
# Connecticut TF-CBT Coordinating Center
# FY 2016 Annual Report

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## Executive Summary

The overall goal of the Trauma Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center is to improve access to evidence-based outpatient behavioral health treatment for children suffering from exposure to violence, abuse, and other forms of trauma. Funded by DCF and CSSD, the Coordinating Center utilizes economies of scale to create centralized support for the statewide network of 37 TF-CBT agencies through six primary functions: 1) Training, consultation, and credentialing; 2) Implementation support and quality improvement; 3) Data collection and reporting; 4) Administration of performance-based sustainment funds; 5) Expanding TF-CBT for youth in the juvenile justice system; and 6) Improving coordination and collaboration between providers, child welfare, and juvenile justice to ensure access to services. Significant changes in FY 16 included most agencies meeting the TF-CBT credentialing requirements, almost 180 clinicians becoming credentialed or nationally certified, the closing of the legacy data systems, and additional agency providers being eligible for sustainment funds.

During this fiscal year, the Coordinating Center provided TF-CBT training to 89 clinicians, completed a statewide TF-CBT clinician and agency credentialing process, continued development of a secure, web-based data collection and reporting system (EBP Tracker) and closed the legacy data system, provided implementation support to 37 agencies and more than 350 provider staff, worked with CSSD to improve access to youth in the judicial system, administered performance-based sustainment funds for all eligible agencies, and held a statewide conference. These efforts resulted in 1,820 children receiving TF-CBT in FY16, improvements in nearly all treatment quality indicators, significant reductions in PTSD and depression symptoms for children receiving treatment and very high levels of caregiver satisfaction with treatment. At least 7.1% of all children receiving outpatient services at these agencies received TF-CBT. More than 35% of children receiving TF-CBT were involved with DCF at the time of treatment. Research suggests TF-CBT and similar trauma-focused evidence-based practices result in significant cost-savings in terms of healthcare, education, work productivity, and involvement in the child welfare and justice systems.

TF-CBT is generally regarded highly favorably by agencies and clinicians, as indicated by the sustainment of TF-CBT by nearly all agencies for up to 8 years; this rate of sustainment is rare in the dissemination of evidence-based practices (EBPs). Agencies continue to struggle with the demands of providing an EBP including the additional staff time and requirements as compared to treatment as usual. The primary challenges to continued improvements include the need for systems and policy incentives to support EBPs (e.g. enhanced reimbursement rates), the need to integrate and align TF-CBT with other EBPs being implemented in outpatient settings, improving coordination with other child-serving systems, and raising the bar for "treatment as usual" by applying lessons learned from EBPs to improve outcomes for the broader population of children receiving outpatient treatment.

## ANNUAL REPORT OVERVIEW

### Introduction

This report summarizes the work of The Connecticut Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center ("Coordinating Center"), funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch's Court Support Services Division (CSSD), for state fiscal year 2016 (July 1, 2015 through June 30, 2016). The Coordinating Center is located at the Child Health and Development Institute (CHDI) of Connecticut. The overall goal of the Coordinating Center is to expand the availability and quality of trauma-focused treatment for children through dissemination and sustainment of TF-CBT at Connecticut agencies. CHDI integrates knowledge about implementation science, evidence-based practices, childhood trauma, and children's mental health to achieve this goal together through our partnerships with treatment developers, community-based agencies, and state systems.

### Background

TF-CBT is an evidence-based, short-term, family-centered behavioral health treatment for children aged 3-18 suffering from exposure to traumatic events, including physical abuse, sexual abuse, domestic or community violence, accidents, or disasters. TF-CBT is indicated for children who are suffering from traumatic stress symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. The Substance Abuse and Mental Health Services Administration (SAMHSA) has designated TF-CBT as an exemplary treatment on the National Registry of Evidence Based Programs and Practices (NREPP).

From 2007-2010, DCF funded a statewide dissemination of TF-CBT across community behavioral health agencies in Connecticut. CHDI was selected as the Coordinating Center for this initiative, called the Connecticut TF-CBT Learning Collaborative. CHDI utilized the Institute for Healthcare Improvement's Breakthrough Series Collaborative quality improvement model to train staff from 16 community behavioral health agencies in TF-CBT. Upon completion of the learning collaboratives in 2010, CHDI and DCF identified the need to provide statewide infrastructure to sustain TF-CBT across the behavioral health agencies trained in the learning collaboratives. In 2010, the Coordinating Center was established at CHDI to provide this support.

Additionally, DCF was awarded a federal grant in 2011 by the Administration on Children and Families to improve trauma-informed care for children in the child welfare system called The Connecticut Collaborative on Effective Practices for Trauma (CONCEPT). The Coordinating Center now provides support to thirteen additional agency teams that implemented TF-CBT through CONCEPT from 2012-2014.

In FY14, the Coordinating Center was expanded to provide additional support for this growing network of TF-CBT providers. This expansion included development of a statewide data collection and reporting system, sustainment funding for TF-CBT providers, additional training, and additional implementation support. Beginning in FY15 CSSD funded 37.5% of the cost of the expanded Coordinating Center through a Memorandum of Agreement with DCF, and thus a focus was also placed on offering TF-CBT to youth in the juvenile justice system and working with CSSD staff. This work continued through FY 15 and FY 16.

This report covers the work of the Coordinating Center for FY 16.

## Goals

The primary goals for the Coordinating Center are to:

(1) Provide access to TF-CBT for all Connecticut children suffering from trauma
(2) Ensure that high-quality TF-CBT is provided
(3) Ensure significant improvements in child outcomes for children receiving TF-CBT

## ACTIVITIES AND DELIVERABLES

The Coordinating Center has worked to support the TF-CBT implementation goals through the following activities carried out in FY16.

1. **Training, Consultation, & Credentialing**
    - Contracted with a national trainer to provide two 2-day TF-CBT new clinician trainings in October 2015 and March 2016
    - Contracted and coordinated with a national TF-CBT Trainer or Consultant to provide 14 series of clinical consultation calls (134 total calls) for 143 clinicians
    - Consultation call groups were completed by 86 clinicians (60%)
    - Coordinated registration, attendance and CEUs for New Clinician Training (89 participants,) and the consultation call groups (143 registrations)
    - Developed a statewide TF-CBT clinician credentialing process and requirements to increase the number of clinicians that complete all training and case requirements; 179 clinicians met the Connecticut credentialing or national TF-CBT certification requirements by the end of FY 16
    - Developed TF-CBT agency credentialing criteria and process to ensure that agency teams meet minimum quality requirements required to continue participation in the statewide network of providers; 28 of 31 agencies met the credentialing criteria
    - Developed and maintained a training record database to track training and consultation attendance of all TF-CBT staff, as well as other credentialing requirements for all TF-CBT clinicians; in FY 2016 there were 369 active clinicians
    - Prepared regular training and case data tables for each provider with updates on individual clinician credentialing status
    - Convened eighth annual statewide TF-CBT Conference for 227 participants from community agencies, DCF, and CSSD staff
    - A CHDI Project Coordinator completed the national TF-CBT Train-the Trainer requirements and became certified as a national TF-CBT trainer
    - Developed and administered a reimbursement program for clinicians who successfully completed the requirements for national TF-CBT certification; 18 clinicians completed national certification during the year

2. **Implementation Support, Quality Improvement, & Technical Assistance**

- Developed agency TF-CBT QI indicators and benchmarks and produced reports for two QI performance periods
- Developed a revised QI process of implementation consultation based on emerging implementation science field and needs of agencies
- Developed agency-specific QI plans using SMARTER Goals focused on agency performance on QI benchmarks and strategies to improve access, quality and service delivery
- Performance Improvement Plans were developed with four low-performing agencies
- Provided 158 in-person implementation consultation support visits with providers to ensure sustainment of high quality services
- Provided transition site consultation visits and developed transition plans for the agencies that completed the Juvenile Justice TF-CBT learning collaborative
- Supported 8 new providers that applied to begin implementation of TF-CBT
- Developed consultation fidelity guidelines and accompanying tracking form that were followed in all consultation contacts
- Convened 3 Senior Leader Advisory Meetings with goals focusing on agency needs to support implementation and strategies to improve TF-CBT access, quality, and outcomes statewide; expanded the committee to include additional representatives from TF-CBT agencies that did not attend a learning collaborative
- Implemented and convened 3 Coordinator meetings focusing on sharing implementation and successful meeting strategies
- Provided updates to all TF-CBT participants through a monthly Data Dashboard
- Distributed additional TF-CBT books, materials, and resources to all TF-CBT teams

**3. Data Systems**

- Continued development and maintenance of a secure, HIPAA compliant, online database (EBP Tracker) that meets the needs of the increasing number of TF-CBT providers and the children and families they serve
- EBP Tracker provides real-time scoring and reports of individual client assessments and progress, more timely and accurate data for agencies and stakeholders, includes CBITS and MATCH-ADTC access and has the capacity for additional EBP models to be included
- Continued improvements to EBP Tracker have been made based upon agency feedback and as possible with available funding

- Launched a public directory site that provides a searchable, public listing of TF-CBT agencies through EBP Tracker (tinyurl.com/ebpsearch)
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT agencies in phasing out the legacy data system and the new EBP Tracker system
- Completed the process of cleaning and coding legacy data to integrate with EBP Tracker data so reports can be provided using all data
- Reported monthly data on the TF-CBT/JJ learning collaborative, including trauma screening and referral data, as well as TF-CBT data
- Provided site-based data assistance and reports as requested
- Completed use of the legacy database by December 2015, within one year of the launch of EBP Tracker, so that all case data is now in EBP Tracker

**4. Agency Sustainment Funds**

- Administered performance-based financial incentives to improve capacity, access and quality care.
- While these financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice, agency leadership reports that they do not adequately cover the costs of providing TF-CBT (See Financial Incentive document in Appendix A for details)
- Developed criteria for agencies that did not attend learning collaboratives to be eligible for provider incentives based on performance indicators
- Developed, executed, and managed contracts with each of the 32 TF-CBT providers eligible for financial incentives to detail implementation expectations, data sharing, and financial incentive details
- Analyzed and reported financial incentives for each agency for two 6-month performance periods.
- Distributed $531,076in performance-based sustainment funds to agencies (33% of total contract funds)

**5. Expanding TF-CBT to Youth in the Juvenile Justice System[1]**

- Developed and held a 12-month Learning Collaborative with three agencies and their local Juvenile Justice staff (Probation and Child Youth Family Support Centers) serving 3 court districts; an average of 26 Learning Collaborative participants attended four days of learning sessions in FY16

[1] A separate TF-CBT/Juvenile Justice report with more detail was provided to CSSD for this piece of the Coordinating Center's work.

