

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

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CONNECTICUT'S TF-CBT COORDINATING CENTER



Connecticut TF-CBT Coordinating Center

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This report was developed for the Connecticut Department of Children and Families (DCF) by the Child Health and Development Institute (CHDI).

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The authors retain full responsibility for all opinions and content.

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I. EXECUTIVE SUMMARY

The Connecticut Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Coordinating Center (“Coordinating Center”) is located at the Child Health and Development Institute (CHDI). Funded by the Connecticut Department of Children and Families (DCF) and the Judicial Branch’s Court Juvenile Support Services Division (CSSD), the goal of the Coordinating Center is to expand access to high-quality, evidence-based practices (EBPs) for children exposed to trauma. Since 2007, the Coordinating Center has supported TF-CBT as an evidence-based treatment for children who experience symptoms related to trauma exposure, including symptoms of posttraumatic stress disorder (PTSD), depression, and anxiety. New in Fiscal Year 2025 (FY25, July 1, 2024 through June 30, 2025), the ARC (Attachment, Regulation, and Competency) intervention was added to increase service flexibility in addressing complex trauma from birth to young adulthood. ARC engages caregivers and addresses attachment disruptions, regulation difficulties, and competency building. **The Coordinating Center supports a network of 42 TF-CBT and 8 ARC providers throughout Connecticut** and provides training, credentialing, implementation support, site-based consultation, data collection and reporting, and ongoing quality improvement. This report summarizes the work of the Coordinating Center, highlighting the performance during FY25.

KEY FINDINGS FY25:



685 Youth received TF-CBT and **202** youth received ARC

Youth from diverse sociodemographic identities (race, ethnicity, sex) who received TF-CBT **experienced equivalent rates of high-quality service** (e.g., engagement, session frequency, available outcome data, symptom improvement, completing treatment components) and **improved treatment outcomes**.

63.2% of trained clinicians served at least one child with TF-CBT and **73.2%** served at least one child with ARC.



Providers **surpassed almost all quality improvement** benchmarks for TF-CBT services in FY25

92.9%
Caregivers

90.2%
Youth

reported **high satisfaction with TF-CBT treatment**



41 clinical staff were newly trained and 13 staff became credentialed in TF-CBT





KEY RECOMMENDATIONS:

- Improve service access by identifying and addressing factors contributing to a prolonged length of treatment and identifying strategies to increase caregiver involvement to support clinicians progressing through the TF-CBT components
- Continue to strengthen the integration of ARC within Connecticut's trauma-informed EBP service array by examining equitable outcomes and providing performance-based sustainability funds to ARC providers
- Enhance trauma screening practices and the provision of trauma interventions such as TF-CBT and ARC through ongoing implementation of Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT) training and consultation for trauma-focused EBP practitioners.

II. INTRODUCTION

The Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) model is an evidence-based treatment (EBT) for children aged 3-18 experiencing post-traumatic stress (PTS) symptoms from exposure to violence, abuse, and other forms of trauma. Since 2007, the Connecticut Department of Children and Families (DCF) has partnered with CHDI to serve as the TF-CBT Coordinating Center. Additional funding support by the Judicial Branch's Court Support Services Division (CSSD) supports access to TF-CBT services. The figure below illustrates the goals and primary activities of the Coordinating Center.¹

TF-CBT Coordinating Center Goals and Activities

Equity



Access



Increase Access to TF-CBT

Activities: Maintain Statewide network of provider agencies, train new clinicians in TF-CBT, support systems screening for trauma

Measured by: Children receiving TF-CBT over time and across the state

Do all groups have equal access to TF-CBT?

Quality



Ensure Quality of TF-CBT

Activities: Credentialing & Certification of clinicians, site-based implementation & consultation, data collection & reporting

Measured by: Clinicians meeting credentialing requirements; performance on quality improvement (QI) indicators and fidelity measures

Are all groups receiving high quality TF-CBT treatment?

Outcomes



Improve Outcomes for Children Receiving TF-CBT

Activities: Ongoing quality improvement work with agencies and periodic collection of assessment measures to monitor child symptoms and track changes

Measured by: Children experiencing reliable & significant improvement in PTSD symptoms, depression, problem severity or functioning

Are all groups benefitting from TF-CBT?

This FY25 report is framed across access, quality, outcome, and equity goals. As a new EBP in FY25, ARC implementation is examined across access and quality through an equity lens. Summary, conclusions, and recommendations are shared to guide future work.

1. A detailed accounting of these activities during FY25 can be found in Appendix A.

Achievements from Previous Fiscal Year

Over the past fiscal year, work has been carried out to address the recommendations from the FY24 annual report. Recommendations met include:

- **Adding ARC:** The inclusion of ARC to the TF-CBT initiative that broadened access to trauma-based services across Connecticut, particularly for youth aged 0 through 21 resulting in 57.4% of children ages 6-11 years of age receiving ARC treatment.
- **T-SBIRT Pilot:** The T-SBIRT protocol was introduced to five network providers to support trauma screening and identification of trauma related reactions, with the goal of motivating youth and families to engage in trauma focused treatment.
- **Advanced Trainings:** Increased advanced training opportunities were offered, including TF-CBT case conceptualization, TF-CBT assessment practices, and an ARC booster training. The ARC booster training focused on engagement factors and strategies when working with caregivers of trauma impacted children and youth, as well as integrating cultural identity into competency driven work with caregivers.
- **Trainings for Leadership:** Agency leadership efforts were supported through training opportunities such as *Cultural Sensitivity: A Framework for Leadership*, focused on providing culturally responsive supervision, with over 25 network leaders in attendance. Two TF-CBT specific office hours, hosted by a National TF-CBT trainer, were offered to support implementation. Additionally, individualized support was provided for leaders new to overseeing TF-CBT, including PIE training, implementation support and participation in TF-CBT training. Leadership was also given opportunities to attend the statewide EBP coordinator meeting to discuss

needs, strengths, and challenges, fostering reflection, shared learning, and identification of resources and training needs to support this work.

- **Supporting Equitable Access:** Outcomes across age, gender, and race/ethnicity continued to be monitored and reported to better understand equitable access to TF-CBT. With the inclusion of ARC, the array of services in Connecticut was expanded, helping to ensure increased access for youth of color, males, and children under the age of six.



