InterQual® Behavioral Health Criteria Bibliography: CHILD

McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. The class ratings, I through V, are intended to provide a classification of the evidence but are not necessarily hierarchical. Classifications appear in parentheses at the end of each reference. References followed by an (NC) are not classified; examples include pre-published research or information from government, manufacturer, laboratory, or patient education websites.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
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<tr>
<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
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<tr>
<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
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<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>
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Class I
A meta-analysis is an analysis of the results 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. An 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. Nonrandomized controlled trials are sometimes used when randomization is impossible or unethical.

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.

Comparative Effectiveness Research (CER)
"Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in 'real world' settings." (U.S. Department of Health and Human Services, Report to the President and the Congress on Comparative Effectiveness Research; 2009. Available from: http://www.hhs.gov/recovery/programs/cer/execsummary.html [cited Apr 20 2010])

Child Psychiatry


Bell et al. Suicide in people with epilepsy: how great is the risk? Epilepsia 2009. 50(8):1933-1942. (I)


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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)


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InterQual® Behavioral Health Criteria Bibliography: CHILD


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Luby et al. Preschool depression: homotypic continuity and course over 24 months. Arch Gen Psychiatry 2009. 66(8):897-905. (III)


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


The Joint Commission. 2010 Standards for behavioral healthcare. Oakbrook Terrace IL: Joint Commission Resources; 2009. (V)


Trollor et al. Neuroleptic malignant syndrome associated with atypical antipsychotic drugs. CNS Drugs 2009. 23(6):477-492. (V)


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)


Wu et al. Substance use, suicidal ideation and attempts in children and adolescents. Suicide Life Threat Behav 2004. 34(4):408-420. (III)


Neuropsychological Testing


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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)


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**


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Pineda et al. The role of neuropsychologic tests in the diagnosis of attention deficit hyperactivity disorder. Pediat Neurol 2007. 36(6):373-381. (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)