- Developed RFQ, reviewed applications, and selected agencies to participate in Learning Collaborative
- Developed a Welcome Packet and Collaborative Goals Framework detailing the JJ Learning Collaborative process, goals, and requirements
- Provided six implementation consultation site visits to the JJ Learning Collaborative teams and agencies
- Implementation consultation calls were provided for clinicians (32 calls), supervisors (8 calls), Senior Leaders (3 calls) and Coordinators 50 calls)
- Developed and reported on a survey to measure the number of trauma screens and referrals by juvenile justice staff as well as the level of collaboration with TF-CBT providers
- Worked with the Consultation Center at Yale to evaluate the impact of the Learning Collaborative via web-based surveys of staff
- Drafted a TF-CBT Protocol for Juvenile Probation that was later revised and implemented by CSSD
- Reported on EBP Tracker data to guide the implementation, QI and consultation provided to each JJ learning collaborative team
- Developed a sustainability plan with each team to provide ongoing consultation and support and integrated them into the statewide TF-CBT initiative

## ACCESS: WHO DID WE SERVE?

During FY 16, TF-CBT was available **at 81 sites across 37 provider agencies**. There were **369 active TF-CBT clinicians**, including **89 clinicians newly trained** during the fiscal year. By the end of the reporting period, **179 TF-CBT team members had been either credentialed or nationally certified in TF-CBT**. The overall **penetration rate was 7.1%** (i.e. 7.1% of children receiving outpatient services in participating agencies were receiving TF-CBT). **More than 27,000 sessions of TF-CBT were provided** during the fiscal year.

In FY 16, **1,820 children received TF-CBT**. Children were 59.7% female, 39.9% male, 0.1% intersex, and 0.3% other.[2] The race/ethnicity breakdown for children served was 41.3% White non-Hispanic, 35.1% Hispanic, 14.9% Black non-Hispanic, and 7.6 Other non-Hispanic. There were 35% of the children with DCF involvement and 5% that had juvenile justice involvement.

Table 1 below highlights the trends in TF-CBT access across the past three fiscal years as well as cumulative numbers. The number of agencies and clinicians offering TF-CBT has continued to increase over the three-year period. In 2014, six new providers joined the Coordinating Center, but were not able to sustain their TF-CBT practice beyond the initial training. One of those agencies reorganized and is now a credentialed agency. An additional agency attended the TF-CBT Learning Collaborative as part of the CONCEPT grant and could not sustain the team after that year due to staff turnover. One credentialed agency (FSGW) closed in August, 2016 due to financial difficulties. While the number of children receiving TF-CBT (at least one session) decreased marginally (4%) from FY 15 to FY 16, the number of TF-CBT sessions increased substantially (30%).

**Table 1: TF-CBT Access**

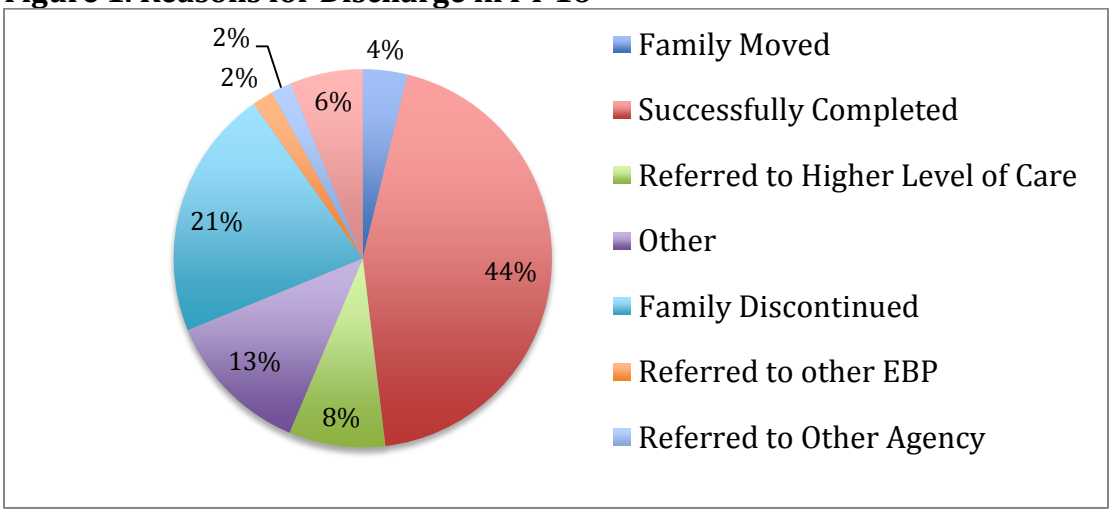
| | FY14 | FY15 | **FY16** | Cumulative Since 2007 |
|---|---|---|---|---|
| Providers of TF-CBT | 34 | 36 | **37** | 44 |
| TF-CBT Penetration Rate | 5% | 7.7% | **7.1%** | N/A |
| New TF-CBT Clinicians | 165 | 115 | **89** | 781 |
| Clinicians Providing TF-CBT | 290 | 330 | **369** | 733 |
| Clinicians Credentialed/ Certified | 34 | 37 | **108** | 179 |
| Children Served: TF-CBT | 1,250 | 1,902 | **1,820** | 6,847 |
| # TF-CBT sessions | 15,523 | 20,764 | **27,016** | 107,446 |
| Children with DCF inv. | 40.4% | 36.2% | **35.1%** | N/A |

[2] Data on sex was available for 1,762 (96.8%) of children.

## QUALITY: HOW WELL DID WE SERVE?

During the fiscal year, 1,154 children ended their TF-CBT treatment episode. Figure 1 shows the breakdown of reasons for discharge. Close to half (44%) of the children receiving TF-CBT successfully completed the entire TF-CBT model, while 21% of families discontinued treatment. The remainder were discharged or transferred for a variety of reasons.

**Figure 1. Reasons for Discharge in FY 16**




In addition to tracking discharge reasons, CHDI reports on TF-CBT quality improvement (QI) indicators twice annually. The definition and explanations of each of the 10 QI indicators are in Appendix B and the prepared reports showing each provider's results over the two FY16 performance periods are included in Appendix C and Appendix D. Agencies are expected to meet the benchmarks set for penetration rate and credentialed clinicians as well as four of the remaining eight benchmarks. In the July to December 2015 period, 26 of 32 agencies met this requirement. In the January to June 2016 period, four additional agencies met this requirement.

Significant improvements in QI indicators were observed over FY16. Clinicians' use of standardized clinical assessment measures with children increased from 59.0% to 76.1% of children served, and on-time reporting of monthly TF-CBT fidelity/session data increased from 71.0% to 89.0%. These improvements were from the first reporting period of the year to the second. These positive changes may be related to the transition to EBP Tracker and the closing of the older data system, as well as increased consultation focus with agencies about using data.

The remaining QI indicators are calculated based on children that ended their treatment episode in each reporting period.

- The percent of children that were considered engaged increased from 70% to 87%. (Improved)

- The percent of children that completed the trauma narrative component stayed consistent at 42%. (No change)
- The percent of children that were considered successful by the clinician *and* completed all required TF-CBT components (another indicator of fidelity) improved from 32% to 35%. (Improved)
- Caregiver involvement decreased from 71% to 64% between the two periods. (Worsening)
- The percentage of children that closed in the target length of stay window increased from 68% to 86%. (Improved)
- The average CSQ score was 4.6 in July –Dec 2015 and 4.7 in Jan-June 2016 (The CSQ is on a 1 to 5 scale, where 5 reflects greater satisfaction). (No change)