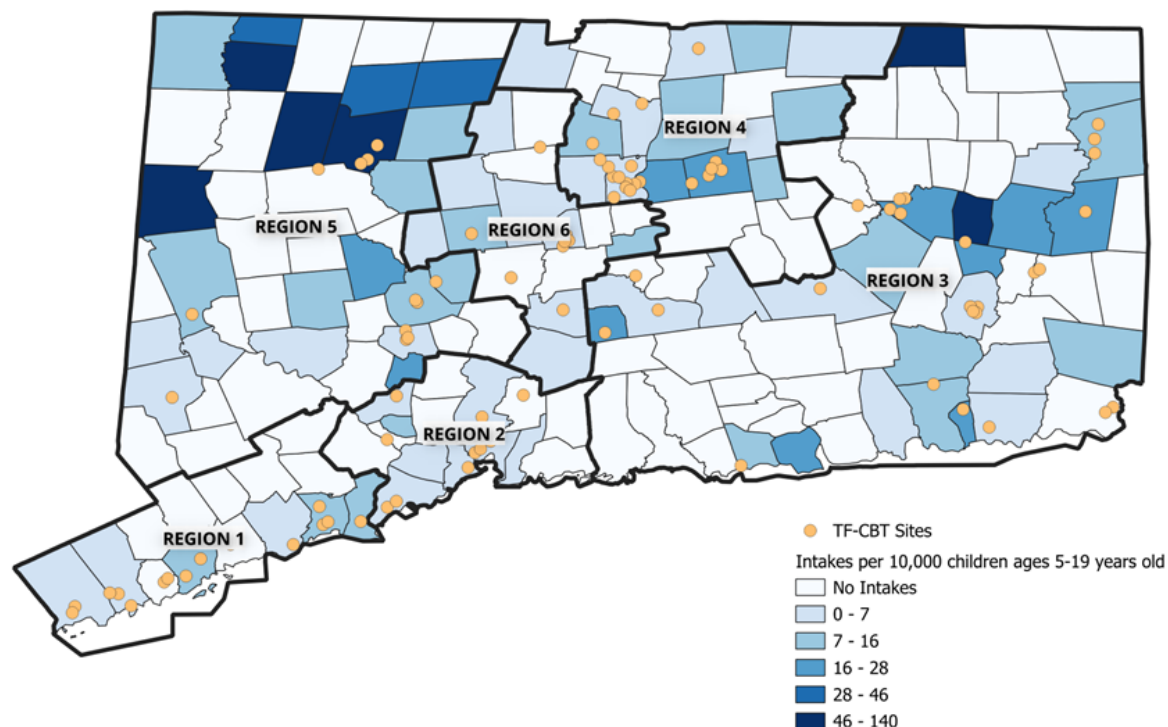
III. ACCESS TO TF-CBT AND ARC

The TF-CBT Coordinating Center aims to increase access to high-quality EBPs for youth exposed to trauma in Connecticut. This includes growing and sustaining the provider network across the state, and monitoring child characteristics to ensure access to TF-CBT and ARC.

Availability across the State

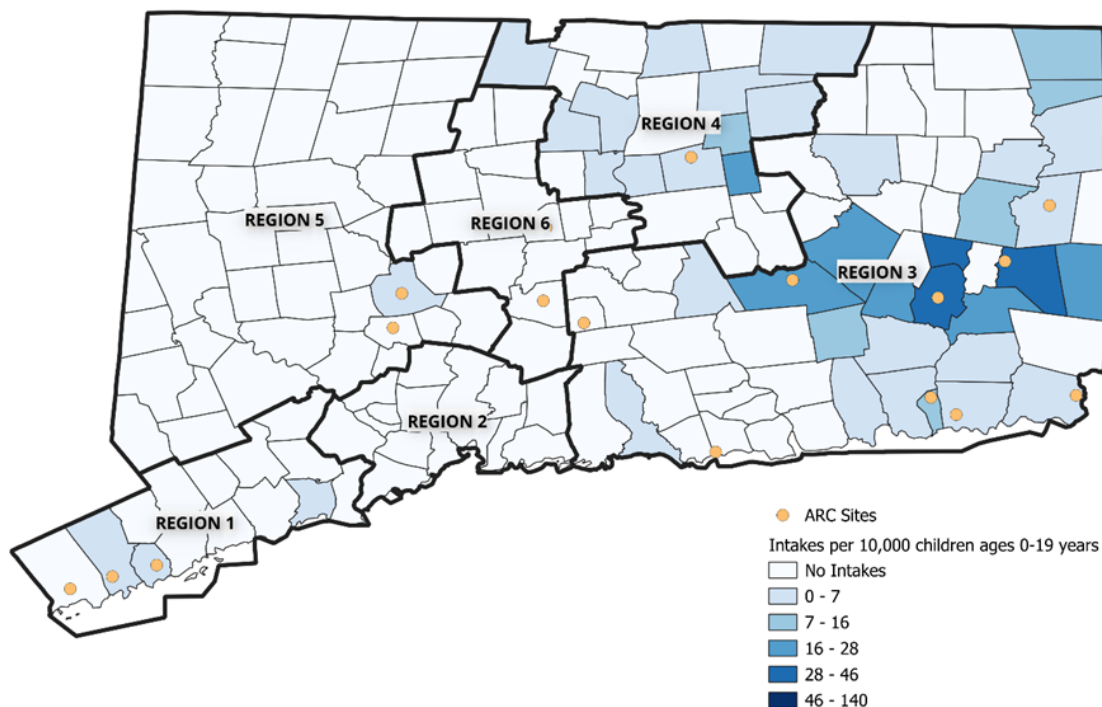
Forty-two providers offered TF-CBT in FY 2025 and eight providers offered ARC in FY 2025. Figure 1 shows the location of TF-CBT sites across the state with DCF regions and the number of intakes relative to population by town. Across the state, approximately 63.2% of clinicians on TF-CBT teams (n=192) provided TF-CBT to at least one youth during the year and approximately 73.2% of clinicians on ARC teams (n=52) provided ARC to at least one youth during the year.

Figure 1. Map of TF-CBT Providers in CT and Intakes per 10,000 Children SFY 2025



Eight providers offered ARC in FY25 across Connecticut. Figure 2 shows the location of ARC sites across the state with DCF regions.

Figure 2. Map of ARC Providers in CT and ARC Intakes per 10,000 Children SFY 2025



Clinician Training and Credentialing

Of the 304 TF-CBT clinicians, 83 (27.3%) left their teams during the year, an increase from FY24 (16.6%). Those agencies and supervisors who experienced attrition received ongoing training and support to enhance workforce development and sustain EBTs. In addition to 41 new clinicians completing TF-CBT clinical training, 37 clinicians participated in advanced TF-CBT training. Furthermore, the provider network was introduced to a one-day T-SBIRT training and consultation that was piloted in the spring with providers. T-SBIRT helps clients generate insight into the extent and effects of their trauma exposure and enhances their motivation to engage in treatment services such as TF-CBT and ARC. To meet the needs of the ARC clinicians and to maintain sustainability, ARC developed and provided its first booster training to 17 clinicians.

