

## From the California Evidence-Based Clearinghouse Website

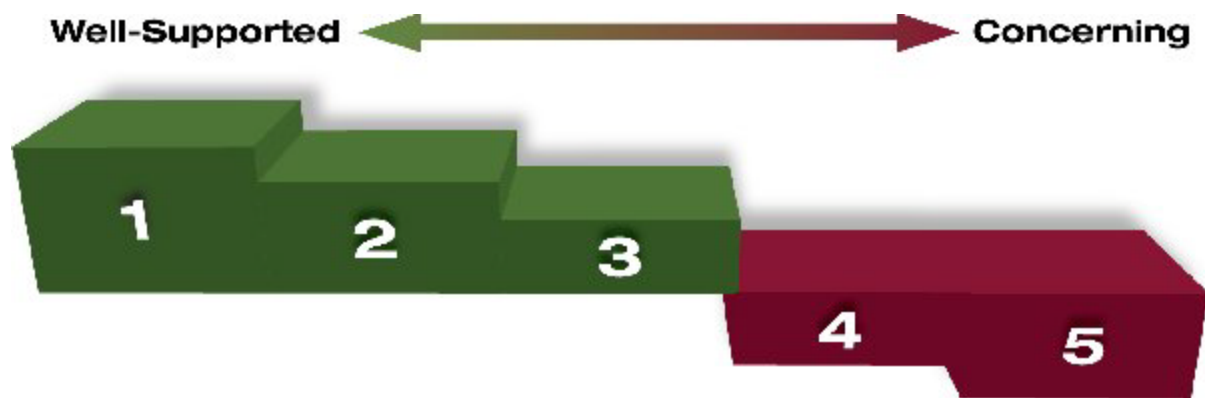
### Scientific Rating Scale

Revised January 2009

The purpose of the CEBC rating scale is to evaluate each practice based on the available research evidence. The topic area expert assists with identifying practices that meet the following criteria:

- Programs that have strong empirical support.
- Programs that are in common use in California.
- Programs that are being marketed in California.

A lower score indicates a greater level of research support. The graphic representation of the scale is shown below:



Adjustments to a program's rating are made on an on-going basis as new research is published, if applicable. The CEBC conducts periodic re-reviews to look for new published, peer-reviewed research on already rated programs. Program representatives are also welcome to submit new published, peer-reviewed studies to initiate the re-review process at any time.

**Specific criteria for each classification system category are presented below:**

#### *1. Well-Supported by Research Evidence*

- There is no clinical or **empirical** evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specify components of the service and describes how to administer it.
- Multiple Site Replication: At least two rigorous **randomized controlled trials** (RCTs) in different usual care or practice settings have found the practice to be superior to an appropriate comparison practice. The RCTs have been reported in published, **peer-reviewed** literature.

- In at least one RCT, the practice has shown to have a sustained effect at least one year beyond the end of treatment.
- Outcome measures must be **reliable** and **valid**, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of the evidence supports the benefit of the practice.

## *2. Supported by Research Evidence*

- There is no clinical or **empirical** evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least one rigorous randomized controlled trial (RCT) in usual care or a practice setting has found the practice to be superior to an appropriate comparison practice. The RCT has been reported in published, **peer-reviewed** literature.
- In at least one RCT, the practice has shown to have a sustained effect of at least six months beyond the end of treatment.
- Outcome measures must be **reliable** and **valid**, and administered consistently and accurately across all subjects.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.

## *3. Promising Research Evidence*

- There is no clinical or **empirical** evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describe how to administer it.
- At least one study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice. The study has been reported in published, peer-reviewed literature.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the benefit of the practice.

## *4. Evidence Fails to Demonstrate Effect*

- Two or more **randomized controlled trials** (RCTs) have found the practice has not resulted in improved outcomes, when compared to usual care. The studies have been reported in published, peer-reviewed literature.
- If multiple outcome studies have been conducted, the overall weight of evidence does not support the benefit of the practice. The overall weight of evidence is based on the preponderance of published, peer-reviewed studies, and not a systematic review or meta-analysis. For example, if there have been three published RCTs and two of them showed

the program did not have the desired effect, then the program would be rated a "4 - Evidence Fails to Demonstrate Effect."

### ***5. Concerning Practice***

- If multiple outcome studies have been conducted, the overall weight of evidence suggests the intervention has a negative effect upon clients served; and/or
- There is a reasonable theoretical, clinical, **empirical**, or legal basis suggesting that the practice constitutes a risk of harm to those receiving it, compared to its likely benefits.

### ***NR. Not able to be Rated***

- There is no clinical or **empirical** evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, and/or other available writings that specifies the components of the practice protocol and describes how to administer it.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from child welfare or related systems and their parents/caregivers.
- The practice does not have any published, peer-reviewed study utilizing some form of control (e.g., untreated group, placebo group, matched wait list) that has established the practice's benefit over the placebo, or found it to be comparable to or better than an appropriate comparison practice.

The "Not able to be Rated" category was added in January 2009.