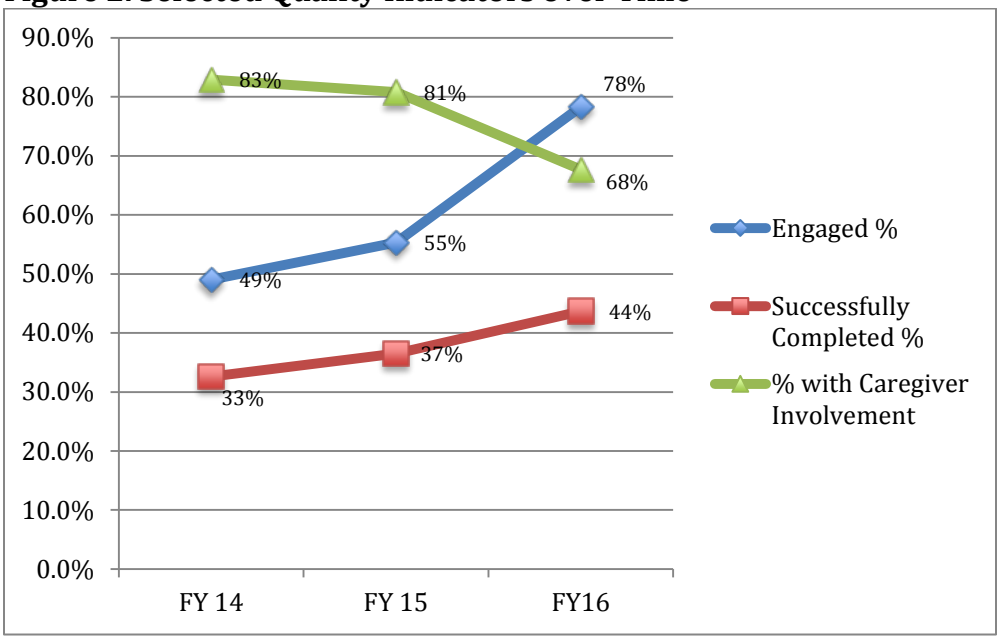
**Table 2.: TF-CBT Quality indicators**

| | FY14 | FY15 | FY16 | Cumulative Since 2007 |
|---|---|---|---|---|
| # closed treatment episodes | 1,024 | 1,178 | 1,154 | 6,215 |
| Children successfully completed TF-CBT[a] | 334 (33%) | 430 (37%) | 511 (44%) | 2,102 (34.5%) |
| # Children Engaged | 502 (49.0%) | 652 (55.3%) | 904 (78.3%) | 3,376 (55.4%) |
| #Cases with Caregiver involvement | 849 (82.9%) | 952 (80.8%) | 781 (67.7%) | 4,878 (80.1%) |

[a] Successfully completed as reported by clinician

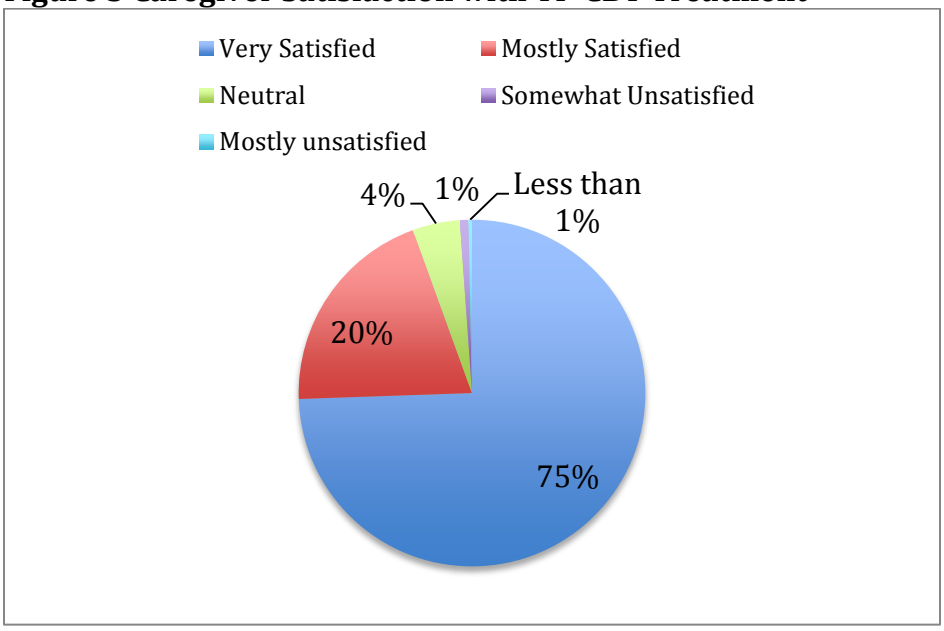
This general pattern of improved performance suggests that as more clinicians become trained and more children continue to receive TF-CBT, the quality of treatment remains high and has in fact continued to increase in most areas. Figure 2 shows three indicators (engagement, caregiver involvement, and successful completion) over the past three years. Rates of successful completion (as indicated by clinician) and engagement in treatment rose steadily from FY 14 to FY 16. Although the overall percentage of caregiver involvement decreased over the three year period, there were changes in how this information was collected from the old data system to EBP Tracker. For FY 14 and part of FY 15, clinicians reported on the number of sessions that included a caregiver. In EBP Tracker, they are asked to specify the percentage of session time that included the caregiver. This more detailed level of collection might account for some changes in overall participation rates.

**Figure 2. Selected Quality Indicators over Time**




Additionally, caregivers report high levels of satisfaction with TF-CBT treatment. In FY 16, there were 1,128 Caregiver Satisfaction Questionnaires completed. The results of the response to the question "Overall, I am satisfied with my child's treatment" are illustrated in Figure 3 below with 95% indicating mostly or very satisfied with treatment.

**Figure 3 Caregiver Satisfaction with TF-CBT Treatment**



## OUTCOMES: IS ANYONE BETTER OFF?

In FY16, CHDI began using the Reliable Change Index (RCI: Jacobson & Traux, 1991) as a metric for reporting outcomes. The approach uses the properties of an assessment measure to calculate an RCI value; when a change score exceeds that value it is considered to be reliable change and not due to chance. The RCI can be used with a measure's clinical cut-offs to identify both reliable and clinically significant changes (Jacobson NS, Truax P (1991). [3]

This method places individuals into one of seven separate categories.

> *1. Improvement with Clinical Significance* is when there is positive change from intake to discharge that meets or exceeds the RCI value **and** there is a move from the clinical to the non-clinical range
>
> 2. *Reliable Improvement* is when there is a positive change from intake to discharge that meets or exceeds the RCI value but there is **no** movement from the clinical to non-clinical range
>
> 3. *Partial Improvement* is when there is positive change that is greater in magnitude than half of the RCI value but does not meet the full RCI value
>
> 4. *No Change* is when the change, positive or negative, is less than half of the RCI value
>
> 5. *Partial Deterioration* is when there is a negative change that greater than half of the RCI values but still less than the full RCI value
>
> 6. *Reliable Deterioration* is when there is negative change that meets or exceeds the RCI value but there is **no** movement from outside to inside the clinical range
>
> 7. *Deterioration with Clinical Significance* is when there is negative change that meets or exceeds the RCI value **and** the score changes from outside the clinical range to inside the clinical range

These seven categories are used below to demonstrate the outcomes on child PTSD symptoms, child depression symptoms, child problem severity, and child functioning. The RCI values for the Child PTSD Symptom Scale (CPSS) and the Short Mood and Feelings Questionnaire were calculated by CHDI using existing TF-CBT data. The RCI values for the Ohio Problem Severity and Functioning scales were given a previous validation report of the measures (TX DMHMR, 2003). The RCI and partial RCI values used in this report are given in table 3 below.

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[3] Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology 59*, 12-19.

**Table 3: RCI Values**

| Measure | Full RCI | Partial RCI |
|---|---|---|
| CPSS Child Report | 11 | 6 |
| CPSS Caregiver Report | 10 | 5 |
| SMFQ Child Report | 7 | 4 |
| SMFQ Caregiver Report | 6 | 3 |
| Ohio Problem Severity (All Reporters) | 11 | 6 |
| Ohio Functioning (All Reporters) | 8 | 4 |

Table 4 below gives the descriptives for the first and last assessment for each of the measures used in TF-CBT. Also indicated in the table, where applicable, are the numbers of children whose score placed them in the clinical or critical range on a particular measure at intake and how many of those had moved out of that range by the last assessment. Change scores are given for each measure broken out by these two groups (those who started in the clinical range and those that did not). This is an important factor in examining change scores because greater change is possible and expected for children who enter with higher scores.

**Table 4: Descriptives for all Assessment Measures**

| Measure | Intake Mean (S.D). | Above Cutoff | Last Mean (S.D.) | Remission |
|---|---|---|---|---|
| THS Child (n=1,102) | 6.72 (3.81) | n/a | n/a | n/a |
| THS Caregiver (n=1,092) | 5.40 (3.26) | n/a | n/a | n/a |
| CPSS Child (n=590) | 20.56 (10.87) | 384 (65.1%) | 10.97 (10.06) | 241/384 (62.8%) |
| CPSS Caregiver (n=548) | 18.49 (10.13) | 305 (55.7%) | 10.00 (8.62) | 208/305 (68.2%) |
| SMFQ Child (n=655) | 9.42 (6.49) | 364 (55.6%) | 5.33 (5.56) | 220 (60.4%) |
| SMFQ Caregiver (n=601) | 9.61 (6.14) | n/a | 5.67 (5.76) | n/a |
| Ohio Problem Severity Child (n=149) | 19.13 (14.66) | 45 (30.2%) | 13.58 (12.55) | 24/45 (53.3%) |
| Ohio Problem Severity Caregiver (n=216) | 20.00 (13.78) | 69 (31.2%) | 15.46 (13.19) | 32/69 (46.4%) |
| Ohio Functioning Child (n=149) | 54.93 (17.14) | 27 (18.1%) | 58.07 (18.71) | 11/27 (40.7%) |
| Ohio Functioning Caregiver (n= 216) | 51.38 (14.77) | 67 (31.0%) | 55.24 (16.43) | 35/67 (52.2%) |