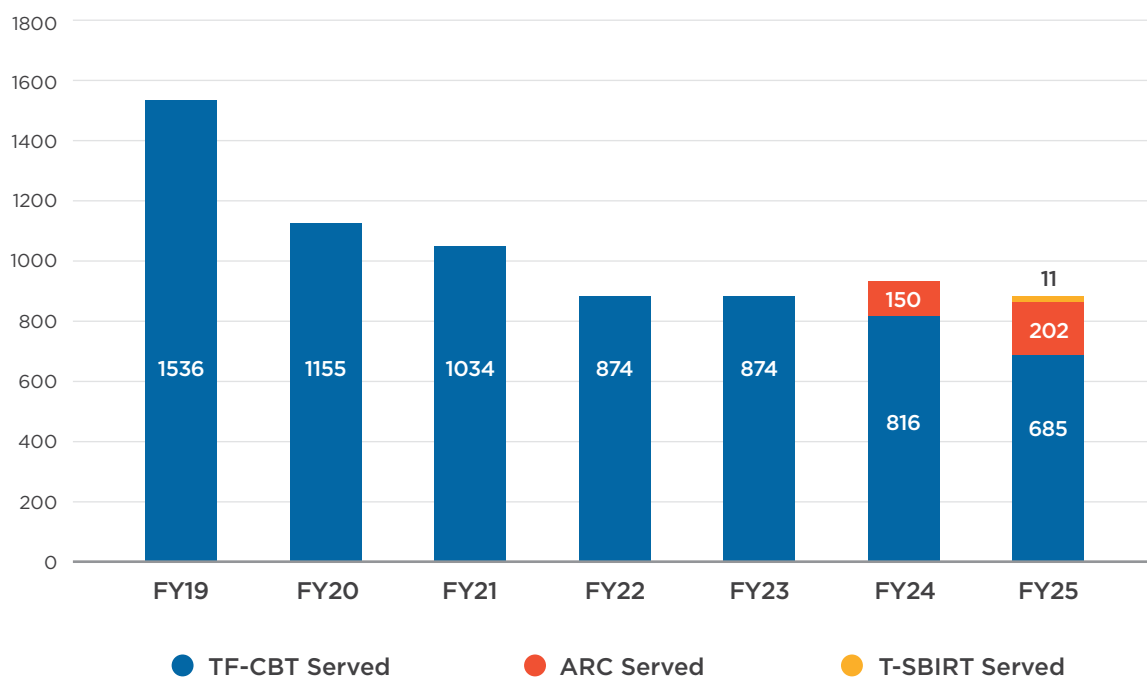
The annual EBP conference offered additional professional development opportunities for EBP clinicians, including presentations focused on increasing family engagement, navigating complex trauma, and working with youth with diverse needs (e.g., neurodiverse youth, therapy-resistant clients, and children with behavioral needs). Two workshops that were particularly well attended focused on cognitive behavioral strategies for irritability and aggression as well as the use of characters and stories children know to promote healing within TF-CBT treatment. Ongoing support to bicultural/bilingual clinicians implementing TF-CBT continued with 6 meetings taking place in FY25 to share resources, strategies and maintain peer support to strengthen service delivery with Latinx youth. As part of their professional development during the course of the year, 13 TF-CBT clinicians attained their TF-CBT state credential.

Children Receiving TF-CBT and ARC

Since 2007, 12,855 children have received TF-CBT in Connecticut. In FY25 alone, 685 children received TF-CBT, which includes 357 children who started treatment in the year. There were 202 children who received ARC this fiscal year with 123 children who started ARC treatment in FY25. Children in TF-CBT reported an average of 7.5 types of potentially traumatic events and children in ARC reported an average of 5.3; caregivers in TF-CBT reported that their children experienced ~6.3 types of potentially traumatic events and caregivers in ARC reported an average of ~4.4 types. TF-CBT remained the most common trauma-informed EBT with quality assurance protocols used in the outpatient setting.

The T-SBIRT training program was introduced at the end of FY25. T-SBIRT trained clinicians served 11 youth in the protocol across outpatient, school-based, and urgent crisis center settings.

Figure 3. TF-CBT, ARC and T-SBIRT Children Served by Fiscal Year



Child Demographics

Table 1 provides child characteristics in TF-CBT services during FY25 with comparisons to those served in outpatient services [as reported in DCF's Provider Information Exchange (PIE) system] and the general CT population. Throughout this report, indicators of access, quality, and outcomes are reported by demographic groups. Social and community context is highly related to service receipt and outcomes. Racism is part of that context that research has shown leads to inequities. Recognizing this, special consideration is given in this report to comparisons across racial and ethnic groups. This year efforts have been directed toward those who are eligible for TF-CBT but are not accessing services at this time. As part of the site consultation, providers were presented with TF-CBT access rates, including race/ethnicity compared to overall outpatient and equitable access. To improve the availability of



Spanish-speaking TF-CBT clinicians, providers received a stipend if they had an active Bilingual or Multilingual clinician on their team, and CHDI supported a regular meeting of Spanish-speaking TF-CBT clinicians.

In FY25, **TF-CBT (40.6%) and general outpatient care (36.7%) both served higher rates of Hispanic, Latino or Spanish (any race) children compared to ARC (26.2%) and the overall CT population (28.0%). TF-CBT (15.8%) and ARC (18.8%) both served higher rates of Black or African American youth than the overall CT population (12.2%). In addition, ARC served higher rates of Black or African American youth than general outpatient care population (16.7%).** In FY25, TF-CBT (2.5%) and ARC (3.5%) served fewer Spanish-speaking youth compared to general outpatient care (10.1%) and the overall CT population (14.3%). Accounting for nearly one in three TF-CBT youth, males (32.6%) were relatively underrepresented compared to ARC (50.5%) youth, outpatient (48.9%) youth and the general CT population (51.2%).

The average age of children who received TF-CBT is 12.2 years (SD=3.4) and average age of children receiving ARC is 7.6 years (SD=3.3). Children receiving TF-CBT and general outpatient services tend to be older compared to the CT population, which is consistent with mental health prevalence research showing lower rates among the youngest children. While the percentage of children under six receiving ARC (29.7%) was similar to the CT population (30.2%), the percentage of children in outpatient care under six was small (10.4%) and it was even smaller for those receiving TF-CBT (2.8%). TF-CBT can be used with children as young as three, but it is used much less frequently with the youngest children. The proportion of **children receiving TF-CBT (26.4%) and ARC (26.2%) who had child welfare involvement was double that of those in general outpatient services (13.0%).**

Table 1. Characteristics of children receiving TF-CBT (n=685) and ARC (n=202) with comparisons²

	ARC		TF-CBT		OPCC	CT Child Pop
	N	%	N	%	%	%
Sex (Male)	102	50.5	223	32.6	48.9	51.2
Race						
American Indian or Alaska Native	0	0	--	--	0.4	0.4
Asian	--	--	0	0	1.2	5.1
Black or African American	38	18.8	108	15.8	16.7	12.2
Native Hawaiian or Pacific Islander	0	0	--	--	0.2	0.1
White	139	68.8	376	54.9	52.2	53.2
Another Race (includes multiracial/ethnic)	23	11.4	31	4.5	3.5	29.0
Did not disclose/Missing	--	--	168	24.6	25.6	N/A
Hispanic, Latino, or Spanish (any race)	53	26.2	278	40.6	36.7	28.0
Age (years)						
Under 6 years	60	29.7	19	2.8	10.4	30.2
6-11 years	116	57.4	256	37.4	45.8	32.6
12-17 years	26	12.9	405	59.1	43.7	37.2
Child welfare involvement during treatment	53	26.2	181	26.4	13.0	2.3
JJ involvement during treatment	--	--	9	1.3	1.2	N/A
Child primary language						
Spanish	7	3.5	17	2.5	10.1	14.3
Neither Spanish nor English	--	--	--	--	1.9	8.5
Caregiver speaks English (no)	5	2.5	59	8.6	N/A	N/A

2. American Community Survey 2023-year estimates. Caution should be used with comparison to OPCC and TF-CBT child demographics. Census race categories exclude Hispanic ethnicity only for White children while TF-CBT, ARC and OPCC race categories exclude Hispanic regardless of race. We recognize there are alternate terms for describing ethnicity. This report uses "Hispanic" and "Latino" to remain consistent with the way it is reported in the data system, which reflects the terminology in the U.S. Census.

Census language is only available by language spoken, not primary language. Used Primary Language Inside of Home for children ages 5-17 for child primary language

Age is percentage of children 0-17 years

*-- category numbers suppressed due to small sample size

In FY25, Connecticut's TF-CBT network consisted of 42 providers. The loss of several private practices and 2 small agency providers contributed to the decline from FY24. In terms of individual clinicians at these agencies, there were 304 clinicians on the TF-CBT team during the year and 71 clinicians on the ARC team. Table 2 provides demographics on the TF-CBT and ARC clinicians.



