and case-control studies are all used to identify possible risk factors. Cross-sectional studies are also used to determine the prevalence of a condition. Cohort studies are used to study incidence, the natural history of a condition, prognosis after a specific exposure, and associated harms.

**Class IV**

Evidence-based guidelines are systematically developed recommendations for clinical practice. Evidence-based guidelines identify the methodology used to gather the evidence on which the recommendations are based. Usually, a grading system for both the quality of the evidence and the strength of the recommendations is provided. Guidelines that are evidence-based may also contain consensus recommendations in areas where evidence is lacking, but these recommendations are clearly identified and appropriately graded.

**Class V**

Class V references may be the best information in the absence of other evidence. Expert opinion, panel consensus, literature reviews, and descriptive studies (case reports or case series) are subject to significant bias. A case series with comparison to historical controls can be plagued with missing data, and data extraction inconsistencies are common. The use of historical controls does not address how the diagnosis of disease or its treatment has evolved over time with newer
technologies or medication. Text book information may be out of date by the time the book is published.


InterQual® Behavioral Health Criteria Bibliography: CHEMICAL DEPENDENCY & DUAL DIAGNOSIS


Budney. Are specific dependence criteria necessary for different substances: how can research on cannabis inform this issue? Addiction 2006. 101 Suppl 1:125-133. (V)

Budney et al. Marijuana abstinence effects in marijuana smokers maintained in their home environment. Arch Gen Psychiatry 2001. 58(10):917-924. (III)


InterQual® Behavioral Health Criteria Bibliography: CHEMICAL DEPENDENCY & DUAL DIAGNOSIS


Feeney et al. Combined acamprosate and naltrexone, with cognitive behavioural therapy is superior to either medication alone for alcohol abstinence: a single centres' experience with pharmacotherapy. Alcohol Alcohol 2006. 41(3):321-327. (III)


InterQual® Behavioral Health Criteria Bibliography: CHEMICAL DEPENDENCY & DUAL DIAGNOSIS


Hillbom et al. Seizures in alcohol-dependent patients: epidemiology, pathophysiology and management. CNS Drugs 2003. 17(14):1013-1030. (I)


Joint Commission on Accreditation of Healthcare Organizations. 2008 Standards for behavioral healthcare. Oakbrook Terrace IL: Joint Commission on Accreditation of Healthcare Organizations; 2008. (V)


Kalant. The pharmacology and toxicology of "ecstasy" (MDMA) and related drugs. CMAJ 2001. 165(7):917-928. (V)


London et al. Mood disturbances and regional cerebral metabolic abnormalities in recently abstinent methamphetamine abusers. Arch Gen Psychiatry 2004. 61(1):73-84. (III)


InterQual® Behavioral Health Criteria Bibliography: CHEMICAL DEPENDENCY & DUAL DIAGNOSIS


Pope et al. Effects of supraphysiologic doses of testosterone on mood and aggression in normal men: a randomized controlled trial. Arch Gen Psychiatry 2000. 57(2):133-140. (II)


Riggs. Treating adolescents for substance use and comorbid psychiatric disorders. NIDA Science and Practice Perspectives; 2003. (V)


InterQual® Behavioral Health Criteria Bibliography: CHEMICAL DEPENDENCY & DUAL DIAGNOSIS


Tellier. The adolescent and substance use, an approach to office management. Prim Care 2006. 33(2):517-530. (V)


Umbricht et al. Opioid detoxification with buprenorphine, clonidine, or methadone in hospitalized heroin-dependent patients with HIV infection. Drug Alcohol Depend 2003. 69(3):263-272. (II)


Velleman et al. The role of the family in preventing and intervening with substance use and misuse: a comprehensive review of family interventions, with a focus on young people. Drug Alcohol Rev 2005. 24(2):93-109. (V)


Wetterling et al. The severity of alcohol withdrawal is not age dependent. Alcohol Alcohol 2001. 36(1):75-78. (III)