## Child Trauma History

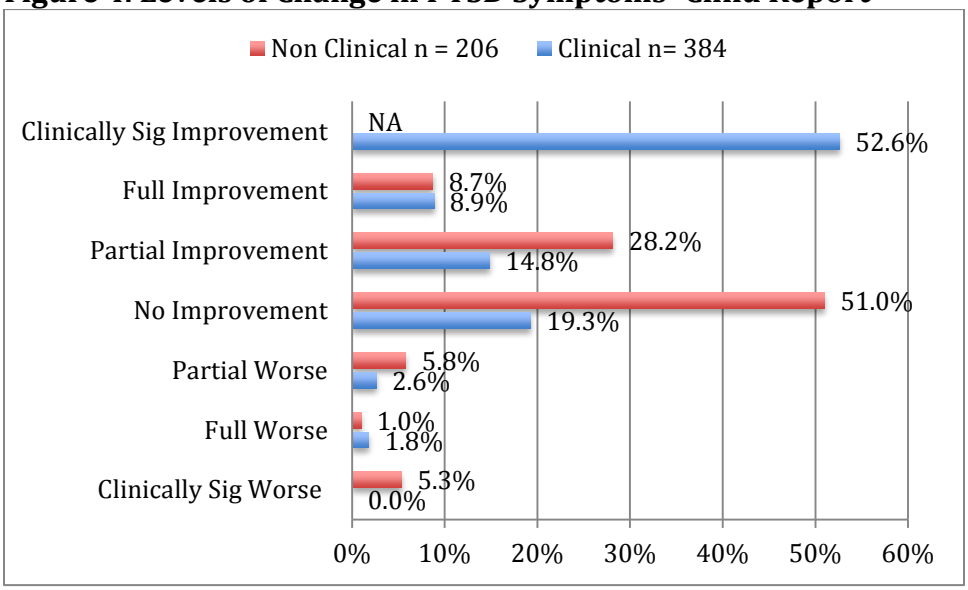
At intake, children and caregivers report completing the Trauma History Screen (THS). This provides the total number of types of potentially traumatic events a to

which a child has been exposed. As can be seen in Table 4 above, children report being exposed to an average of 6.72 different types of events and caregivers report an average of 5.40 events. While there is no post-test or change across time on the THS, this information is included here as it provides an indication of the significance of the trauma histories the children have experienced, which is important contextual information in interpreting the other assessment measure scores.

## Child PTSD Symptoms

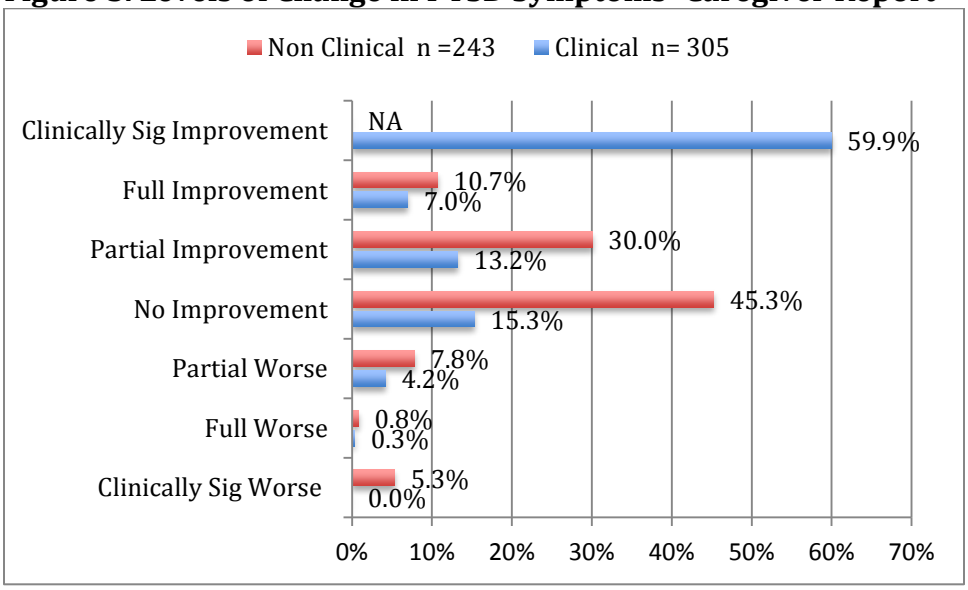
Child PTSD symptoms are measured by the Child PTSD Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001). The CPSS is a 17-item instrument used to measure post-traumatic stress disorder severity in children. There are two versions: a child self-report and a caregiver report. Measure descriptives for the first and last reporting period are in Table 4 above. For FY16 CPSS child report change scores were available for 590 children; in the full sample, 369 (62.5%) demonstrated some level of improvement (either partial, reliable, or clinically significant). Figure 4 shows the levels of change separately for those that began in the clinical range and those that did not. For those that began in the clinical range, 52.6% had clinically significant improvement and 23.7% had full or partial improvement.

**Figure 4. Levels of Change in PTSD Symptoms- Child Report**




Similarly, CPSS caregiver report change scores were available for 548 youth; of these, 345 (63.0%) demonstrated some level of improvement. Figure 5 shows the levels of change separately for those that began in the clinical range and those that did not. For those that began in the clinical range, 59.9% had clinically significant improvement and an additional 20.2% had full or partial improvement.

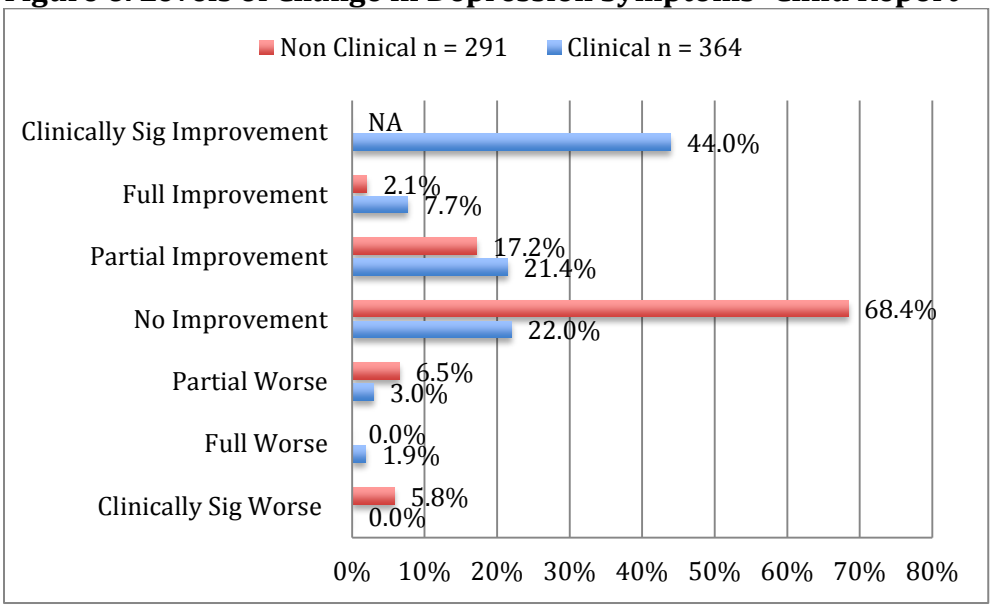
**Figure 5. Levels of Change in PTSD Symptoms- Caregiver Report**




## Child Depression Symptoms

Child depression symptoms are measured by the Short Mood and Feelings Questionnaire (SMFQ; Angold et al., 1995). The SMFQ has 13-items and there are two versions: a child self-report and a caregiver report. Measure descriptives for the first and last reporting period are in Table 4 above. For FY16 SMFQ child report change scores were available for 655 children; of these 322 (49.2%) demonstrated some level of improvement (either partial, reliable, or clinically significant). Figure 6 shows the levels of change separately for those that began in the clinical range and those that did not. For those that began in the clinical range, 44.0% had clinically significant improvement and 29.1% had full or partial improvement.

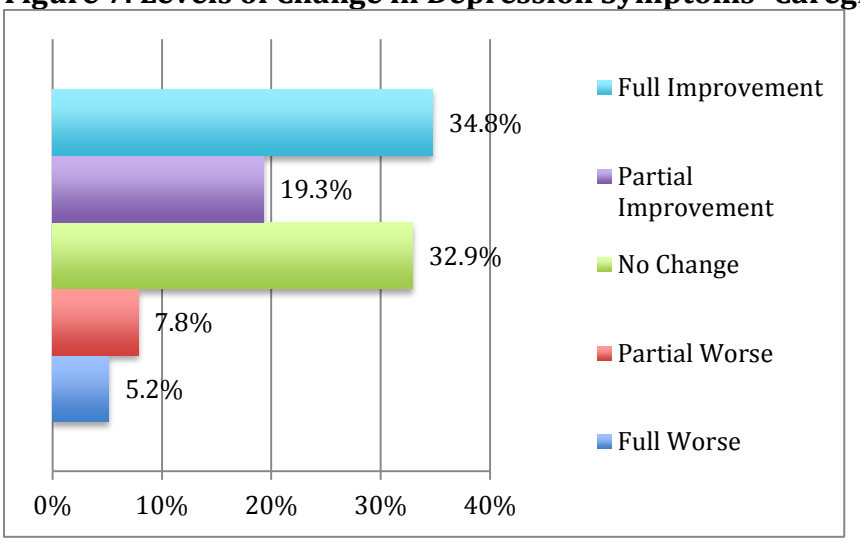
**Figure 6. Levels of Change in Depression Symptoms- Child Report**




Similarly, SMFQ caregiver report change scores were available for 601 children. The RCI categories are in Figure 7; on this measure 325 children (54.1%) demonstrated

some level of improvement. The caregiver version of the SMFQ does not provide a clinical-cut off for depressive symptoms, so the number of RCI categories on this measure is limited to five and it is not possible to break out the analysis into clinical and non-clinical groups.