Table 2. Characteristics of Clinicians providing TF-CBT (n=304) and ARC (n=71)		
	ARC %	TF-CBT %
Sex (Male)	7.0%	9.9%
Race/Ethnicity		
Black or African American Non-Hispanic	5.6%	10.5%
Hispanic, Latino, or Spanish (any race)	12.7%	21.7%
White Non-Hispanic	63.4%	54.6%
Other Race/Ethnicity Non-Hispanic	5.6%	4.9%
Missing Non-Hispanic	12.7%	8.2%
Languages Spoken		
Spanish	4.2%	18.8%
Other	5.6%	4.3%

IV. QUALITY: CONSULTATION AND CLINICAL IMPLEMENTATION

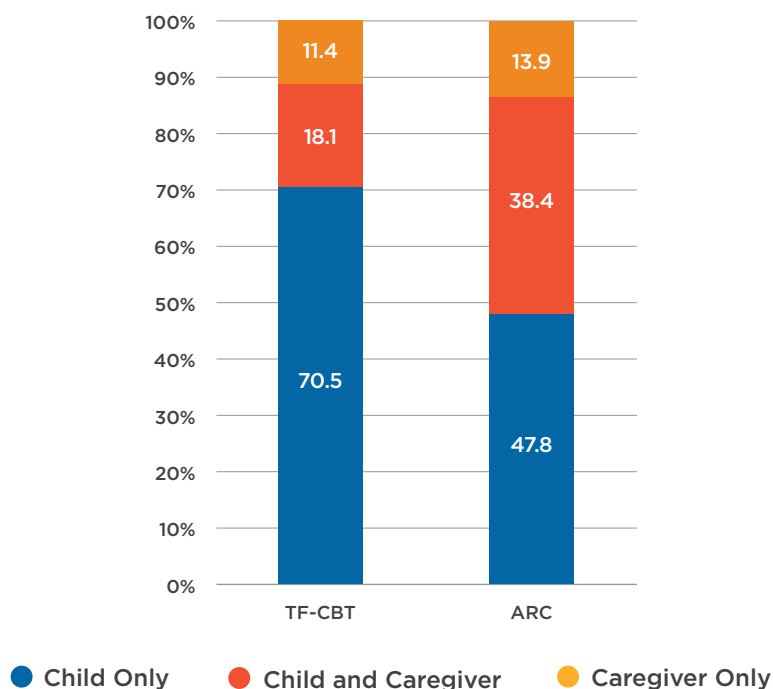


Model Implementation

Children completing TF-CBT attended an average of 23.96³ (SD=20.28) sessions. The average episode length of 9.9 (SD=6.6) months increased from last year and was higher than conventional expectations of model completion (between 12 to 16 sessions).

3. The mean was computed after winsorizing outliers in the data

Figure 4. FY25 TF-CBT and ARC Percentage Child and Caregiver Involvement



In FY25 caregiver involvement during TF-CBT sessions (29.5%) fell short of statewide benchmarks (33%). TF-CBT incorporates psychoeducation and parenting skills as integral components of the treatment program. As part of TF-CBT clinical training and consultation, caregiver engagement is addressed and continues to be emphasized as professional development needs among clinicians and new supervisors of the model.

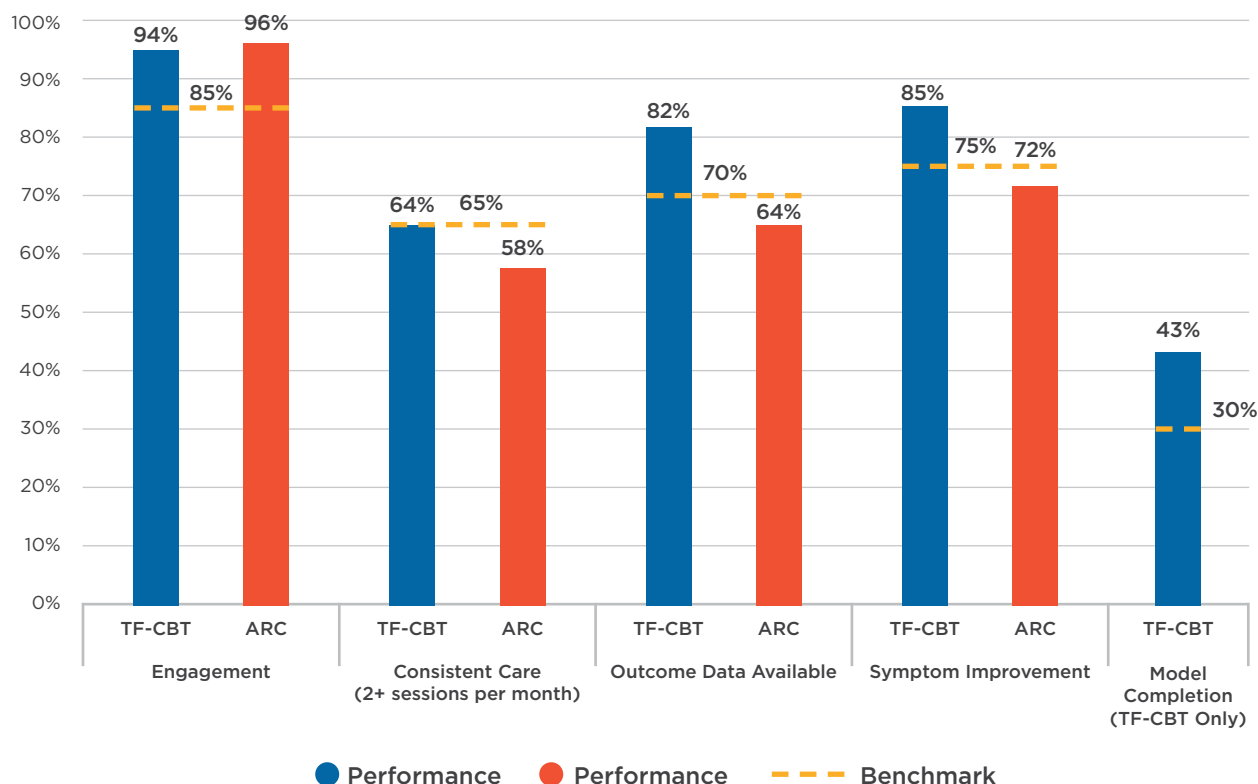
Nearly all children who received TF-CBT had a measure of baseline symptoms (98.8%). Of children discharged, 78.5% had at least one first and last version of a child symptom assessment (child or caregiver reporter) and 11.6% had data on caregiver symptoms. For children receiving ARC, 96.1% had a measure of baseline symptoms. Of children discharged in ARC, 63.2% had at least one first and last version of a child symptom assessment (child or caregiver reporter) and 51.3% had data on caregiver symptoms

Quality Improvement (QI) Indicators

Once children begin a TF-CBT or ARC episode, it is important they receive high-quality care that adheres to best practices and is associated with improved outcomes. The Coordinating Center monitors and reports on quality indicators that are used in site-based consultation with providers and to inform technical assistance efforts. The Coordinating Center, with funding from DCF, awards funding to agencies who meet QI indicators. Incentives are provided twice a year covering the performance periods of July 1-December 31 and January 1-June 30. Please note that sustainability funds were not awarded for ARC QI indicators in FY25. **Definitions of each quality indicator can be found in Appendix D.** Below are state-level results for key indicators of quality for FY25; they are calculated on the 404 children that had a TF-CBT episode and the 76 children that had an ARC episode that ended this year.

For this report, each indicator for children receiving TF-CBT was analyzed for difference between racial/ethnic/sex groups and no differences were found.

