## 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>
</tr>
</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>
</tbody>
</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.
Child Psychiatry


Foley et al. Proximal psychiatric risk factors for suicidality in youth: the Great Smoky Mountains Study. Arch Gen Psychiatry 2006. 63(9):1017-1024. (III)


Greenhill et al. Summary of the practice parameter for the use of stimulant medications in the
40(11):1352-1355. (IV)

Greening et al. Pathways to suicidal behaviors in childhood. Suicide Life Threat Behav 2008.
38(1):35-45. (III)

Gregory et al. Medical screening in the emergency department for psychiatric admissions: a

Groholt et al. Suicide among children and younger and older adolescents in Norway: a comparative


Harris and Barraclough. Suicide as an outcome for mental disorders. A meta-analysis. Br J
Psychiatry 1997. 170:205-228. (I)

Hawton et al. Suicide and attempted suicide in bipolar disorder: a systematic review of risk factors.

26(5):378-383. (III)


Herrenkohl et al. The psychosocial consequences of living environment instability on maltreated

Hetrick et al. Selective serotonin reuptake inhibitors (SSRIs) for depressive disorders in children

Hickling et al. Open general medical wards versus specialist psychiatric units for acute psychoses.

Hishimoto et al. A functional polymorphism of the micro-opioid receptor gene is associated with

Hjern et al. Avoidable mortality among child welfare recipients and intercountry adoptees: a

Huey et al. Multisystemic therapy effects on attempted suicide by youths presenting psychiatric

Orthopsychiatry 2002. 72(4):539-547. (III)

46(8):989-1002. (II)

Johnson et al. Association of maladaptive parental behavior with psychiatric disorder among

Josephson. Practice parameter for the assessment of the family. J Am Acad Child Adolesc
Psychiatry 2007. 46(7):922-937. (IV)

46(9):911-914. (III)

Kashani et al. Hopelessness in inpatient youths: a closer look at behavior, emotional expression,


Kratochvil et al. The role of stimulants in the treatment of preschool children with attention-deficit hyperactivity disorder. CNS Drugs 2004. 18(14):957-966. (V)


Lewis. Recognizing and meeting the needs of patients with mood disorders and comorbid medical illness: a consensus conference of the Depression and Bipolar Support Alliance. Biol Psychiatry 2003. 54(3):181-183. (V)


Stover et al. Depression and comorbid medical illness: the National Institute of Mental Health perspective. Biol Psychiatry 2003. 54(3):184-186. (V)


InterQual® Behavioral Health Criteria Bibliography: CHILD


Webb et al. Death by unnatural causes during childhood and early adulthood in offspring of psychiatric inpatients. Arch Gen Psychiatry 2007. 64(3):345-352. (III)


Neuropsychological Testing


InterQual® Behavioral Health Criteria Bibliography: CHILD


Riccio et al. Relations between the Test of Variables of Attention (TOVA) and the Children's Memory Scale (CMS). J Atten Disord 2007. 11(2):167-171. (III)


InterQual® Behavioral Health Criteria Bibliography: CHILD


Yantz and McCaffrey. Social facilitation effect of examiner attention or inattention to computer-administered neuropsychological tests: first sign that the examiner may affect results. Clin Neuropsychol 2007. 21(4):663-671. (III)


Psychological Testing


Biederman et al. The CBCL as a screen for psychiatric comorbidity in paediatric patients with ADHD. Arch Dis Child 2005. 90(10):1010-1015. (III)


InterQual® Behavioral Health Criteria Bibliography: CHILD


InterQual® Behavioral Health Criteria Bibliography: CHILD


InterQual® Behavioral Health Criteria Bibliography: CHILD


Riccio et al. Relations between the Test of Variables of Attention (TOVA) and the Children’s Memory Scale (CMS). J Atten Disord 2007. 11(2):167-171. (III)


Yates and Taub. Assessing the costs, benefits, cost-effectiveness, and cost-benefit of psychological assessment: we should, we can, and here's how. Psychol Assess 2003. 15(4):478-495. (V)