**Figure 7. Levels of Change in Depression Symptoms- Caregiver Report**

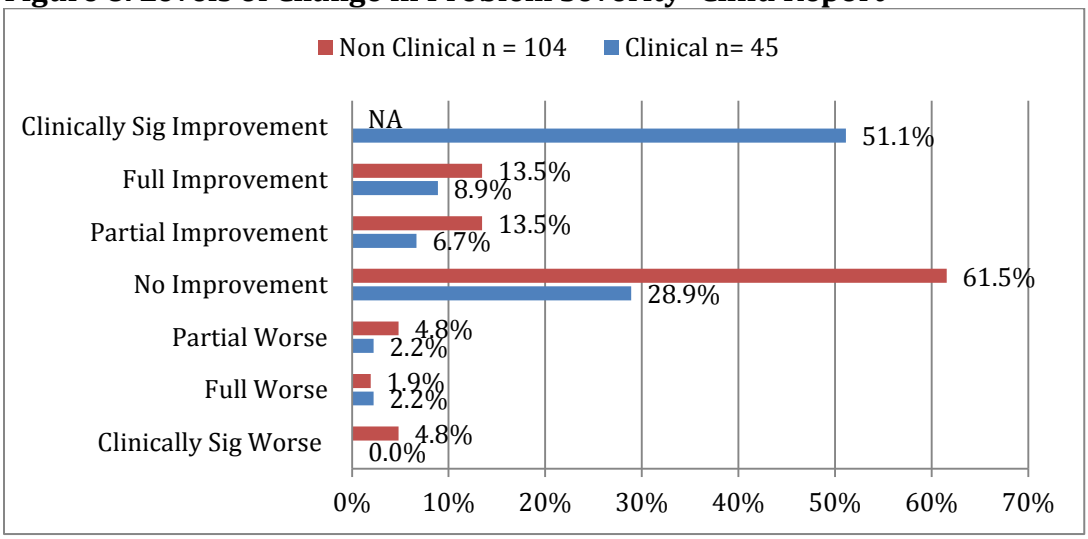



## Child Problem Severity

In November 2015, EBP Tracker began collecting Ohio Youth Problem Severity scale (Ogles, Melendez, Davis, & Lunnen, 2001) scores on newly entered TF-CBT cases. The Ohio Youth Problem Severity scale measures the degree of problems a child is currently experiencing and in TF-CBT both child and caregiver reports are collected. This measure was not routinely collected until almost halfway through the fiscal year and then was only collected on new incoming cases and is not used by all providers. The number of cases with change score data is much lower than for the PTSD and depression measures. Measure descriptives for the first and last reporting period are in Table 4 above.

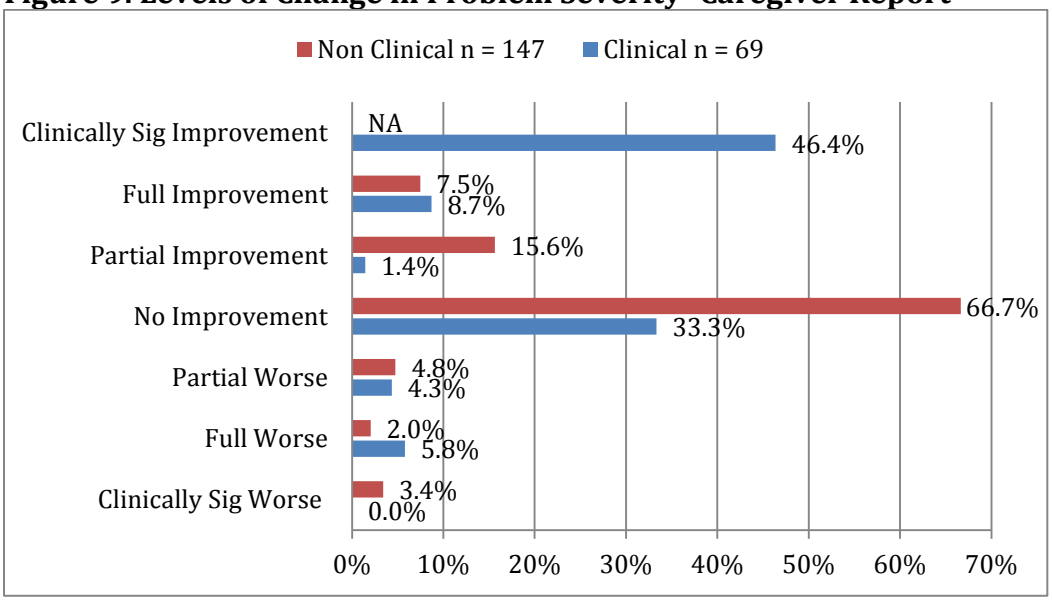
Ohio Problem Severity- Child Report scores were available for 149 children. Of the full sample, 38.9% had some level of improvement. However, only 30% scored in the clinically elevated range at intake. This means that not all youth had the same potential for change as many youth do not necessarily need improvement. To better understand the change in problem severity ratings, it is necessary to look at the outcomes separately for those that did score in the elevated range at intake and those that did not. These are illustrated in Figure 8. Of the youth scoring in the clinical range, 51.1% had clinically significant improvement and another 15.6% had full or partial improvement.

**Figure 8. Levels of Change in Problem Severity- Child Report**




Ohio Problem Severity- Caregiver Report scores were available for 216 children. Of these children, 33.8% experienced improvement. However, only 31.9% scored in the clinical range at intake. Of these children, 46.4% experienced clinically significant improvement and another 10.1% experienced full or partial improvement.

**Figure 9. Levels of Change in Problem Severity- Caregiver Report**



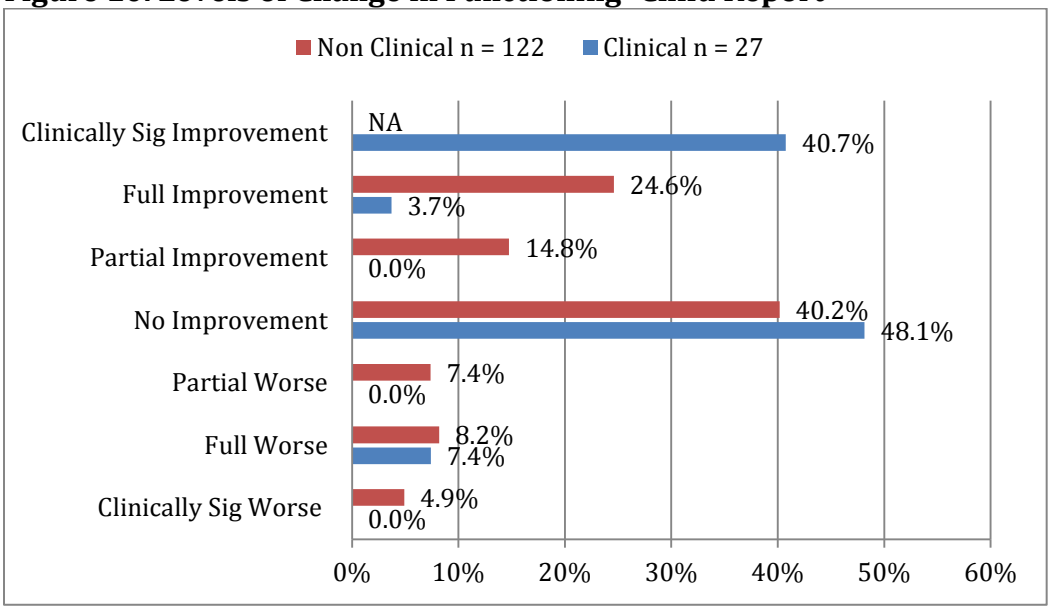

## Child Functioning

Similar to the Ohio Youth Problem Severity scale, EBP Tracker began collecting Ohio Youth Functioning scale (Ogles, Melendez, Davis, & Lunnen, 2001) scores on newly entered TF-CBT cases in November 2015. The Ohio Youth Functioning scale measures the degree to which a child's problems affect their day-to-day activities. In TF-CBT both child and caregiver reports are collected. This measure was not routinely collected until almost halfway through the fiscal year and then was only collected on new incoming cases, so the number of cases with change score data is much lower than for the PTSD and depression measures. It is important to note that

unlike the other measures presented in this report, the Ohio Youth Functioning scale is scored such that higher scores reflect greater levels of functioning; so while on the PTSD, depression, and problem severity scales reductions are considered positive change, on functioning increases are indicative of positive change. Measure descriptives for the first and last reporting period are in Table 4 above.

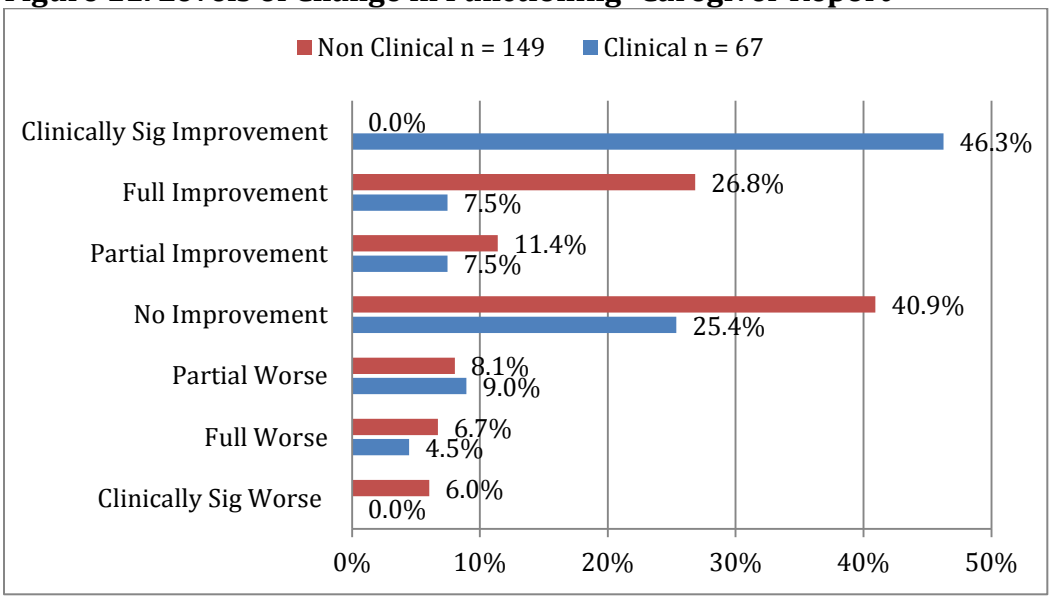
Ohio Functioning- Child Report scores were available for 149 children; of these, 40.3% had improvement. However, only 18.1% were in the critical range at intake. Figure 10 below shows the results broken out by clinical and non-clinical groups. Of the children who were in the clinically elevated range at intake, 44.4% showed some level of improvement.