Figure 5. FY25 TF-CBT and ARC QI Indicators



All quality improvement indicators for TF-CBT surpassed benchmarks except for Consistent Care, which fell to 64% and just missed the 65% benchmark. Quality improvement indicators for ARC met the benchmark for engagement but fell short of the consistent care, collection of measures and improved outcomes benchmarks, as seen in Figure 5 above.

Satisfaction

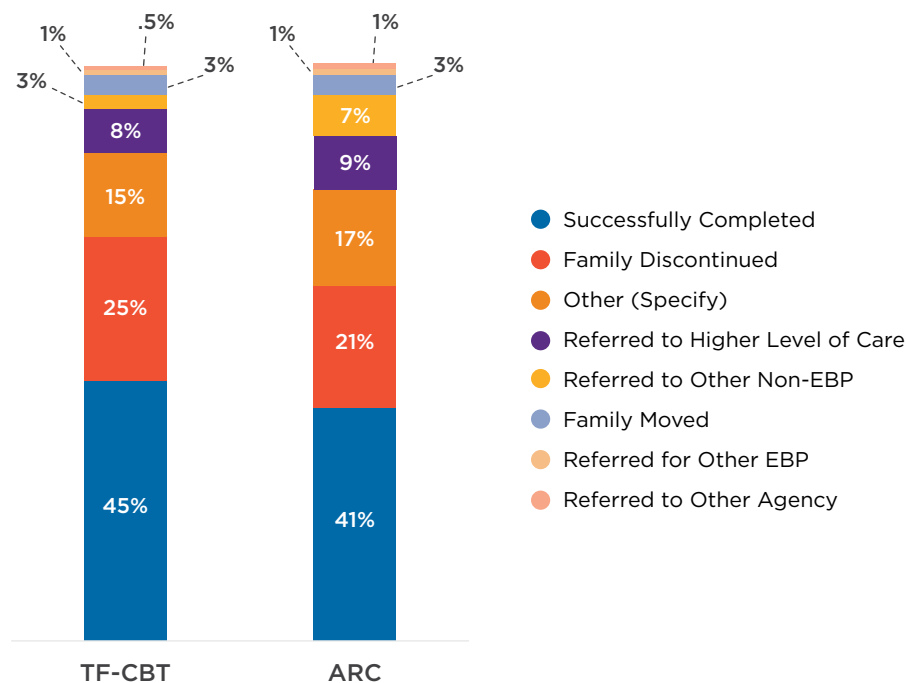
Of all caregiver reports (n=225), approximately 92.9% were moderately to extremely satisfied with TF-CBT treatment and of ARC caregiver reports (n=40), 87.5% were moderately to extremely satisfied. Of the child satisfaction reports (n=234), approximately 90.2% were moderately to extremely satisfied with TF-CBT treatment and of the child satisfaction reports (n=22), 95.4% were moderately to extremely satisfied with their treatment. **There were no differences in satisfaction by race/ethnicity or sex.**

V. OUTCOMES: IMPROVEMENT FOR CHILDREN

Successful Completion

In FY25 404 children ended their TF-CBT treatment episodes and 76 children ended their ARC treatment. Nearly half of TF-CBT (45%) and ARC children (41%) ended their treatment as “completing all EBT requirements”, seen in Figure 6, a slight increase from last year. While family discontinuation accounted for 25% of children who did not complete TF-CBT and 21% of ARC children, approximately 11% of TF-CBT children and 16% of ARC children were referred to either a higher level of care or other non-evidence-based practice (EBP) service. **Rates of successful discharge for TF-CBT children reported by clinicians were equivalent across sex, age, race/ethnicity, or trauma exposure (Appendix B, Table B1).**

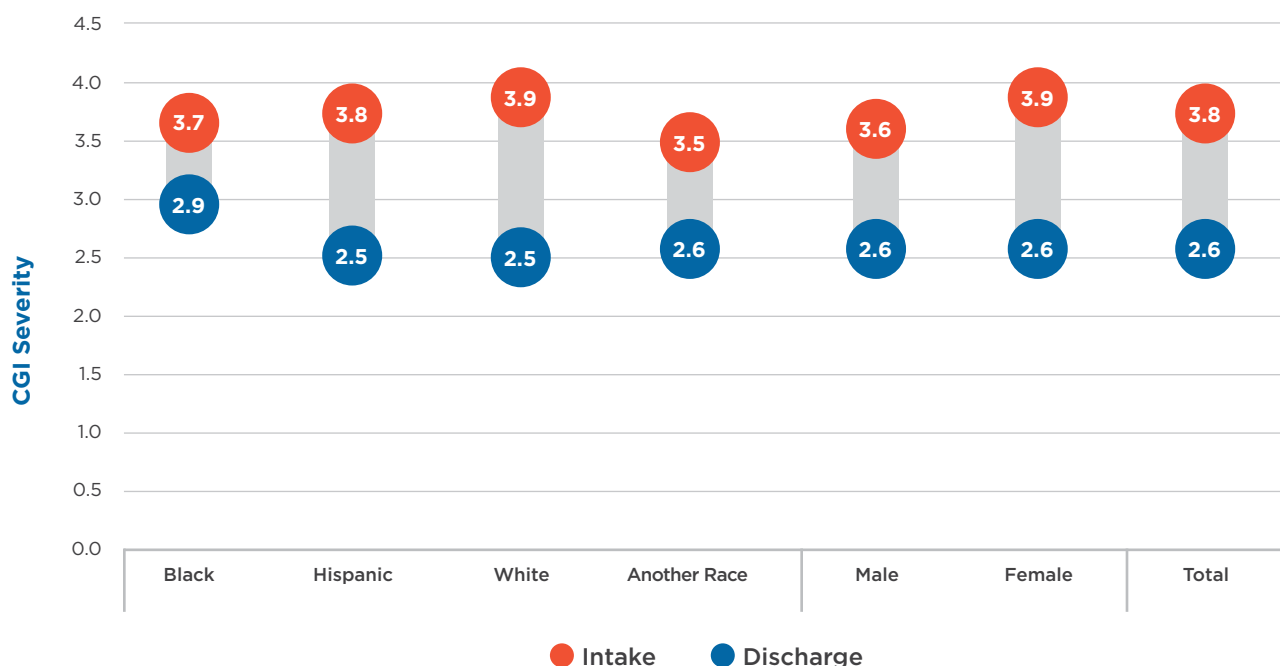
Figure 6. TF-CBT and ARC Reasons for Discharge in FY25



Clinical Global Impressions (CGI) Scale

The CGI Severity (CGI-S) and Improvement (CGI-I) scales were introduced in March 2021 and were increasingly used in FY25 to indicate clinical severity and improvement. On the CGI-S, 68.3% of TF-CBT youth changed from a more severe to a less severe category during treatment. **TF-CBT Youth showed equivalent rates of clinical severity improvement from Intake to Discharge regardless of race, ethnicity, and sex (Figure 7).** Clinicians reported symptom improvement for the majority of youth (87.7%) with the CGI-I.

Figure 7. TF-CBT CGI-S Intake and Discharge Scores



On the CGI-S, 64.1% of ARC clients changed from a more severe to a less severe category during the course of treatment. Clinicians reported symptom improvement for the majority of ARC youth (77.8%) with the CGI-I. The ARC sample size was too small to complete group comparisons.

Symptom Improvement

Overall Clinical Improvements

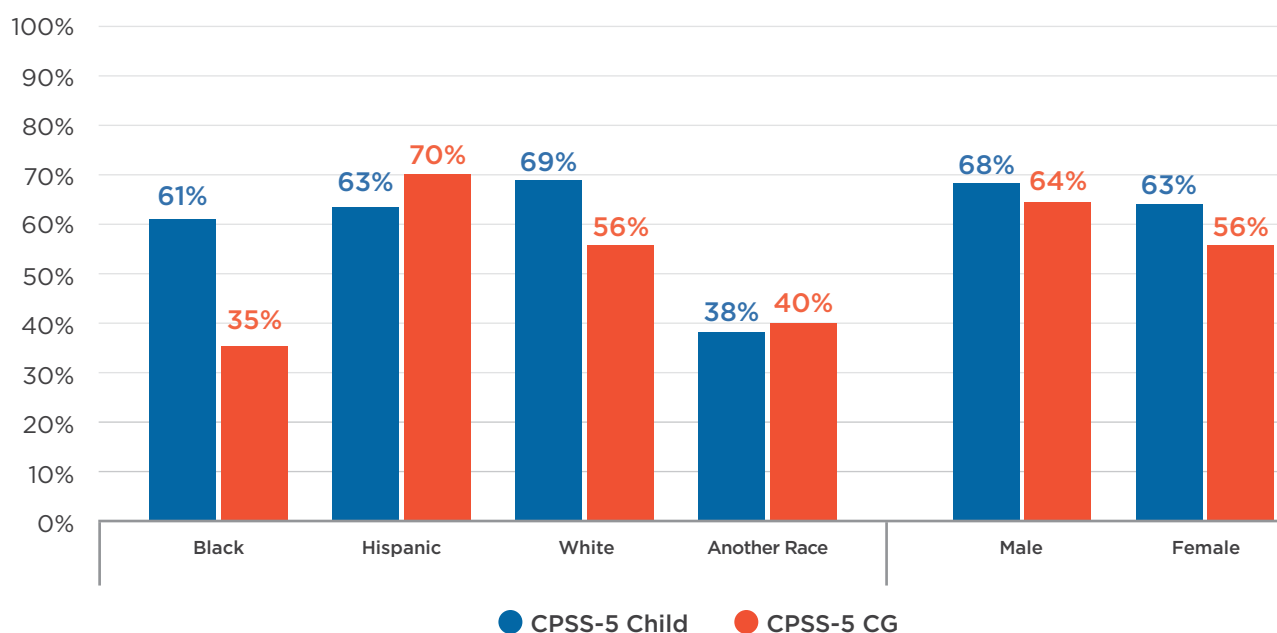
Across all measures, **83.9% of TF-CBT children showed significant reductions in one or more child symptom domains.** Children experienced **significant reductions in trauma, depression, and problem severity symptoms, as well as significant gains in functioning** (Appendix B, Table B2). Caregivers also experienced significant reductions in their own depression symptoms. In addition to documenting the overall rates of symptom improvement, it is important to monitor if any subgroups are experiencing disproportionate outcomes. Analyses were done to look at the effect of demographics (age, race/ethnicity, sex) on any reliable symptom improvement (RCI) across all measures. Analyses controlled for trauma exposure and successful completion. Youth who successfully completed treatment had higher rates of reliable change on any measure. **Youth showed equivalent improvement rates of RCI in any measure regardless of age, race, ethnicity, and sex.** (Appendix B, Table B4). These analyses were not conducted for ARC.

Child Improvement in Posttraumatic Stress Symptoms

Change scores were calculated when children were assessed at two or more time points, and the Reliable Change Index (RCI) values determined the percentage of children who experienced reliable

improvement (see Appendix C). On measures of posttraumatic stress symptoms, the most used measures, 64.1% of all youth showed reliable improvement on child reports, and 59.1% of youth showed reliable change on caregiver reports. Figure 8 shows the rates of improvement in CPSS scores by subgroup. **Black Non-Hispanic youth (35%) were less likely to show reliable improvement in Posttraumatic Stress Symptoms as reported by the caregiver than Hispanic youth (70%). There was no difference by Race/Ethnicity on reliable improvement on post-traumatic stress symptoms as reported by the child. (Figure 8 below).** These analyses were not conducted for ARC.

Figure 8. Percentage of TF-CBT Children that Show Improvement in Posttraumatic Stress Symptoms



In analyses controlling for child-level factors, youth who successfully completed treatment had greater posttraumatic stress symptom improvement. **Youth showed equivalent posttraumatic stress symptom improvement regardless of age, race, ethnicity, and sex** (Appendix B, Table B3).

VI. SUMMARY AND CONCLUSIONS

In FY25, high-quality TF-CBT and ARC services remained despite continued reports of workforce turnover and acute client needs. The total number of TF-CBT clinicians decreased in FY25 (304) with 63.2% active clinicians with at least one open case, as compared to FY24 (320) with 67.5% active clinicians. The addition of ARC broadened the array of services in Connecticut and helped ensure more youth of color, males, and children under 6 had access to trauma-informed EBPs. Furthermore, the addition of T-SBIRT is aimed at helping caregivers and youth better understand trauma exposure and symptoms, identify the need for trauma treatment, and improve engagement in needed services.

Of the 304 TF-CBT clinicians, 27.3% left their teams during the year compared to FY24's 16.6%. This increase in attrition reflects continued workforce turnover. Opportunities for reflection and providers to share best practices and successes in staff retention were provided through various network spaces to support the overall network. To enhance the TF-CBT workforce, 41 new TF-CBT clinicians were trained, 37 trained clinicians attended an advanced clinical training, and 13 TF-CBT clinicians became credentialed in TF-CBT.

In FY25, 685 youth received TF-CBT and 202 youth received ARC. The average age of children who received TF-CBT is 12.2 years ($SD=3.4$) and the average age of children receiving ARC is 7.6 years ($SD=3.3$). While the percentage of children under six receiving ARC (29.7%) was similar to the CT population (30.2%), the percentage of children in outpatient care under six was small (10.4%) and it was even smaller for those receiving TF-CBT (2.8%). TF-CBT can be used with children as young as three, but it is used much less frequently with the youngest children.

On average, children discharged from TF-CBT attended just under 24 sessions over the course of 9.9 months, which exceeds the recommended range (12 to 16 sessions). Caregivers participated in an average of 29.5% of TF-CBT sessions, which fell just short of the 33% benchmark, and 52.2% of ARC sessions. All quality improvement indicators for TF-CBT including engagement, collection of measures, improved outcomes, and model completion surpassed benchmarks except for Consistent Care. Just below the benchmark of 65%, Consistent Care fell at 64% in FY25 for TF-CBT services. Quality improvement indicators for ARC met the benchmark for engagement but fell short in consistent care, collection of measures and improved outcomes, but these indicators were not required for performance-based sustainment funds in FY25.



The primary reasons for discharge as reported by clinicians were successful completion (TF-CBT 45%; ARC 41%), family discontinued (TF-CBT 25%; ARC 21%) and terminating for other (TF-CBT 15%; ARC 17%) reasons (e.g., referred to a higher level of care or another service, model or agency). Successful discharges predicted symptom improvement, and the rate of successful completion is similar to the past three years. The majority of children who did not successfully discharge, still improved by the end of treatment. Across all measures, 83.9% of children showed significant reductions in one or more child symptoms. The CGI-I showed a similar rate of improvement (87.7%) indicating that this brief measure is comparable to lengthier clinical measures.