**Figure 10. Levels of Change in Functioning- Child Report**




Ohio Functioning- Caregiver Report scores were available for 216 children. Of these children, 45.4% experienced improvement. However, only 31.0% scored in the clinical range at intake. Of these children, 46.3% experienced clinically significant improvement, and another 15.0% experienced full or partial improvement. Figure 11 shows the levels of change in functioning as reported by caregiver for both clinical and non-clinical groups.

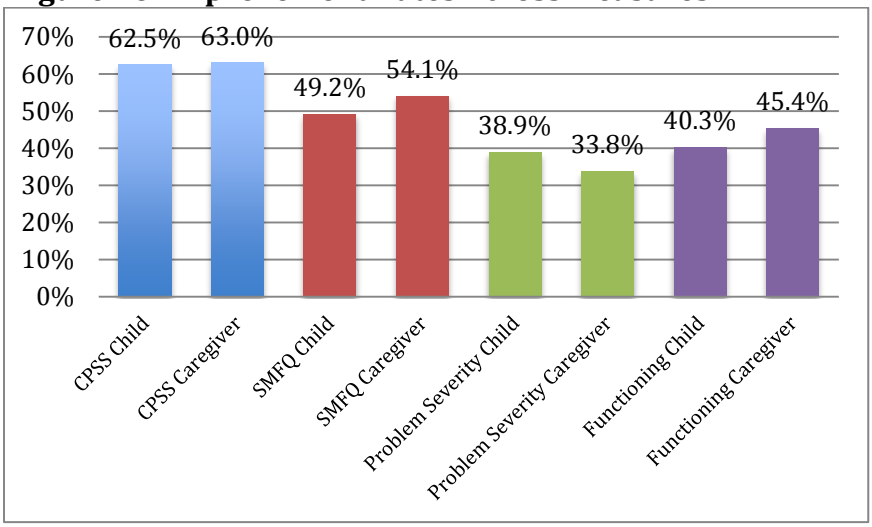
**Figure 11. Levels of Change in Functioning- Caregiver Report**




## IMPROVEMENT ACROSS MEASURES

Children receiving TF-CBT were assessed on four measures, each with child and caregiver report versions. When children were assessed at two or more time points, change scores were calculated and RCI values were used to see the percentage of children who experienced reliable change. Collapsing across the three improvement categories (partial improvement, reliable improvement, and reliable improvement with clinical significance), Figure 16 below shows the relative rates of improvement across the measures. The highest rates of improvement were on the CPSS and SMFQ. Rates of improvement were lower on the two Ohio scales, but these measures also had lower number of children scoring in the critical range at intake. Given the high rates of trauma exposure for this population as indicated on the THS at intake (an average of nearly seven events by child report and over five events by caregiver report), the higher rates of improvement on trauma symptoms is an important and positive outcome.

**Figure 16. Improvement Rates Across Measures**



## RECOMMENDATIONS

The following recommendations are made for continued support of the TF-CBT statewide network:

### 1. Coordinating Center:

- Continue to provide training and consultation opportunities for clinicians in all areas of the state, clinical settings other than outpatient clinics, and in private practice and school-based settings
- Expand training and consultation for clinicians to include advanced training and/ or booster training
- Provide training opportunities on use of standardized assessments in clinical practice
- Where appropriate, consolidate data, reports and consultation to provide more efficient feedback and consultation to agencies
- Continue to collect relevant financial data and advocate for adequate reimbursement rates for the implementation and sustainability of TF-CBT and other EBPs
- Improve consultation and TA provided to agencies by using implementation consultation guidelines based on implementation science and agency needs
- Develop consultation model that will address QI needs of each agency and will include multiple treatment models
- Use real time data and a performance improvement process to develop QI plans for all agencies
- Use the QI process to identify low performing agencies and develop performance improvement plans with agencies that have not met the QI benchmarks and agency credentialing requirements
- Develop outcome based criteria for agency sustainability funds (completed 8/2016)
- Calculate and administer revised, outcome based sustainability funds to all eligible agencies
- Calculate individual active clinician status twice annually and provide that information to each agency
- Utilize revised provider sustainability criteria to include incentivizing clinical outcomes
- Continue to develop capacity of EBP Tracker to produce reports at the client, clinician, agency and statewide levels

### 2. System:

- Develop strategies for linking or integrating EBP Tracker and PIE to eliminate redundancies. Opportunities to create efficiencies are likely to exist since both systems were developed by the same contractor.

- Continue funding performance-based sustainment funds to improve capacity, access and quality care financial incentives are intended to partially offset the increased agency costs of providing an evidence-based practice
- Consider strategies for implementing a more sustainable approach to integrate performance-based payments into reimbursement rates and/or DCF contracts with OPCCs directly.
- Develop a consistent, standardized trauma screening process and screening measure for all agencies in order to ensure consistent trauma screening of all children receiving behavioral health services.
- Support collaboration among child welfare, juvenile justice, and TF-CBT providers to monitor and coordinate referrals and care for children receiving TF-CBT.
- Provide education to child welfare staff about the value of evidence-based treatment and TF-CBT for youth with behavioral health services, how to determine the type of treatment a child is receiving, and how to advocate for evidence-based treatment.
- Develop a plan for a Coordinating Center that works to identify, disseminate, support, and integrate EBPs beyond TF-CBT. Such a Center could have a broader impact on the children's behavioral health system and could test and implement population-based strategies and models (e.g. for all children seen in OPCCs) through use of standardized assessment measures (measurement based care) and clinical and organizational strategies that are relevant for all children (e.g. engagement, behavioral rehearsal, use of supervision, self-care).
- Embed the cross-system work of TF-CBT, along with data on utilization and outcomes, within relevant statewide committees and councils, including but not limited to: the Behavioral Health Plan Advisory Board; the Juvenile Justice Policy and Oversight Committee (JJPOC); and the Behavioral Health Partnership Quality Access and Policy Subcommittee.

**3. Providers:**

- Develop sustainability plans and provide clinical staff the needed resources for implementation of multiple evidence based treatment models
- Utilize EBP Tracker reports to monitor case data entry as well as receive more timely feedback on agency performance.
- Develop QI strategies that will increase focus on child outcomes, symptom reduction and successful completion of treatment
- Agency Senior Leaders report the inadequacy of provider incentives to cover the cost of providing evidence based practices, and need to continue to advocate for adequate reimbursement rates to sustain TF-

CBT treatment

- Advocate for funding to sustain the support provided by CHDI to agencies. Specifically, the need for ongoing training and consultation.

# Sustainability Funding Plan for Fiscal Year 2017

This document summarizes the proposed plan for awarding sustainability funds to TF-CBT agencies beginning July 1, 2016. Provider incentives are awarded twice a year: based on performance January 1-June 30 and July 1- December 31. Sustainability funds are dependent on DCF funding. Due to the fact that the exact amount available varies, the plan is based on percentages and points that can be adjusted for any amount.

Currently, only TF-CBT agencies are eligible for sustainability funds. However, this plan was designed to apply across treatment models and incentives general best practices in delivering any EBP to children in outpatient settings.

## Agency Eligibility

TF-CBT agencies will be eligible for sustainability funds if they are:

1) Credentialed as an agency
2) Have met 50% of the Quality Improvement benchmarks in either the current or previous reporting period (i.e., failure to meet the QI benchmarks for two consecutive periods would disqualify an agency from receiving incentive money.

## Implementation and Child Outcomes Distribution

The available money will be allocated according to performance of an agency based on aggregated case data. Due to the amount of money varying in each performance period, calculations will be done in points.

Cases eligible to earn points in any given performance period are those that ***closed*** in that period. All of their case data, including data from before the performance period, will then be used to calculate the points.

Points are calculated based on the following categories:

- Engaged (40 points): Cases that have 4 or more sessions
- Satisfaction (20 points): Cases that completed a CSQ with a total score of 4.3 or higher
- Symptom Reduction (40 points): Given for cases that meet the reliable change benchmark (full or partial RCI) for reduction of symptoms on ***at least one*** assessment measure (currently the CPSS Child, CPSS Caregiver, SMFQ Child, SMFQ Caregiver). NOTE: Forty points is the maximum for a case to earn. If a case meets this benchmark on more than one assessment, they still only get 40 points.

Taken together, these categories allow for each case to be worth 100 points.

- There will be an adjustment for cases that are considered complex due to the presence of risk factors. Cases deemed to be "complex" will earn an additional 10 points in the engagement and symptom change and categories and 5 points in the satisfaction category if they meet

the criteria. This would allow for a potential 125 points to be earned for each complex case.