Youth from diverse sociodemographic identities (race, ethnicity, sex) who received TF-CBT experienced equivalent rates of access, high-quality service (e.g. engagement, session frequency, available outcome data, symptom improvement, completing treatment components) and improved treatment outcomes. The only exception was for PTSD symptoms reported by the caregiver, where **Black Non-Hispanic youth (35%) were less likely than Hispanic youth (70%) to show reliable improvement in Posttraumatic Stress Symptoms as reported by the caregiver. There was no difference by Race/Ethnicity on reliable improvement on post-traumatic stress symptoms as reported by the child.**

Compared to child outpatient services and ARC, children younger than six and male youth received TF-CBT services at lower rates of service, Black youth were served at a slightly lower rate than outpatient services, and children with child welfare involvement and youth or who identified with Hispanic, Latino or Spanish origins had proportionally higher access to the TF-CBT model. Attention to these access differences during quality improvement consultation and additional training will help to ensure youth with trauma exposure equitably receive TF-CBT services. Of note, youth who identified as male,



Black/African American, or Multiracial/Multiethnic received ARC services at proportionally higher rates than similar youth in TF-CBT services. Though preliminary, this early trend is a positive step in broadening access to high-quality, trauma-informed EBPs in Connecticut.

Conclusion

In FY25, the statewide implementation of TF-CBT and ARC continued to ensure that youth across Connecticut have access to high quality, trauma-informed care. Despite the lower numbers of children served and fewer clinicians offering TF-CBT, high-quality TF-CBT and ARC services remain. Within TF-CBT, consistent rates of treatment completion, symptom improvement, and quality care were found across all racial, ethnic and gender groups. Notably, Black youth met model completion requirements at equivalent rates to other racial and ethnic groups this fiscal year, representing an improvement of FY24 and contributing to improved equitable access and outcomes. Further, engagement rates in TF-CBT reached a post-pandemic high (94.3% FY25 vs. 87.0% FY19) along with rates of measures being completed at two timepoints (81.9% FY25 vs 81.0% FY19 and 77.5% FY24). Youth who ended their TF-CBT treatment in FY25 reported high satisfaction with treatment (90.2%) along with their caregivers (92.9%). The inclusion of ARC continues to complement TF-CBT by offering flexibility for youth and families. ARC was frequently used with children under the age of 6, serving a similar percentage of children under 6 compared to the general population (29.7% ARC vs. 30.2% CT population) and serving a higher percentage of children under 6 compared to TF-CBT (29.7% ARC vs 2.8% TF-CBT). ARC also showed strong representation of Black/African American youth, (18.8%) exceeding both the overall CT population (12.2%) and general outpatient care population (16.7%). Improving access to TF-CBT and ARC remains a high priority and, to that end, a brief trauma screening, brief intervention, and referral to treatment protocol (T-SBIRT) was also introduced toward the end of FY25 in an effort to improve identification of children and youth in need of trauma-focused services, enhance engagement with trauma focused interventions, and thereby expand access.



VII. RECOMMENDATIONS

To further strengthen access, quality, and outcomes within the TF-CBT statewide network, the following goals are recommended for FY26:

- Continue to strengthen the integration of ARC within Connecticut's trauma-informed EBP service array by examining equitable outcomes and providing performance-based sustainability funds to agencies that provide ARC.
- Improve service access by identifying and addressing factors contributing to a prolonged length of treatment and identifying strategies to increase caregiver involvement to support clinicians progressing through the TF-CBT components. Additionally, examine whether symptom acuity limits clinicians' capacity to take on additional cases and identify strategies to address this barrier.
- Maintain high standards of care while improving service access by offering incentives to clinicians who conduct new intakes with the aim of increasing the number of youth and families who successfully complete TF-CBT treatment.
- Enhance trauma screening practices and the provision of trauma interventions such as TF-CBT and ARC through ongoing implementation of Trauma Screening, Brief Intervention, and Referral to Treatment (T-SBIRT) training and consultation for trauma-focused EBP practitioners.
- Strengthen resources for bicultural/bilingual clinicians by creating and distributing a centralized resource platform, and offering peer support group opportunities to foster a connected and supported bilingual workforce across the state.
- Support equitable service access and quality across race, ethnicity, and sex by implementing culturally responsive CBT training for clinicians and supervisors across the network to enhance effectiveness in working with diverse families.

VIII. APPENDIX A: ACTIVITIES, TRAININGS, AND DELIVERABLES

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

1. Training, Consultation, & Credentialing

- Provided two TF-CBT clinical trainings in September 2024 and January 2025 for 41 new clinicians.
- Completed 6 series of clinical consultation calls (64 total calls) for 52 clinicians.
- Completed two advanced clinical trainings (37 clinicians in total attended) that focused on assessment use and case conceptualization.
- Conducted 2 one-hour office hour sessions that offered clinicians that opportunity for guidance and support on various aspects of TF-CBT clinical practice.
- Provided one T-SBIRT Training in March 2025 for 11 clinicians.
- Completed one ARC Booster training in June 2025 to 17 ARC clinicians
- Maintained a training record database to track training and consultation attendance of all TF-CBT providers.
- Convened the 17th annual EBP conference, featuring 32 workshops with 17.6% meeting the cultural competency CE requirement. A total of 398 unique participants from community providers, DCF, CSSD and other partners attended the conference.

2. Implementation Support, Quality Improvement, & Technical Assistance

- Produced reports for two QI performance periods based on developed TF-CBT QI Indicators and Benchmarks (Appendix D).
- Provided 120 virtual implementation consultation site visits.
- Convened three Coordinator meetings focusing on sharing implementation and successful meeting strategies.
- Convened six meetings for bicultural/bilingual TF-CBT clinicians
- Provided monthly data dashboards, quarterly QI benchmarks reports, quarterly RBA, and annual reports.

3. Data Systems

- Maintained a public directory site that provides a searchable, public listing of TF-CBT providers through EBP Tracker (<https://ebp.dcf.ct.gov/ebpsearch/>).
- Monitored, maintained, and provided technical assistance for online data entry for all TF-CBT providers in PIE.
- Continued data-driven reporting and ad hoc data support requests as needed.

4. Agency Sustainment Funds

- Analyzed and reported two aggregated and team-specific financial incentive reports for six-month performance periods and administered biannual performance-based sustainability funding.
- Distributed \$377,336 in performance-based sustainment funds to agencies.

IX. APPENDIX B: REGRESSION TABLES

Table B1. TF-CBT Logistic regression analyses for predicting successful discharge from selected background characteristics

Predictors	N	β	SE	Wald	e^B (95% CI)
Hispanic	93	-0.263	0.283	0.866	0.768 (0.441,1.338)
Black Non-Hispanic	29	-0.655	0.443	2.191	0.519 (0.218,1.237)
Sex (male)	80	-0.18	0.288	0.391	0.835 (0.475,1.468)
Child age	236	-0.059	0.048	1.501	0.943 (0.857,1.036)
Trauma Exposure-THS Child	236	-0.035	0.049	0.5	0.966 (0.877,1.064)
Trauma Exposure-THS CG	236	-0.011	0.055	0.042	0.989 (0.888,1.101)
Constant		1.229	0.661	3.46	3.419