- This is to recognize that certain benchmarks may be more difficult for certain cases to meet; rather than attempting to change the benchmark for these cases, we are instead providing additional points for the complex cases that meet each benchmark in recognition of the potential difficulties clinicians might have
- A case is considered complex when two or more of the following factors are indicated: DCF Involvement, JJ involvement, Suspended/Expelled, IEP, Arrested/Detained/Incarcerated, Alcohol or other drug use, Evaluated in ER, or Medically complex

## Proposed Sustainability Funding Report Document

| Agency | # Closed Cases | # Complex Cases | # Engaged (40 pts) | # Complex Engaged (10 pts) | # Satisf. (20 pts) | # Complex Satisf. (5 pts) | # Symp Change (40 pts) | # Complex Symp Change (10 pts) | Total Points |
|---|---|---|---|---|---|---|---|---|---|
| Agency A | | | | | | | | | |
| Agency B | | | | | | | | | |
| Agency C | | | | | | | | | |

TF-CBT
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## QI Overview

The indicators provided in this report cover the period from January- June 2015. Some definitions have changed since the last reporting period. A complete list of the current definitions is included as well as a brief overview of the major changes.

The QI indicators and definitions are color-coded to make them easier to interpret.

| Color | Indicators | Description |
|---|---|---|
| Gray | -Penetration Rate<br>-# Clinicians Credentialed | These indicators are based on agency-wide data in the given period |
| Red | -% Assessment Up-to-Date<br>-% Monthly Session On Time | These indicators are based on all cases active in the QI period; this includes cases that closed during the period as well as those that remain open |
| Blue | -Caregiver Involvement<br>-Engaged<br>-Trauma Narrative Complete<br>-Agency average CSQ score | These indicators are based only on cases that *closed* in the QI period; Assessment Only cases are not counted in these numbers. |
| Green | -% Successfully Completed with All Required Components<br>-% in 2-12 mo. Length of Stay Window | These indicators come from cases that closed, were indicated as successful, and met all required components for a complete TF-CBT case |

**Definitions that Changed:**

- **% Monthly Data On Time:** Prior QI reports only accounted for monthly data being complete, not on time. The new definitions reports on percentage of monthly data forms that were both completed and on time. Because of the change in definition, ***the benchmark was lowered from 80% to 75%***.
- **% Caregiver Involvement:** This is now only calculated on cases that are closed.
- **% Successfully Completed with All Required Components:** Prior QI reports looked at closed cases that the clinician indicated discharged successfully; the new definition looks at the clinician reports as well as if the case completed the required TF-CBT components and had 8 or more sessions. Because of the change in definition, ***the benchmark was lowered from 45% to 30%***.
- **% in 2-12 mo. Length of Stay:** Prior QI reports looked at the length of stay for closed cases with the benchmark being below 9 months. The new definition looks only at the average length of stay for "successfully completed with all required components" cases; the benchmark is for 65% of the cases to close within 2 to 12 months

**In order to be credentialed, agencies must meet the following benchmarks:**

1) Penetration rate
2) Credentialed clinician
3) Four of the remaining eight indicators

Child Health and Development Institute of Connecticut, Inc.

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TF-CBT
Coordinating Center

**QI Definitions**

| | |
|---|---|
| [a] Penetration Rate | Proportion of Annual TF-CBT cases in total outpatient caseload in agencies or programs offering TF-CBT |
| [b] # "Clinicians" Credentialed | Number of clinicians in agency who have completed state credentialing or national certification at any point in time |
| **[c] # "Active" in "Time" Period** | **All cases, both currently open and closed, that received at least one session of TF-CBT at any point in the reporting period** |
| [d] Assessments Up to date | Proportion of TF-CBT "cases that had a" complete and up to date assessment battery |
| [e] Monthly Data On Time | Proportion of monthly session data completed on time |
| **[f] # "of" Closed Cases** | Cases that closed during the reporting period, excluding Assessment Only cases |
| [g] CG Involved | Proportion of cases in which 33% of session time included a caregiver |
| [h] Engaged | Proportion of cases that had a complete baseline assessment and at least 4 sessions |
| [i] TN Complete | Proportion of cases that completed a trauma narrative |
| [j] CSQ | Average score for last recorded Caregiver Satisfaction Questionnaire across all cases that closed in the QI period in an agency |
| **[k] Successfully) Completed with All Required Components** | Cases that closed during the reporting period which: a) had at least 8 sessions b) were indicated "as" successful "by" clinician c) "completed" all "required" treatment components |
| [l] % "of" closed "that" successfully completed | Proportion of closed cases that met the definition of "Successfully Completed with All Required Components" |
| [m] % "with" LOS "between" 2 and 12 mos. | Proportion of cases that had a length of stay between 2 and 12 months |

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# TF-CBT Quality Improvement Indicators
## July to December 2015

| Provider Name | a. Penetration Rate | b. # Clinicians Credentialed | c. # Active in Time Period (Open and Closed) | d. Assessment Up To Date | e. Monthly Session On Time | f. # Closed | g. % Caregiver Involved | h. % Engaged | i. % TN Complete | # Closed j. with CSQ | Average CSQ | k. #Succ Completed with all Components | l. % Succ Completed with All Components | m. % Closed in LOS Window |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BENCHMARK** | **4.0%** | **1** | n/a | **65%** | **75%** | n/a | **65%** | **55%** | **35%** | | **4.3** | n/a | **30%** | **65%** |
| Clifford Beers Clinic | 5.6% | 7 | 44 | 54.7% | 41% | 27 | 63.0% | 77.8% | 40.7% | 10 | 4.64 | 8 | 29.6% | 50.0% |
| Community Health Resources | 7.8% | 9 | 114 | 63.1% | 87% | 59 | 72.9% | 69.5% | 40.7% | 15 | 4.59 | 14 | 23.7% | 85.7% |
| Family & Children's Aid, Inc. | 3.1% | 2 | 62 | 74.3% | 79% | 30 | 50.0% | 90.0% | 40.0% | 13 | 4.74 | 13 | 43.3% | 53.8% |
| Klingberg Family Centers | 10.6% | 1 | 10 | 29.4% | 73% | 4 | 25.0% | 75.0% | 50.0% | 2 | 4.75 | 2 | 50.0% | 100.0% |
| United Comm. and Fam Serv. | 5.3% | 3 | 34 | 62.7% | 74% | 24 | 91.7% | 95.8% | 41.7% | 14 | 4.46 | 6 | 25.0% | 16.7% |
| Wheeler Clinic | 6.5% | 5 | 80 | 64.5% | 75% | 39 | 74.4% | 56.4% | 25.6% | 16 | 4.58 | 11 | 28.2% | 27.3% |
| CGC Southern | 5.7% | 1 | 17 | 60.0% | 38% | 10 | 90.0% | 90.0% | 60.0% | 3 | 4.78 | 2 | 20.0% | 50.0% |
| Family Services of Grtr Wtby | 34.8% | 2 | 29 | 72.1% | 80% | 14 | 78.6% | 78.6% | 35.7% | 8 | 4.40 | 4 | 28.6% | 100.0% |
| The Village | 4.7% | 4 | 69 | 68.0% | 78% | 26 | 61.5% | 46.2% | 34.6% | 5 | 4.50 | 5 | 19.2% | 100.0% |
| Wellmore | 6.9% | 2 | 64 | 8.3% | 33% | 22 | 81.8% | 45.5% | 13.6% | 5 | 4.25 | 2 | 6.9% | 100.0% |
| Bridges | 27.5% | 5 | 56 | 64.3% | 94% | 23 | 65.2% | 65.2% | 13.0% | 2 | 4.54 | 4 | 17.4% | 50.0% |
| CGC Central | 7.5% | 1 | 38 | 66.1% | 76% | 16 | 75.0% | 93.8% | 50.0% | 5 | 4.45 | 3 | 18.8% | 66.7% |
| Charlotte Hungerford | 11.2% | 6 | 39 | 70.8% | 78% | 35 | 91.4% | 82.9% | 54.3% | 18 | 4.76 | 16 | 45.7% | 81.3% |
| Child and Family Agency of SE CT, Inc. | 10.6% | 5 | 48 | 59.0% | 70% | 18 | 50.0% | 77.8% | 44.4% | 8 | 4.60 | 6 | 33.3% | 66.7% |
| Community Health Center | 1.8% | 0 | 23 | 50.0% | 33% | 4 | 0.0% | 75.0% | 25.0% | 2 | 4.38 | 1 | 25.0% | 0.0% |
| Cornell Scott Hill Health | 5.9% | 1 | 30 | 61.9% | 90% | 23 | 43.5% | 69.6% | 56.5% | 7 | 4.60 | 6 | 26.1% | 33.3% |
| Child and Family Guidance Center | 13.3% | 6 | 50 | 73.6% | 82% | 33 | 78.8% | 69.7% | 33.3% | 16 | 4.41 | 9 | 27.3% | 55.6% |
| Community Child Guidance Clinic | 7.7% | 4 | 42 | 60.0% | 82% | 23 | 65.2% | 73.9% | 47.8% | 7 | 4.81 | 7 | 30.4% | 42.9% |
| Community Mental Health Affiliates, Inc. | 12.6% | 3 | 55 | 75.8% | 93% | 24 | 83.3% | 58.3% | 37.5% | 9 | 4.65 | 5 | 20.8% | 80.0% |
| Lower Naugatuck Valley | 11.1% | 4 | 26 | 83.3% | 82% | 12 | 100.0% | 75.0% | 41.7% | 7 | 4.54 | 5 | 41.7% | 40.0% |
| CGC Mid Fairfield | 6.5% | 2 | 12 | 80.0% | 90% | 8 | 100.0% | 62.5% | 62.5% | 6 | 4.74 | 5 | 62.5% | 80.0% |
| United Services, Inc. | 5.4% | 5 | 32 | 68.8% | 79% | 22 | 81.8% | 59.1% | 59.1% | 11 | 4.55 | 12 | 54.5% | 91.7% |
| Catholic Charities | 5.3% | 1 | 13 | 68.8% | 44% | 5 | 100.0% | 20.0% | 20.0% | 0 | n/a | 1 | 20.0% | 100.0% |
| Day Kimball Healthcare | 12.1% | 2 | 16 | 5.9% | 52% | 8 | 87.5% | 12.5% | 50.0% | 0 | n/a | 3 | 37.5% | 33.3% |
| Family Centers, Inc. | 13.9% | 2 | 24 | 60.5% | 78% | 9 | 66.7% | 77.8% | 44.4% | 1 | 4.75 | 3 | 33.3% | 100.0% |
| Lifebridge | 27.5% | 5 | 24 | 87.0% | 93% | 21 | 71.4% | 81.0% | 71.4% | 14 | 4.45 | 15 | 71.4% | 100.0% |
| Yale Child Study Center | 10.1% | 4 | 53 | 55.7% | 93% | 13 | 76.9% | 92.3% | 46.2% | 6 | 4.74 | 3 | 23.1% | 66.7% |
| Yale CSC- West Haven | 41.6% | 2 | 12 | 16.7% | 9% | 7 | 85.7% | 42.9% | 28.6% | 1 | 5.00 | 1 | 14.3% | 0.0% |
| Boys and Girls Village | 15.9% | 1 | 12 | 33.3% | 67% | 7 | 85.7% | 14.3% | 57.1% | 1 | 3.42 | 3 | 42.9% | 66.7% |
| Jewish Family Services | n/a | 0 | 7 | 37.5% | 86% | 1 | 100.0% | 100.0% | 0.0% | 0 | n/a | 0 | 0.0% | n/a |
| Connecticut Junior Republic | 21.3% | 3 | 10 | 65.5% | 48% | 10 | 20.0% | 100.0% | 70.0% | 4 | 4.56 | 7 | 70.0% | 71.4% |
| Waterford | 17.6% | 1 | 11 | 10.5% | 24% | 2 | 0.0% | 100.0% | 100.0% | 0 | n/a | 1 | 50.0% | 100.0% |
| Steve Kukolla | n/a | 1 | 3 | 100.0% | 100% | 1 | 0.0% | 100.0% | 100.0% | 1 | 4.00 | 1 | 100.0% | 100.0% |
| Helping Hands | n/a | 0 | 6 | 60.0% | 100% | 3 | 33.3% | 66.7% | 0.0% | 2 | 5.00 | 0 | 0.0% | n/a |
| **AVERAGE** | **7.7%** | **100** | **1165** | **59.0%** | **71%** | **583** | **71.4%** | **70.4%** | **42.0%** | **220** | **4.60** | **185** | **31.7%** | **67.6%** |