* p<.05

As compared to White females

**p<.01

Outliers were found and corrected for child reported trauma exposure

***p< .001

Another race/ethnicity non-Hispanic group removed due to low n

Table B2. TF-CBT Descriptives and change scores for all assessment measures

Assessment Name	Construct	Above Cutoff	Intake Mean (S.D.)	Last Mean (S.D.)	Change Score	t-score	Effect Size (Cohen's d)	Remission
CESD-R (n=38)	Caregiver Depression	17	17.89	10.45	-6.89***	-3.97	Medium	8/17
		44.7%	(12.15)	(9.35)			0.644	47.1%
CPSS V Child (n=276) CPSS V Caregiver (n=193)	Symptoms	171	35.35	21.47	-13.86***	-14.395	Large	109/171
		62.0%	(15.87)	(15.39)			0.866	63.7%
		67	26.47	15.62	-16.81***	-12.77	Large	49/67
		34.7%	(14.03)	(12.8)			0.919	73.1%
SMFQ Child (n=74) SMFQ Caregiver (n=50)	Depressive symptoms	51	10.59	7.82	-2.60***	-4.59	Medium	23/51
		68.9%	(5.88)	(6.12)			0.534	45.1%
		30	9.86	6.81	-2.97***	-3.59	Large	13/30
		60.0%	(6.54)	(6.66)			0.800	43.3%
Ohio Problem Severity Child (n=194) Ohio Problem Severity Caregiver (n=230)	Severity of internalizing/externalizing behaviors	89	24.45	18.49	-5.71***	-6.69	Small	48/89
		45.9%	(14.13)	(13.12)			0.480	53.9%
		79	21.66	14.99	-6.59***	-8.58	Medium	52/79
		34.3%	(13.87)	(12.51)			0.566	65.8%
Ohio Functioning Child (n=196) Ohio Functioning Caregiver (n=240)	Child's adjustment and functioning	48	52.95	58.56	5.71***	6.57	Small	34/48
		24.5%	(12.97)	(12.07)			0.469	70.8%
		66	51.9	57.14	5.08***	6.74	Small	35/66
		27.5%	(14.00)	(13.63)			0.435	53.0%

* p<.05 Effect sizes were derived using Cohen's d as follows: .2 = small, .5 = medium, .8 = large
 **p<.01 Outliers were found and corrected for the following first scores: CESD-R, SMFQ (caregiver), Ohio PS (child and caregiver),
 ***p< .001 Ohio Functioning (child and caregiver). Another race/ethnicity non-Hispanic group removed due to low n
 Outliers were found and corrected for the following last scores: CPSS 5 (caregiver), SMFQ (caregiver), Ohio PS (child and caregiver), Ohio Functioning (child and caregiver)
 Outliers were found and corrected for the following change scores: CESD-R, CPSS 5 (child and caregiver), SMFQ
 Caregiver, Ohio PS (child and caregiver), Ohio Functioning (child and caregiver)

Table B3. TF-CBT Multiple regression analysis of selected demographic variables on change in outcome scores.

Predictors	Change in CPSS 5 Child			Change in CPSS 5 Caregiver		
	β	SE	95%CI	β	SE	95%CI
Constant	-4.511	5.819	(-15.981,6.959)	-21.298	7.677	(-36.468,-6.127)
Trauma Exposure	-0.86*	0.337	(-1.525,-0.196)	-0.775	0.494	(-1.752,0.201)
Hispanic	0.214	2.734	(-5.174,5.603)	-0.899	4.143	(-9.085,7.288)
Black non-Hispanic	1.86	3.923	(-5.872,9.591)	-1.179	7.713	(-16.422,14.064)
Sex (male)	0.618	3.611	(-6.498,7.735)	0.389	4.633	(-8.766,9.545)
Child age	0.024	0.395	(-0.754,0.803)	0.404	0.54	(-0.663,1.47)
Child discharged as "successful"	-8.04***	2.207	(-12.39,-3.69)	6.067	3.184	(-0.226,12.36)
R²	0.062			0.075		
F	2.523*			2.151		

* p<.05 As compared to White females
 **p<.01 Another race/ethnicity non-Hispanic group removed due to low n
 ***p< .001 Outliers were found and corrected for child reported trauma exposure and CPSS change scores

Table B4. TF-CBT Logistic Regression analyses for predicting any child symptom RCI from selected background characteristics

Predictors	N	β	SE	Wald	e ^B (95% CI)
Hispanic	93	0.135	0.354	0.145	1.144 (0.572,2.291)
Black Non-Hispanic	29	0.04	0.517	0.006	1.041 (0.378,2.866)
Sex (Male)	80	-0.089	0.354	0.063	0.915 (0.457,1.833)
Child Age	236	0.059	0.061	0.916	1.061 (0.94,1.196)
Trauma Exposure-THS Child	236	0.111	0.063	3.102	1.117 (0.988,1.263)
Trauma Exposure-THS Caregiver	236	-0.086	0.069	1.575	0.917 (0.802,1.05)
Child Discharged as "Unsuccessful"	122	-2.136***	0.391	29.782	0.118 (0.055,0.254)
Constant		1.449	0.822	3.105	4.259

* p<.05 As compared to White females
 **p<.01 Another race/ethnicity non-Hispanic group removed due to low n
 ***p< .001 Outliers were found and corrected for child reported trauma exposure and CPSS change scores

X.APPENDIX C: RELIABLE CHANGE INDEX

Reliable change index (RCI) values were proposed by Jacobson and Traux (1991) as a way to identify when a change in scores is likely not due to chance. The value for a given instrument is calculated based on the standard deviation and reliability of the measure. Change scores are then calculated and when the change exceeds the RCI value, it is considered to be reliable and significant. When values exceed half of the RCI value, but do not meet the RCI value, that is considered partial RCI.

A review of available literature was conducted for the assessments included in this manual, which are used in EBP Tracker and PIE. If articles did not include an explicit RCI value, one was calculated using the equation proposed by Jacobson and Traux (1991) with the appropriate values indicated in the research. Values used in the calculation were drawn from literature on the assessment unless noted otherwise. The following table includes a summary of the appropriate RCI values for the assessments.

Measure		Full RCI	Partial RCI
Child Assessments	CPSS IV (retired)	11	6
	CPSS V	15	8
	PROMIS	6	3
	SMFQ	7	4
	UCLA	16	9
Ohio Scales	Ohio Problem Severity* (Child, Caregiver, & Worker versions)	10	5
	Ohio Functioning (Child, Caregiver, & Worker versions)	8	4
Caregiver Assessments	CESD-R	9	5
	CPSS IV (retired)	10	5
	CPSS V	15	8
	PCL-5	10	5
	PROMIS	6	3
	PSS	11	6
	SMFQ	6	3
	UCLA	11	6
	YCPC	18	9

XI. APPENDIX D: QI OVERVIEW

A complete list of the current QI indicators, benchmarks, and definitions is included below.

QI Indicators	Benchmark	QI Description
Engagement	85% of closed episodes	Percentage of closed episodes with four or more clinical sessions attended. Starting SFY21 the benchmark for this indicator changed from 55% to 85%.
Outcome Data Available/ Measures	70% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with at least one measure available at two different time points for any measure of child or caregiver symptoms.
Symptom Improvement/ Improved Outcomes	75% of closed and engaged episodes with measures available	Percentage of closed and engaged treatment episodes with measures available with at least partial reliable change (symptom improvement only) on any measure. Includes any measure of child or caregiver symptoms.
Consistent Care	65% of closed and engaged episodes	Percentage of closed and engaged treatment episodes with an average of two or more treatment episodes per month. Calculated by dividing the LOS by number of visits.
All Components/ Model Completion *TF-CBT Only	30% of closed and engaged episodes	Percentage of closed and engaged treatment episodes that fully complete the model. Model completion definitions are: TF-CBT: completion of all required child treatment components and 8 or more sessions

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