## TF-CBT Quality Improvement Indicators

January to June 2016

| Provider | c. Active in QI Period (Open and Closed) | d. % Assessment Up to Date | f. # Closed | g. % Caregiver Involved | h. % Engaged | i. % TN Complete | Closed with CSQ | j. Average CSQ | k. # Succ Complete with All Components | l. % Succ Completed with All Components | m. % Closed in LOS Window | # Benchmarks out of 8 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BENCHMARK | n/a | 65% | | 65% | 55% | 35% | n/a | 4.3 | n/a | 30% | 65% | 4 |
| Clifford Beers Clinic | 52 | 81% | 17 | 53% | 88% | 47% | 25 | 4.48 | 8 | 47% | 100% | 6 |
| Community Health Resources | 97 | 84% | 64 | 80% | 81% | 41% | 14 | 4.50 | 14 | 22% | 86% | 6 |
| Family & Children's Aid, Inc | 78 | 82% | 39 | 44% | 92% | 38% | 20 | 4.51 | 15 | 38% | 93% | 6 |
| Klingberg Family Centers | 10 | 90% | 6 | 50% | 100% | 67% | 1 | 5.00 | 3 | 50% | 67% | 6 |
| United Community and Family Services | 28 | 86% | 8 | 63% | 88% | 50% | 14 | 4.32 | 4 | 50% | 100% | 6 |
| Wheeler Clinic | 87 | 56% | 40 | 80% | 95% | 48% | 37 | 4.51 | 16 | 40% | 63% | 5 |
| Child Guidance Center of Southern Connecticut, Inc | 14 | 36% | 3 | 67% | 100% | 67% | 4 | 4.60 | 0 | 0% | | 4 |
| Family Services of Greater Waterbury, Inc | 40 | 95% | 21 | 76% | 76% | 38% | 19 | 4.30 | 8 | 38% | 100% | 7 |
| The Village for Families & Children, Inc | 56 | 77% | 27 | 74% | 93% | 30% | 15 | 4.69 | 7 | 26% | 86% | 5 |
| Wellmore Behavioral Health | 59 | 64% | 24 | 54% | 75% | 17% | 8 | 4.39 | 3 | 13% | 67% | 3 |
| Bridges, A Community Support System | 61 | 74% | 23 | 78% | 83% | 48% | 13 | 4.37 | 8 | 35% | 88% | 7 |
| The Child Guidance Clinic For Central Connecticut, Inc | 51 | 92% | 24 | 58% | 96% | 33% | 12 | 4.41 | 7 | 29% | 86% | 4 |
| Charlotte Hungerford Hospital | 56 | 96% | 25 | 84% | 88% | 72% | 24 | 4.64 | 14 | 56% | 100% | 7 |
| Child and Family Agency of Southeastern Connecticut, Inc | 63 | 51% | 19 | 32% | 95% | 47% | 19 | 4.57 | 9 | 47% | 78% | 5 |
| Community Health Center, Inc | 38 | 74% | 17 | 41% | 59% | 41% | 9 | 4.51 | 8 | 47% | 88% | 6 |
| Cornell Scott Hill Health Center | 43 | 88% | 17 | 18% | 100% | 12% | 14 | 4.41 | 1 | 6% | 100% | 4 |
| The Child and Family Guidance Center | 68 | 84% | 28 | 64% | 93% | 39% | 27 | 4.46 | 9 | 32% | 78% | 6 |
| Community Child Guidance Clinic, Inc | 36 | 81% | 13 | 46% | 85% | 62% | 17 | 4.57 | 6 | 46% | 83% | 6 |
| Community Mental Health Affiliates, Inc | 52 | 88% | 21 | 67% | 71% | 48% | 26 | 4.47 | 10 | 48% | 80% | 7 |
| Lower Naugatuck Valley Parent Child Resource Center | 26 | 58% | 14 | 93% | 100% | 21% | 8 | 4.60 | 3 | 21% | 67% | 4 |
| The Child Guidance Center of Mid-Fairfield County | 18 | 94% | 6 | 83% | 100% | 67% | 9 | 4.49 | 3 | 50% | 67% | 7 |
| United Services, Inc | 38 | 82% | 17 | 76% | 82% | 47% | 13 | 4.36 | 7 | 41% | 100% | 7 |
| Catholic Charities Archdiocese of Hartford | 25 | 68% | 12 | 92% | 83% | 17% | 6 | 4.69 | 2 | 17% | 100% | 5 |
| Day Kimball Healthcare | 16 | 38% | 5 | 40% | 100% | 40% | 2 | 4.54 | 1 | 20% | 100% | 4 |
| Family Centers, Inc | 25 | 80% | 13 | 23% | 69% | 31% | 3 | 4.31 | 3 | 23% | 67% | 4 |
| LifeBridge Community Services | 38 | 71% | 25 | 72% | 80% | 48% | 11 | 4.76 | 11 | 44% | 100% | 7 |
| Yale Child Study Center | 67 | 70% | 9 | 78% | 100% | 33% | 27 | 4.51 | 1 | 11% | 100% | 5 |
| Yale Child Study Center-West Haven | 10 | 80% | 3 | 33% | 67% | 33% | 3 | 4.50 | 0 | 0% | | 3 |
| Boys & Girls Village | 5 | 100% | 5 | 100% | 80% | 40% | 1 | 4.67 | 2 | 40% | 100% | 7 |
| Jewish Family Services | 10 | 60% | 6 | 83% | 83% | 50% | 4 | 4.52 | 3 | 50% | 100% | 6 |
| Connecticut Junior Republic | 18 | 67% | 6 | 50% | 100% | 67% | 3 | 4.00 | 4 | 67% | 75% | 5 |
| Waterford Country School, Inc. | 18 | 72% | 9 | 11% | 89% | 44% | 2 | 4.16 | 4 | 44% | 75% | 5 |
| Steve Kukolla LMFT | 3 | 67% | 1 | 0% | 100% | 100% | 2 | 4.75 | 1 | 100% | 100% | 6 |
| Veronica F. Quinn, LPC, NCC | 2 | | 2 | 50% | 100% | 0% | | n/a | 0 | 0% | | 1 |
| Helping Hands, Healing Hearts Counseling Services, LLC | 4 | 50% | 2 | 50% | 100% | 100% | 2 | 4.96 | 2 | 100% | 100% | 5 |
| Hop Brook Counseling Center, LLC | 2 | 100% | | | | | 1 | 4.50 | 0 | 0% | | 2 |
| Barbara L. Kauffman, LPC | 3 | 100% | | | | | 0 | n/a | 0 | 0% | | 1 |
| Elizabeth Domack | 1 | 100% | | | | | 0 | n/a | 0 | 0% | | 1 |
| AVERAGE/TOTAL | 1318 | 76.1% | 571 | 63.7% | 86.5% | 41.5% | 415 | 4.66 | 197 | 34.5% | 86.3% | |